REVISED TEMPLATE FOR
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	239,761 people
Square miles	8817 sq miles
Population density	27
Number of counties (total)	9
◆ **Number of urban counties**	0
◆ **Number of rural counties**	8
◆ **Number of frontier counties**	1

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
Portland	San Patricio	16408	70895	101	23%

Sinton	San Patricio	5676	70895	101	8%
Taft	San Patricio	3396	70895	101	5%
Aransas Pass	San Patricio and Aransas Counties	10189	70895	101	14%
Rockport-Fulton	Aransas	9938	27530	114	36%
Beeville	Bee	13129	34105	39	38%
George West	Live Oak	2524	12409	12	20%
Alice	Jim Wells	19010	42455	49	45%
San Diego	Duval	4753	12041	7	39%
Kingsville	Kleberg	12575	31990	36	39%
Falfurrias	Brooks	5297	7866	8	67%

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.

- High number of bilingual (English/Spanish) speaking individuals who reside in service area
- Kingsville has an Air Force base
- Aransas County just went through closure of military base, many unemployed individuals in San Patricio and Aransas Counties
- Multiple refineries/chemical plants in San Patricio and Aransas county – limited health insurance coverage due to “turn-arounds” or “shutdowns”
- Large ranching areas in several counties
- Multiple “border check points” in service area
- Recent closure of Naval Station Ingleside in San Patricio, County

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.

FY 2008-2009 Planning Cycle:

- Posted 2008-2009 procurement documents as directed by rule: external website, DSHS website, Electronic Business Daily
- Posted 2008-2009 procurement documents in local newspapers

- Planning meetings held with stakeholders to obtain feedback from community and notify potential providers of upcoming procurement process
- Contacted potential providers to notify them of RFP
- Notified community coalitions and community support groups of RFP (NAMI Rockport; Law Enforcement Coalition Group – Southern Counties)
- Conducted follow-up contacts with identified providers
- Potential provider meeting scheduled – not attendance
- Posted RFP
- No RFP Responses

FY 2010-2011 Planning Cycle:

- Reviewed previous listing of potential providers from FY 2008-2009 planning cycle
- Sent letters to the 4 interested providers from the previous planning cycle, informing them of the upcoming procurement process and how to post interest on LPND/DSHS website
- Notified current providers of procurement and how to post interest on LPND/DSHS website
- Checked local yellow-pages and web browser to see if any new Mental Health service providers had located to the south Texas area (none noted that provide rehabilitative services in their advertisements)
- Contacted all interested providers who posted on the DSHS website to coordinate provider conference call
- Held interested provider conference call

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	Posting on DSHS Website FY 2010-2011 and letter potential provider list	Teleconference held on April 26, 2010. Explained CPMHMR's plans for procurement. Asked potential providers if they had any alternative ideas for procurement. The Wood Group expressed that they do not feel that there are enough consumers in CPMHMR service area to contract out to two providers. Not interested in providing crisis hotline/MCOT services. Will send letter expressing this.	No further action necessary. See attached letter

Peggy J. Heuston	Posting on DSHS Website FY 2010 – 2011 potential provider list	Ms. Heuston is not currently licensed in the State of Texas to provide CBT/Counseling services. She was notified by mail that upon receipt of her license, she can apply, vial open enrollment, to become a provider for CBT services as per our Center's RFA	Provider not currently licensed in the state of Texas to provide services
National Smart Health Care	Posting on DSHS Website FY 08-09 potential provider list	No interest expressed in FY 2010-11 planning cycle.	Further follow-up not necessary
Maxim Health Care	Posting on DSHS Website FY 08-09 potential provider list	No interest expressed in FY 2010-11 planning cycle.	Further follow-up not necessary
Tele-Care Mental Health Services of Texas	Posting on DSHS Website FY 2010-2011 potential provider list	Teleconference held on April 26, 2010. Explained CPMHMR's plans for procurement. Asked potential providers if they had any alternative ideas for procurement. Telecare expressed that they do not feel that there are enough consumers in CPMHMR service area to contract out to two providers. Not interested in providing Crisis Hotline/MCOT services. Will send letter expressing this.	No further action necessary. See attached e-mail
Avail Solutions, Inc.	Posting on DSHS Website FY 2010-2011 potential provider list	Teleconference held on April 26, 2010. Explained CPMHMR's plans for procurement. Asked potential providers if they had any alternative ideas for procurement. Avail Solutions, Inc. expressed that they do not provide anything but Crisis Hotline/MCOT services. They will bid on these services when posted.	Post Crisis Hotline/MCOT for procurement as planned.
Rebecca Kraatz, PhD	Posting Rcd via e-mail 5/27/10 not posted on website	Indicated that she wanted to provide all services. Left message on June 2, 2010 to clarify services she wished to provide. On June 3, 2010 Dr. Kraatz clarified she wished to provide cognitive behavioral therapy (CBT), not all services and supports.	Currently CBT provider for Center. No further follow-up needed.

