June 8, 1993
msb::

Introduced by: Sims

Proposed No.: 93-449

MOTION NO. 9034

A MOTION adopting the resource management plan of the human services department/mental health division to support Title XIX and the Early Periodic Screening, Diagnosis, and Treatment program and releasing funds for its implementation.

WHEREAS, the restructuring of the State Medicaid program for mental health services will require regional support networks to manage all outpatient mental health services for Medicaid-eligible adults and children, and

WHEREAS, the regional support network's responsibilities managing children's mental health services will be further expanded through the State's plan to meet the requirements of the Early Periodic Screening, Diagnosis, and Treatment program, and

WHEREAS, the county council, through a proviso to Ordinance 10641, Section 78, required a plan for enhanced resource management services in response to State initiatives.

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The county executive is hereby authorized to release from contingency the amount of $632,500 from Ordinance 10641, Section 78 to the Mental Health Fund.

B. The resource management plan, dated April 28, 1993, (Attachment A) is hereby adopted.

C. The county executive is requested to submit a final recommendation before December 31, 1993 regarding the advisability, cost and service impact, and plan for becoming a prepaid health plan under the recently approved waiver of the

State's Medicaid program, including necessary revisions to the adopted adult and children's service plans.

PASSED this 14th day of June, 1993.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Audrey Grugen
Chair

ATTEST:

Gerald A. Peterson
Clerk of the Council

Attachments: King County Regional Support Network Resource Management Plan
Draft Work Plan

KING COUNTY REGIONAL SUPPORT NETWORK

RESOURCE MANAGEMENT PLAN

BACKGROUND

In 1989, the Washington State Legislature passed a major reform of the public mental health system. The reform moved accountability for services from the state to regional organizations termed Regional Support Networks (RSNs). The reform charged RSNs to:

- stabilize the patient populations of the two adult State psychiatric hospitals;
- create a community support model of care;
- increase local capacity for housing and short-term inpatient care;
- expand the consumer voice in the development of delivery of services; and
- develop the necessary resource management services to ensure an equitable balance of access, quality, and cost for all populations, including the traditionally underserved..

The reform was designed to be implemented over six years with enhanced revenues coming to RSNs in each of the three biennia covered in the 1989-95 period.

In 1990, King County became a Regional Support Network. To administer the new responsibilities, the Department of Human Services was reorganized to create a Mental Health Division (MHD). King County Regional Support Network (KCRSN) has made substantial progress in each of the areas required in the 1989 reform. This report focuses solely on the resource management responsibilities defined in the law. These activities extend far beyond the traditional administrative tasks found in a grants-managed social or health service program.

Resource management services, as used in this report, include all the non-direct service responsibilities of KCRSN in the Mental Health Division and provider agencies.

The review of KCRSN resource management capability is critical due to three major policy changes at the state level which will impact RSN resource management functions. Those changes are: 1) restructuring of the state Medicaid program for outpatient mental health services, moving RSNs from having no responsibility for Medicaid to full responsibility under a capitated model; 2) broad expansion of RSN responsibilities for managing children's mental health services through federal

requirements of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program; and 3) health care reform which, in Washington state, will include mental health benefits in the uniform benefit package.

Each of these initiatives creates a fundamentally altered environment for the delivery of mental health services and new expanded role for RSNs. The common feature is managed care where services are designed and delivered based on negotiated quality at a negotiated price for an identified population. KCRSN is not currently prepared to operate effectively in a managed care environment.

This report will describe the policy options facing the County related to TXIX reform. It will describe the compatibility of the state-initiated waiver with current KCRSN values and goals. It will identify potential fiscal, legal, and service risks and opportunities and make recommendations for action.

A component of TXIX reform, operating on a separate track at the state level, is the EPSDT program for children's mental health services. This report will also describe the potential impact of the EPSDT program on KCRSN and make recommendations for action.

Finally, this report will propose changes in the current resource management capability of the MHD and its provider agencies to improve KCRSN's capability for current responsibilities and prepare it for transition to managed care as required by EPSDT/TXIX reform.