Local Planning

Guidelines for Gathering Community Input

- CONDUCT THE PROVIDER ASSESSMENT BEFORE GATHERING INPUT FROM THE COMMUNITY.
- The scope and focus of community input will depend on the availability of external providers.
- Seek guidance on network development based on your knowledge of provider availability at the time.
- Information presented in this section of the plan should be specific to the network development plan. Ensure that stakeholders understand the statutory mandate to develop the provider network when qualified providers are available. Community input should be focused on how to use available external capacity based on local needs and priorities.
- If an LMHA has no interested providers, community input should be focused on other elements of the plan (e.g., reducing identified barriers to new providers, on potential strategies for attracting external providers, improving consumer access and choice)
- When gathering input, use the previous plan as the starting point for discussion, including the plans for procurement and the results.
- Before finalizing your plan, review the DSHS website to identify any additional potential providers.

3) Status of provider availability assessment

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

___X__ Yes _____ No

If no, briefly describe the difference.

4) Community Engagement

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

Description, Location/Format, and Date or Timeframe	**Participating Organizations (List)**	**Summary of Input** Briefly summarize input relating to the network development plan. If the LMHA has identified interested providers, include recommendations for how the LMHA should implement the mandate to develop the provider network.	**Number of Individuals**		
			Consumers	**Family**	**Other**
Surveys – completed 11/13/09	**Stakeholders from all nine counties**	Respondents continue to feel that psychiatric services (doctors) should be contracted out; would like more doctors to decrease wait time. A few respondents felt that services should be contracted out to provide more choice. Most respondents indicated that they were satisfied with services and didn't want to change, though they did want less staff turnover, more doctors services and "talk" therapy, not just "skills training and/or case management" **448 respondents – 39 surveys thrown out due to incompleteness of demographic information (respondent type/location)**	322	36	51
PNAC meeting **8/8/2009**	**Consumers, Family Members,** **Community Members**	Review of Procurement attempt of Aransas and Bee Counties – no respondents to RFP. PNAC members questioned value of attempting to procure services (cost of RFP process as potential contractors were sent RFP packets, newspaper, local and state website postings were completed to notify potential bidders of the procurement opportunity and staff time) when there are no responses to RFP. Other contracting of services were reviewed and approval of contracts (laboratory and pharmacy services were approved, based upon best value)	**1**	**2**	**2**
Rockport MH Advisory Meeting **10/14/09**	**School Representatives and NAMI members**	Surveys were provided to the group. Procurement process was reviewed with the group. Group expressed concern regarding transition of consumers. Planning coordinator explained that a transition plan would be developed to assist consumers if two contractors were found. Agreed choice would be nice, however didn't feel that community could support two providers.	**1**	**0**	**4**
Community Action MH Support Group **10/15/09**	**CACOST and MH Consumers**	Surveys were provided to the group. Procurement process was reviewed with the group. Many group members expressed concern that they would lose their case managers and psychiatrist. They did not like the idea of contracting out MHMR services. Many stated that they had a choice and still choose to come to MHMR. Very animated group discussion as fear that MHMR was going to be "taken away from them". Advantages of choice were explained and procurement process, in detail. Multiple follow-up conversations occurred to reassure consumers that they were not going to loose MHMR services.	**10**	**0**	**2**
CRCG South	**School,**	Surveys were provided to the group. Procurement process was reviewed with the	**0**	**0**	**10**