Title XIX

TXIX or Medicaid revenues currently support over half of the mental health expenditures for eligible adults and children. Current Medicaid data suggests that caseloads of KCRSN provider agencies range from 25 - 80% Medicaid enrollees. Anecdotal information suggests that an even greater proportion of current caseloads may be eligible for Medicaid but not enrolled in the program. Further analysis of State Medicaid records is underway to more completely describe the current service population's use of Medicaid-supported services.

The Department of Social Health Services (DSHS), Division of Mental Health, has submitted a waiver to the federal government to fundamentally change the structure of its TXIX program for mental health services. If approved, the waiver would allow RSNs to manage federal TXIX dollars, in addition to their current responsibilities for state dollars. The reimbursement mechanism would shift from the traditional fee-for-service

to capitation with KCRSN becoming the Prepaid Health Plan (PHP). The waiver has designed a regional managed care program with the PHP role assigned to RSNs.

The waiver establishes three tiers of service, Tier 1 being short-term care, Tier 2 long-term, moderate intensity care, and Tier 3 long-term, high intensity care. The waiver projects the number of individuals in each tier based on historical Medicaid payments.

The PHP provides coverage of medically necessary mental health services for members of the plan. Under the proposed Medicaid plan, KCRSN would be responsible for assuring that the full range of outpatient community mental health rehabilitation services would be available to Medicaid-eligible individuals. As administrator of the plan, KCRSN staff are responsible for the planning, coordination, and authorization of services. In addition, KCRSN must assure access to quality and cost efficient services that are delivered in a manner that is acceptable to users of the services. State Medicaid criteria mandates the involvement of consumers, advocates, and families in all aspects of development, implementation, and evaluation of services offered under local plans.

The DSHS waiver request is found in Attachment A. Attachment B describes, in some depth, the risks and opportunities for KCRSN associated with participation in the waivered TXIX program. In summary:

COMPATIBILITY OF THE WAIVER WITH VALUES AND GOALS OF KCRSN:

For both children's and adult services, the waivered program could result in a more coordinated service system with greater involvement of users in the design and evaluation of care. The capitated system would reinforce the value of resource management, particularly for utilization management, quality assurance, and financial forecasting at the KCRSN/PHP level. It would diminish the effects of fee-for-service billing categories and programs on individual service plans. For service providers, it could mean more consistent policy direction for service delivery from major fund sources . The combination of broader benefit packages and tighter utilization management criteria could result in more flexible uses for dollars, improved targeting of services to needs, and better control of expenditures. The waivered program supports the intent of SB5400 and KCRSN regarding consumer involvement. Responsibilities of consumers and advocates are stipulated by the waiver through quality assurance and ombudsperson functions. In general, the potential benefits of the capitated TXIX system are consistent with the direction established by mental health reform and the values and goals of KCRSN.

The positive impact of the waiver could be increased if it was expanded to include voluntary hospitalization for both adults and children within its capitated rate. The voluntary inpatient service area is yet to be captured into mental health reform under SB5400. Its inclusion in the waiver could advance the policy direction for the system as a whole.

RISKS AND LIABILITIES OF THE TXIX WAIVER:

Financial Risk

The primary risk of the waivered program is the potential for underfunding by DSHS. One must assume that the mental health system will never be funded to a level required to meet all legitimate demand. In fact, the proposed waiver is driven by the need to contain TXIX billings and their drain on the State treasury for match. The key difference is that, under a waivered system, KCRSN would be given responsibility and tools to manage the system more effectively, but for that control, RSNs would take on the risks associated with running a capitated program for a federally-entitled population. The scope of that risk may be larger in the children's service area as compared with the adult. Given the low historic provision of children's mental health services, the planned expansion of EPSDT screenings and the children's entitlement for services under EPSDT, demand for children's services could far outstrip capacity. The increase in demand and cost of children's service could require redistribution of funds/resources from adult's and non-Medicaid children's services to Medicaid-eligible children's services. (See EPSDT Section.)

The risks in both children's and adult services could result from:

- unforeseen growth in the enrollment base (i.e., the Medicaid-eligible population), and the resulting increase in service users.
- increased "penetration" into the enrollment base, with the accompanying increase in demand for services by the new users. A good example would be the potential growth in the number of persons using Tier 1 services under the waiver program, services historically not available to this population.
- an increase in utilization or in service intensity by users (e.g., more individuals qualifying for the high service Tier 2 or Tier 3 levels of care).
- the actual cost of care for adults exceeds the capitation reimbursement.

Responsibility for a broader population

The transition to a PHP requires significant change in the role and focus of the RSN as it assumes responsibility for serving the full range of severity for an enrolled population,

only some of whom may become service users. In this case, the "at-risk" population consists of all individuals in King County who are eligible for and entitled to medically-necessary services under the federal Medicaid program. This includes chronically mentally ill adults and seriously emotionally disturbed children now eligible for RSN services as well as individuals not currently eligible for RSN services but who would meet the medical necessity definition. The State has primary authority for the definition of medical necessity. RSNs will create operational definitions of medical necessity for approval by the State.

Reduced service capacity for non-Medicaid population

A growing risk in the system, whether under a fee-for-service or a capitated model, is that more and more resources and services will be focused on the Medicaid-eligible population. The capitated model does not increase that risk, nor does it diminish it. Both systems require a state/local match of federal dollars. Whichever system is chosen must assure that there are different resources to serve these persons who meet the clinical requirements of medical necessity but not the financial requirements of Medicaid.

Barriers to access for traditionally underserved groups

A potential risk under a managed care system is that the definitions of medical necessity which control access to services; benefit packages; utilization and quality indicators will all be based on the characteristics and needs of mainstream populations. The needs of traditionally underserved groups, such as ethnic minorities, sexual minorities, persons with physical disabilities, must be carefully considered in the development of the managed care system to maintain/enhance the system's accessibility and appropriateness for traditionally underserved groups.

FEE-FOR-SERVICE ALTERNATIVE

KCRSN has the option of rejecting the waiver approach and continuing operation under a modified fee-for-service system. In this model, the state maintains direct contracting with local service providers for TXIX reimbursement. This is not a status quo option, as the State will be forced to implement one or more cost containment strategies as early as July 1993. Current options under consideration are: 1) an across-the-board ratable reduction of 15-25%; 2) a cap on maximum billing per consumer; and 3) service limits on billing categories. For July 1993, the most likely option is a $3,500/month limit on billings per consumer.

If current trends are predictive, these strategies would need to be employed on an escalating basis as they do not create incentives to change billing behavior. Further, without a waiver, the State has no apparent mechanism to control the proliferation of new TXIX providers. This most troubling scenario would require a static amount of State dollars, now contracted to RSNs, to be distributed and redistributed (by the RSNs or the State directly) over a growing number of providers. The primary factor in determining allocation of State dollars to provider agencies would become TXIX billing potential. The basic principles of mental health reform would be violated, care for current and future users would be seriously compromised, and costs would still not be managed.

Staff is currently analyzing the extent of KCRSN exposure under the modified fee for service system related to redistribution of match to cover current billings and new providers. In the aggregate, current KCRSN providers will not have a match problem over the next twelve months.

However, there are currently 4 providers who have made application for or have provisional licenses. Once the licenses are fully approved these agencies are eligible for TXIX contracts. Two of the four are currently subcontractors to lead agencies. A third is a children's provider and the last is a private case management organization. Beginning July, 1993 it is possible that some or all of these providers will seek a TXIX contract. Without State controls and/or local strategies, new providers could seek a portion of existing State dollars allocated to current providers by KCRSN. If additional providers (beyond the four) seek licensure, there will be a one-year provisional period before a TXIX contract could be issued. To manage the new provider problem, the KCRSN contract with DSHS will have to specify protection against the entrance of new providers into our system.

For current providers, KCRSN must develop mechanisms to assure available match at the agency level. These mechanisms must be consistent with overall policy direction and cannot violate County procurement practices.