10/21/09	**CACOST, Hospital, detox center, MHMR**	group. Group felt that focus of state should be education of community regarding mental illness, substance abuse services and providing additional funding for services.			
Law Enforcement Meeting **10/21/09**	**Sheriff, Police, BH Hospitals, Medical Hospitals, Judges, Probation**	Review of procurement requirements by MHMR staff. Majority of law enforcement officials indicated that they did not wish for services to be contracted out to private agencies – they wished for CPMHMR local staff to provide services, 24 hours a day, 7 days a week. They did not wish to hear the laws requiring procurement of services. They felt that day time staff should be on-call at night and on weekends to provide services and supports to consumers.	**0**	**0**	**14**
NAMI Rockport meeting **10/29/09**	**Family Members Consumers**	Surveys were provided to the group. Procurement process was reviewed with the group. Several in group expressed that they did not wish to see a change, that they were satisfied with CPMHMR. Others expressed concern regarding transition of consumers if there were two contractors that came in. Planning coordinator explained that a transition plan would be developed to assist consumers if two contractors were found and safety net services available. Some agreed that a choice might be nice, however, if they have insurance they already have a choice. Most of group felt that Rockport could not support two providers.	**7**	**4**	**0**
PNAC meeting **11/14/09**	**Consumers, Family Members, Community Members**	Review of Surveys completed 11/13/09. PNAC agreed that multiple surveys needed to be thrown out due to incompleteness of the survey. Agreed that choice of individual service providers (e.g. doctors, CBT therapists, etc…) needed. Education regarding services and limitations needed, especially in regards to CBT and benefits of skills training.	**1**	**2**	**1**
PNAC meeting **2/6/10**	**Consumers, Family Members, Community Members**	Reviewed/made recommendations regarding procurement of Mental Health Services. Agreed to continue with Network Development Plan – attempt to procure Aransas and Brooks Counties first. If two providers interested, procure or procure with one and be secondary, if State Authority will allow. Approved RFP for MH Crisis follow-up (possibly) and temp services for MR services.	**2**	**3**	**2**
PNAC meeting **5/1/10**	**Consumers, Family Members,** **Community Members**	Reviewed response to LPND Inquiries posted on the DSHS website and contacts made with the agencies who expressed interest in being providers of mental health services. Teleconference call was discussed and potential providers responses were provided to the PNAC. PNAC agreed that as the two providers who had expressed interest in providing complete MH service pkgs are no longer interested that the Center should not pursue the RFP process for complete service pkgs. RFP should go out for Crisis hotline/MCOT. They also agreed that the Center should continue with the current contracts such as CBT, psychiatric services, lab, etc…as they have previously agreed	**4**	**1**	**1**

		upon.			
CRCG North **6/16/10**	**Community Members**	Reviewed LPND Plans and response to teleconference. Provided survey regarding contract services and barriers to choices of mental health providers. Concern expressed regarding why the state would want to split up MHMR services. An explanation of the network development process was provided, to include the opportunity for choice. The CRCG members expressed understanding but also expressed that the consumers needed consistency. There was a concern that there sometimes was a long time to get into services. Service package 5 and intake process was explained. Agree that consistency with one crisis hotline/crisis response team keeps things consistent and provides continuity of services.	**0**	**0**	**9**
CRCG South **6/23/10**	**Community Members**	Reviewed LPND Plans and response to teleconference. Provided survey regarding contract services and barriers to choices of mental health providers. Members expressed understanding of the process and noted that it would be difficult for two providers to be able to support themselves in the rural areas, but expressed how this might provide choice in urban areas.	**0**	**0**	**6**
Voices Leadership Group **6/24/10**	**Consumers and Community Members**	Reviewed LPND Plans and response to teleconference. Provided survey regarding contract services and barriers to choices of mental health providers. Barriers identified to attracting private providers include: lack of regular, affordable transportation; rural area = increased drive time for providers and large service area with low density of population making it difficult to support two or more providers; larger cities are more attractive to private providers. Agree that one crisis hotline and crisis response team keeps things consistent. Some people would like more choice in doctors.	**12**	**1**	**3**

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
PNAC meeting **8/8/2009**	Review of Procurement attempt of Aransas and Bee Counties – no respondents to RFP. PNAC members questioned value of attempting to procure services (cost of RFP process as potential contractors were sent RFP packets, newspaper, local and state website postings were completed to notify potential bidders of the procurement opportunity and staff time) when there are no responses to RFP. Other contracting of services were reviewed and approval of contracts (laboratory and pharmacy services were approved, based upon best value – cost, services for consumers, etc…)

PNAC meeting **11/14/09**	Review of Surveys completed 11/13/09. PNAC agreed that multiple surveys needed to be thrown out due to incompleteness of the survey. Agreed that choice of individual service providers (e.g. doctors, CBT therapists, etc…) needed. Education regarding services and limitations needed, especially in regards to CBT and benefits of skills training.
PNAC meeting **2/6/10**	Reviewed/made recommendations regarding procurement of Mental Health Services. Agreed to continue with Network Development Plan – attempt to procure Aransas and Brooks Counties first to see if there are potential providers willing to provide services in our service area, have the qualifications to provide the services and can provide quality services and supports prior to branching out to the larger clinics. If two providers interested, procure or procure with one and be secondary, if State Authority will allow. Approved RFP for MH Crisis follow-up and temp services for MR services.
PNAC meeting **5/1/10**	Reviewed response to LPND Inquiries posted on the DSHS website and contacts made with the agencies who expressed interest in being providers of mental health services. Teleconference call was discussed and potential providers responses were provided to the PNAC. PNAC agreed that as the two providers who had expressed interest in providing complete MH service pkgs are no longer interested that the Center should not pursue the RFP process for complete service pkgs. RFP should go out for Crisis hotline/MCOT. They also agreed that the Center should continue with the current contracts such as CBT, psychiatric services, lab, etc…as they have previously agreed upon.

Provider Network Development

6) <u>Contract Expenditures</u>

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	$3,997,074	$1,918,169	48%	$4,062,506	$1,932,607	48%	$4,015,274	$1,908,002	48%	$1,996,620	$950,838	48%
Child/Adol MH Services	$1,300,080	$180,986	14%	$1,197,885	$179,767	15%	$1,181,512	$263,554	22%	$625,892	$94,839	15%
TOTAL MH Services	$5,297,154	$2,099,155	40%	$5,260,391	$2,112,374	40%	$5,196,786	$2,171,556	42%	$2,622,512	$1,045,677	40%
Breakout of CONTRACTED SERVICES:												
Medication and Labs		$1,257,550	60%		$1,201,882	57%		$968,268	45%		$478,874	46%
Physician Services**		$459,196	22%		$489,809	23%		$525,394	24%		$248,968	24%
Counselor Services**		$9,546	0%		$16,876	1%			0%			0%
Crisis Services		$26,100	1%		$26,100	1%		$166,800	8%		$69,500	7%
Residential Services			0%			0%			0%			0%
Inpatient Services		$346,763	17%		$377,707	18%		$429,288	20%		$197,350	19%
Other (list):			0%			0%	Family Part	$3,920	0%	Family Part	$6,369	1%
			0%			0%	CBT	$64,876	3%	CBT	$34,951	3%
			0%			0%	Peer	$13,010	1%	Peer	$9,665	1%
TOTAL		$2,099,155	100%		$2,112,374	100%		$2,171,556	100%		$1,045,677	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
South Texas Psych.	◆ Psychiatric	Organization	597,600
Avail Solutions	◆ Mobile Crisis, Hotline	Organization	166,800
North Bay	◆ Inpatient	Organization	Total Inpatient 368,000
Northwest Behavioral	◆ Inpatient	Organization	

Padre Behavioral	◆ Inpatient	Organization	
Barbara Granger	◆ Family Partner	Individual	Total Family Part 5,500
Elizabeth Trevino	◆ Family Partner	Individual	
Walter Ebarb	◆ Peer Provider	Individual	Total Peer 13,850
Sylvia Molina	◆ Peer Provider	Individual	
Billy Johnson	◆ Peer Provider	Individual	
Heather Janosky	◆ Peer Provider	Individual	
Bonnie Ryder	◆ Peer Provider	Individual	
Adela Trejo	◆ CBT	Individual	Total CBT 67,700
Mary Ann Johnson	◆ CBT	Individual	
Rebecca Kraatz	◆ CBT	Individual	
Quest Diagnostics	◆ Lab	Organization	47,825
ETBH	◆ Drugs	Organization	887,000