There are several mechanisms now under staff review to manage the problem for current providers over the next 6-12 months. They include:

- identifying additional non-State match within the current revenues of KCRSN providers
- subcontracting of agency services and match through lead providers who have excess available match

- anticipating the new allocation of State dollars to be appropriated by the legislature for children's services by making a one-time-only allocation from fund balance July 1-December 31, 1993
- assuring that agency contracts for RSN services are funded to the extent possible with matchable dollars (replacing federal block grant with State dollars wherever possible)

Staff expect that some combination of these strategies could delay the match problem until as late as June 1994. Ultimately, however, the continuance of the fee for service model will only be possible through the implementation of ratable reductions, severe limitations on eligible populations or reimbursable services.

RECOMMENDATION:

Staff recommend that KCRSN maintain the option to become a PHP but reserve final decision until October 1993. Further, staff recommend that KCRSN target April 1, 1994 as the earliest start date to implement TXIX managed care for outpatient services. If KCRSN becomes a PHP, KCRSN should advocate to incorporate inpatient services into the waiver, either through incentive payments or full capitation. Finally, staff recommend that limited resources be applied now to further analyze options and prepare systems for a new role.

The State must allow the PHPs maximum flexibility to design and administer its program. If this direction is approved, staff will continue development of necessary standards and options. Attachment C, the TXIX workplan, outlines the key tasks, players, and timelines for the development work. This work will enhance the capability of the RSN to meet its current responsibilities as well as prepare it for a new role. Final action by the Mental Health Board, Executive, and Council on participation in the TXIX capitated program will be requested in October, 1993 and will be based on the final content of the approved waiver, the success at negotiating the above requirements with the state, and the feasibility of building the necessary resource management capability within KCRSN. See resource management recommendations beginning on page 17.

EPSDT

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) is a preventive health care benefit for Medicaid recipients under 21 years of age. EPSDT became a benefit within the Federal Medicaid Program in 1967 and was adopted as a benefit in this State's plan in 1972.

In 1989, Congress passed sweeping reforms in the EPSDT section of Medicaid. The original program focused on physical health screening for children 0-6 years. The new EPSDT program is a much broader mechanism for delivering a full range of physical and behavioral health services to all children 0-21 years. It is mandatory for the State to offer the EPSDT screen and whatever resulting services are deemed medically-necessary. The State cannot, however, require parents to avail themselves of the service on behalf of their children.

As in all TXIX programs in this state, services authorized for Medicaid-eligible persons are paid for with a combination of federal and state dollars. The current formula requires a match ratio of approximately 45% state or local government dollars and 55% federal dollars.

In 1991, DSHS developed an implementation plan for mental health services required under the EPSDT program. The plan made RSNs the gatekeeper to authorize all mental health services identified through EPSDT screens and assessments. Children identified through an EPSDT screen and assessed by a licensed mental health provider would be authorized to receive treatment at one of two levels. Level 1 is short-term care; level 2 is long-term, more intensive, often multi-system care.

The plan called for development of local RSN plans by November 1992 with limited implementation beginning in January 1993. Under EPSDT the State expects the RSN to increase service to 40% of the eligible population by 1995. The RSN is currently serving approximately 10% of the eligible population.

RSNs were given no new resources to begin these considerable new responsibilities. although new service and administrative dollars have been promised (and appear likely in 1993-95).

The KCRSN EPSDT Plan, which was adopted in draft only by the King County Mental Health Board, called for a limited obligation for the January- July 1993 period. Further participation is dependent on Board, Executive, and Council action (see Attachment D for the draft plan).

RISKS AND OPPORTUNITIES

EPSDT will allow KCRSN to control entrance into the system, determine the level of service, and insure those most in need receive services. By having control of State and Federal dollars, the RSN will have greater flexibility in developing individualized services.

The EPSDT program is a logical and consistent platform on which to build a capitated TXIX program. Combined with the overall TXIX initiative, it offers the best opportunity to develop and manage a system of mental health care for children. KCRSN has already developed an assessment tool and is piloting a gatekeeping system April - June 1993.