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	1334								1
Adult RDM SP 2	70								1
Adult RDM SP 3	292								1
Adult RDM SP 4	22								1
Adult RDM SP 0	99								
Adult RDM SP 5	18								1
TOTAL Adult Services	1835								
Child Service Packages									
Children's RDM SP 1.1	406								1
Children's RDM SP 1.2	12								1
Children's RDM SP 2.1	0								1
Children's RDM SP 2.2	10								1
Children's RDM SP 2.3	0								1
Children's RDM SP 2.4	0								1
Children's RDM SP 4	45								1
Children's RDM SP 0	21								
Children's RDM SP 5	0								1
TOTAL Children's Services	494								

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, Adult*	10685 events	100%	100%	100%	100%	100%	100%	1	1
Diagnostic Eligibility Assessment, Adult**	2175 events	100%	100%	100%	100%	100%	100%	1	1
Counseling, Adult	6056 units	74%	74%	74%	74%	74%	74%	4	1
Crisis Intervention Services, Adult ***	6605 units	35%	35%	35%	35%	35%	35%	1	1
Inpatient Psychiatric Services, Adult	739 events	100%	100%	100%	100%	100%	100%	3	1
Pharmacological Management, Child*	2795 events	100%	100%	100%	100%	100%	100%	1	1
Diagnostic Eligibility Assessment, Child**	478 events	100%	100%	100%	100%	100%	100%	1	1
Counseling, Child	485 units	52%	52%	52%	52%	52%	52%	4	1
Crisis Intervention Services, Child***	1399 units	20%	20%	20%	20%	20%	20%	1	1
Family Support Group	269 units	100%	100%	100%	100%	100%	100%	1	1
Family Partner Services	15	100%	100%	100%	100%	100%	100%	1	1
Inpatient Psychiatric Services, Child	29	100%	100%	100%	100%	100%	100%	3	1

* 100% of doctor/psychiatric services are provided by external contract psychiatrists. This line item's events includes ancillary nursing services.

** Diagnostic Eligibility Assessment should be titled "Initial Psychiatric Evaluations" as the Intake Services conducted by LPC's have been removed from the units of services to accurately reflect the external contract psychiatric services.

*** Crisis Intervention Services – 100% of Crisis Hotline services are provided by external contract. Beginning February 2010 100% of MCOT evening, weekend and holiday face-to-face crisis assessments are provided by external contract. Prior to February 2010, this was a part-time contract for non-peak evening/weekend hours.

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.

Rationale for procurement of select/individual services:

Private providers of MH Rehabilitative Services who expressed interest in providing full service package services indicated on the teleconference call that the service area and population served could not support two (2) providers in the service area. Letters expressing this were provided to the Center.

Select/Individual Services to be Procured:

- **Crisis Hotline and Mobile Crisis Outreach Team services. Sole-source procurement process through RFP process. Sole-source as to prevent confusion for the consumers and local community and to ensure continuity of care.**
  - **100% of crisis hotline (24 hour/day; 7 days a week; 365 days a year)**
  - **Peak and non-peak after hour mobile crisis outreach for all 9 counties. Day-time crisis outreach will continue to be provided through the mental health clinic through activation from crisis calls and crisis-walk-ins**

- **Continued contracting of Cognitive Behavioral Therapy (CBT) through open enrollment**
  - Adult CBT 74%**;**
  - Children's CBT 52% due to availability of trained CBT therapists in area of need.

- **Psychiatric services – for both Adult and Children's Services – 100%**

Other Services (Non-billable) Procured:

- **Pharmacy – 100%**
- **Laboratory – 100%**
- **Peer Support – 100%**
- **Family Partners – 100%**

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			

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
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.

n/a

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.

- **n/a**

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
n/a	

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

Award date: 9/1/10	RFP	Crisis Hotline	All 9 counties	100%	➢ Re-compete for this service through RFP Competitive Bid ➢ Discrete services – 24 hour crisis hotline to be certified by AAS and meet all state authority qualifications, to include QMHP-CS screeners to ensure a single, centralized system is in place to prevent confusion for the consumers, family members and the community. ➢ All 9 counties to be served to ensure centralized system to prevent confusion for the public
Award date: 9/1/10	RFP	Mobile Crisis Outreach Team	All 9 counties	100%	➢ Re-compete for this service through RFP Competitive Bid ➢ Competitive Bid ➢ Discrete services – 24 hour crisis hotline to be certified by AAS and meet all state authority qualifications, to include QMHP-CS screeners to ensure a single, centralized system is in place to prevent confusion for the consumers, family members and the community. ➢ All 9 counties to be served to ensure centralized system to prevent confusion for the public
Ongoing	RFA	Cognitive Behavioral Therapy	All 9 counties	Up to 100%	➢ Network Maintenance - Open enrollment ➢ Discrete services – CBT to attempt to provide choice of therapists and ensure therapy services are provided to those who qualify for CBT in both adult and children's service packages ➢ Therapists can choose to provide services based upon county they reside in/are closest to. Office space is provided within the mental health clinics to provide access for consumers of services and assistance in scheduling is provided.
Award date: 9/1/11	RFA	Psychiatric Services	All 9 counties	100 %	➢ Open Enrollment ➢ Discrete services – psychiatric group currently under contract. Contract includes requirement to travel to MH Clinics; provide face-to-face services; provide a minimum

					number of service units per clinic; to provide on-call crisis consultation services and medical director/Utilization Management oversight ➢ All 9 counties to be served
Ongoing /various award dates	RFA	Inpatient Psychiatric Hospital	All 9 counties	100%	➢ Network Maintenance - Open enrollment ➢ Discrete services – to provide least restrictive setting for psychiatric inpatient services – currently 3 hospitals on contract ➢ Contracts typically run for 2 years to ensure best value/lock in of bed-day cost

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.

Continuity of Care oversight through Authority Oversight with the Center's LPHA's authorization of hospitalizations and continuing to be on-call for face-to-face assessments for crisis and for consultations. The LMHA will also provide Quality Management oversight to ensure appropriate service provision, quality service issues and oversight of rights issues, to include least restrictive environment. A system is already in place to review crisis logs and crisis rehabilitation assessments, as well as an annual site visit to ensure staff training, accreditation and quality assurance efforts are ongoing for crisis services. Internal monitoring of contract provider services is also ongoing through review of progress notes and quality assurance efforts to ensure fidelity to the model, when applicable. The Center has a stringent compliance plan protocol to also provide oversight to ensure compliance with state contract requirements.

15) Enhanced Staff Qualifications
Do you require any individual practitioners to meet higher standards than those described in the DSHS performance contract?
__X___Yes _____ No

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

- **Psychiatric Services** – require Board Certified Psychiatrists and majority of services by psychiatrists to be face-to-face

Consumer Choice

16) <u>Single Provider</u>
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. <u>Enter NA if you have no interested providers</u>.

Service to be Provided by a Single Provider	Reason(s) for Limiting Client Choice
Crisis Hotline and Mobile Crisis Outreach Team	To ensure a single, centralized system is in place to prevent confusion for the consumers, family members and the community

17) <u>Choice and Access</u>
Using bullet format, briefly describe plans for maximizing consumers' choice of providers and access to services, including relevant procedures, procurement specifications, and contract provisions.

- **Psychiatric Services:** Current psychiatric group of three (3) doctors work together to provide choice of doctors to consumers who have personality differences with current doctor, to include providing opportunity to change practitioner, clinic, or poly-com with another doctor
- **CBT:** Center continues open enrollment and offer CBT training through certified practitioner/trainer employed by the Center. Two service sites have multiple CBT therapists for consumer's to choose from.
- **Crisis Hotline/Mobile Crisis Outreach Team:** 24 hour hotline is accessible to anyone in the community. Consumers/family members and community members are educated regarding hotline services. Hotline is listed in local telephone books and website. MCOT team is located at centralized site with 24 hour awake staff who can access all service area's w/in one hour of activation.

18) <u>Diversity</u>
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.

- **Crisis Hotline and Mobile Crisis Outreach Team** contracts require contractors to have bi-lingual (Spanish and English) speaking people on staff and ability to access translators, to include deaf interpreters
- **Crisis Hotline/MCOT**: Current contract with Crisis Hotline and temporary contract for MCOT requires bi-lingual (Spanish and English) speaking people on staff and ability to access translators, to include deaf interpreters
- **CBT:** Several CBT providers are bilingual (Spanish and English)
- **Biligual staff are available at all clinic site to provide translation for any contractors (psychiatrists/CBT) and contracts are in place/arrangements continue to be made for individuals who require translation other than Spanish** *(e.g. ASL, Vietnamese)*

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.