However, the EPSDT system is not without risk. Demand for children's services has been artificially constrained by the lack of available resources. With the EPSDT case-finding potential and the requirement to provide services to children who meet the medical-necessity definition established by KCRSN, demand is likely to grow more quickly than capacity can expand. Since KCRSN would be determining who is served and at what level, individuals who have services limited or who are denied access could pursue a legal course of action.

To limit these risks in a program that is considered an entitlement at the federal level, KCRSN must assure that our DSHS contract provide for additional funding and limit KCRSN's EPSDT requirements to assess and serve a specified number of children based on available resources. The State has already agreed to this provision in principle, specific contract numbers are under negotiation. The negotiations will take into account the following information:

The 1993-95 state budget is likely to add approximately $750,000 per year to children's services in King County (Governor Lowry's proposal, which is essentially the same as current House and Senate budgets). This translates to approximately 500 additional children to be served per year using average cost of current service per child. Depending on the type of service enhancement, the additional number of children served could vary from 400 to 1200. The total number of children served by KCRSN for the available resources would be between 2100 and 2900 per year.

It is difficult to determine the increased demand resulting from the EPSDT program. The state has set screening goals for 1993-94 at 30% of the eligible population and for 1994-95, 40%. Depending on the methodology used to project demand, the number of children expected to be served could be as high as 5100 in 1993-94. These numbers cannot be achieved with available resources assumed in Governor Lowry's budget.

The staff recommendation assumes the negotiation of a specific number of assessments and a specific number of children served at Level 1 and Level 2 based on available resources. The recommendation further assumes at least the Governor's proposed budget level for EPSDT services and TXIX administration.

If KCRSN decides not to participate in the EPSDT program, the only apparent alternative would be for the State to manage the program directly. In that scenario, the State would retain all children's mental health service and administrative dollars and contract directly with providers. This approach would undo all the cross-system collaborative work accomplished by KCRSN in the past three years. It would fragment service delivery and undermine the basic principles of mental health reform. Essentially, King County would be deciding not to administer children's mental health at all.

RECOMMENDATION:

Staff recommend that KCRSN maintain its participation in the EPSDT program, assuming 1) new service dollars are allocated by the State to respond to the increased demand generated by EPSDT screens; 2) TXIX administrative dollars are available to support growing authorization functions; 3) State contract is limited to a fixed number of children served based on available resources.

CURRENT RESOURCE MANAGEMENT CAPABILITY

Since 1990, the KCRSN system of resource management has been focused primarily on system structure/design, program development, and resource allocation. While these functions are both critical and appropriate for initial focus, the present environment calls for greater emphasis on utilization management, quality assurance, and cost control.

ANALYSIS OF CURRENT CAPABILITIES:

1. Financial Management

   Adequate for grants-managed system but could be improved by with better tools at the program level, consolidation of responsibilities within the Division, and staff training.

2. Contracts Management

   Adequate contract management systems for current responsibilities. Recent State certification visit called for some modifications/enhancements in implementation. Improvements include standardization of contract management procedures and implementation of agency on-site visits to verify contract compliance.

Significant changes would be required in contract structure and monitoring under a managed care system. It will require performance-based contracts which incorporate utilization standards, quality indicators, and outcome expectations.

3. Authorization of Services

Currently, the MHD delegates authorization for enrollment of adults into comprehensive community support and residential services to ten enrolling agencies (lead and special population providers). Eligibility criteria for enrollment have been established by the RSN. There is no monitoring of agency intake/authorization decisions done by the RSN beyond review of aggregate data on admissions and discharges by agency.

KCRSN also delegates all decisions on which children receive what services to our childrens' service providers except for intensive programs developed under mental health reform (200 intensive program slots.)

No prior authorization is required for crisis services. MHD controls the gate into involuntary inpatient beds through detention decisions made by County-Designated Mental Health Professionals (County staff).

Managed care systems are normally designed with direct control of entry by the PHP equivalent organization. This plan requires authorization of service at the RSN/PHP level.