- Emergency contract with Avail Solutions, Inc. for Mobile Crisis Outreach Team services resulted in cost savings in the form of deletion of Administrative Personnel; also savings in benefits for employees (insurance, retirement plan, etc.) and overhead costs such as vehicle maintenance, cell phones, and building usage at night.
- Decreased Center cell phone by 18 phones
- 17 landlines (telephone) eliminated with zero loss of efficiency or access to services
- Mileage costs and dispersements are regularly evaluated to prevent padding of mileage and ensure accuracy, thus decreasing costs
- Locked in low electricity rate for the next two years, resulting in decreased energy bills
- Purchased building in Beeville saving in rental costs
- Evaluated current contractors for maintenance and repairs – replaced several based upon performance and costs
- Changing over to electronic records to save on paper/filing costs
- Contract Psychiatrists and CBT providers travel to clinics at their own expense resulting in no mileage costs
- Laboratory Services – previous lab services came to the local clinics to conduct draws, current lab contract the consumers are responsible for going to local lab for annual/ordered lab work. Lab contract cost decreased significantly.
- Pharmacy contract change resulted in significant decrease in medication costs, better assistance in patient assistance program applications/approval thus increase in free/reduced cost medications for consumers.
-

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
9/1/09	East Texas Behavioral Health	Pharmaceutical Services
89/1/09	Camino Real	CPMHMR provides QM Oversight of Crisis Hotline Services

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

-

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)
n/a	

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.

- Billing Department continues to improve efficiency in submission, collection of funds
- External providers (CBT) have access to internal electronic medical records system to allow for submission of progress notes and internal monitoring to ensure compliance with state and federal guidelines
- Center-wide process has been is in the beginning phase of implementation to have all internal and external providers submitting progress notes electronically to increase efficiency in managing the provider network for billing and to ensure accuracy of data submitted.

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
Rural areas served has small service population which is not large enough to support two providers	Barring dramatic population growth in our areas, this will continue to be a barrier to providing choice to our consumers from at least two private providers for our consumers. Center will continue to pursue single service providers through the procurement process.
Service area is large (9,349 square miles of both land and water, majority of this is land), with many consumers residing in rural areas and towns; Gas prices continue to rise. Limited public transportation	The Center continues to work closely with rural transportation service providers (e.g. Medicaid transportation, Community Action Agency, REAL transportation) to link consumers up to low cost transportation resources. Center will work with public providers of transportation to

	improve joint transportation efforts

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.

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.

- Crisis Hotline and Mobile Crisis Outreach Team will continue to be procured
- Psychiatric services will be posted for procurement to see if there are any new interested providers
- CBT will continue to be posted as RFA to encourage open enrollment to provide choice for people served
- Inpatient Hospitalization will continue to be posted as an RFA to encourage open enrollment to provide opportunities for least restrictive environment (hospitalization close to home) for people served

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.

-

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
7/1/10 – 7/15/10	Draft procurement document (RFA/RFP) posted for public comment (at least 14 days) * In FY 2011 Mobile Crisis Outreach (MCOT) and 24 hour Crisis Hotline Services will be procured. Currently, Avail Solutions, Inc is providing these service. There have been no other agencies that have expressed interest in being a provider of these service.
7/16/10	Publication of final procurement

8/2/10	Due date for procurement responses
8/17/10	Award date
9/1/10	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.

*** the only services that will be procured in FY 2011 will be Mobile Crisis Outreach (MCOT) and 24 hour Crisis Hotline Services. Avail Solutions, Inc is currently providing these services. There have been no other agencies that have expressed interest in being a provider of this service. If there is a change in providers, this consumer transition timeframe will be followed. If there is no change in providers, it will not be necessary to notify the consumers of any change or choice as this will be a "sole source" provider.**

The above procurement

Date or Timeframe	**Key Activities and Milestones**
8/17/10	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

**** In FY 2012 Psychiatric Services will be procured. This service will be procured as an RFA through Open Enrollment for psychiatric services to provide choice to consumers. If another group or multiple individual psychiatrists apply and receive contracts for the psychiatric services, a timeline will have to be developed upon award of the contract and based upon the procurement process, willingness of doctors to travel and how many doctors are willing to practice in each service area. The timeline for this phase of procurement cannot be developed at this time.**

Date or Timeframe	**Key Activities and Milestones**

8/17/11	Date provider list will be posted to website and distributed to consumer and advocacy groups
8/17/11 - 9/15/11	Date to EDUCATE consumers and public about the changes

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.