4. Utilization Management/Quality Assurance (UM/QA)

Currently the MHD has limited capacity for UM/QA. Managed care will require PHPs to have standard benefit packages, utilization standards, quality indicators, outcome expectations, and the procedures to monitor them.

At the agency level, there are quality assurance procedures in place as required by licensure. Utilization management procedures are not in place at all agencies. The quality assurance procedures are generally sufficient for current responsibilities but are not adequate for a managed care system. Growth of utilization management capability will be a key component for managed care.

5. MIS Capability

There have been substantial improvements in Management Information System (MIS) capability. KCRSN now has its own MIS system which has been designed to meet current needs and has the flexibility to expand to meet future managed care needs. It has the capability to interact with the MIS systems of State and local hospitals, the Health Department, the Department of Youth Services, and other DSHS divisions.

It will be critical to fully integrate IS capability into KCRSN management. Enhancement of IS systems will be required to support all major resource management functions: financial control, utilization management, quality assurance, authorization, and public information. Expenditures for hardware, software, and training will be necessary at the MHD and agency level.

6. Public Information/Education and Training

MHD has established several vehicles to provide information to users of our services and to the public. They include a monthly newsletter with a circulation of over 800, distribute quarterly reports on services delivery, an annual report on services provided and dollars spent, an active citizen advisory board (King County Mental Health Board) which guides service delivery through a broad public process, a small resource library open to the interested public. Our policies meet Americans with Disabilities Act of 1990 standards.

Mental health providers also distribute public information materials on mental illness and access/availability of services.

KCRSN commits a majority of its training resources to systemwide efforts, aimed primarily for training of agency staff. Stipends to support conference participation and training are also available to consumers, parents, and family advocates.

To meet current responsibilities, KCRSN must develop and widely disseminate a brochure/s on how to access mental health services in King County. These materials must be published in five languages: Spanish, Vietnamese, Cambodian, Laotian, and Chinese to comply with State DSHS policy on limited English proficiency.

To meet new responsibilities under TXIX/EPSDT, KCRSN must expand significantly its training and public information investments.

Attachment E details the current MHD organizational structure and budget with resource management (non-direct service) costs capturing approximately 5.8% of total RSN planned expenditures in 1993.

Attachment F details the range of agency administrative/resource management costs of 9% to 24% (self reported as all costs not associated with the direct delivery of clinical services).

RECOMMENDATIONS FOR RESOURCE MANAGEMENT

These recommendations have been organized into two sections: actions required at the MHD level and actions required at the provider agency level. The recommendations focus on the first of two steps: those activities that allow KCRSN to meet current responsibilities in a way that positions/prepares for expanded responsibilities under EPSDT and Medicaid reform plus the necessary consultation and analysis to determine the specific contract elements and management systems necessary to successfully become a PHP.

The second step would put in place the transitional activities required to move KCRSN to new and expanded managed care responsibilities. This step is contingent on final decisions regarding Medicaid which cannot be made before October 1993.

Whenever new funds are proposed, the recommendation designates whether the expense is ongoing or one-time-only. Details are provided only on Step one as it is the only step proposed for 1993 action. Step 2 will be detailed through subsequent budget processes and will be guided by the King County Mental Health Board (KCMHB)/King County Executive/King County Council final action in October on participation in the waivered Medicaid program.

To support the TXIX and EPSDT recommendations, the KCRSN resource management plan calls for a systems approach with clear definitions of roles and responsibilities for MHD, providers, consumers, advocates, and parents. The basic framework of the managed care approach is described in the following paragraphs.

The managed care system, for both Medicaid and non-Medicaid populations, will be based on definitions of medical necessity tied directly to benefits packages, service standards, utilization and quality indicators, and outcome expectations. These elements will be developed jointly by the MHD, service providers, consumers, parents, and advocates. An arm of the KCMHB, the Quality Council, will recommend final elements to the RSN/PHP. This Council will consist of consumers, advocates, parents, clinicians from the community, the RSN medical director, and will be chaired by a

KCMHB member with clinical credentials. For children's services, recommendations would pass first through the Regional Policy Team to assure cross-system cooperation.

Payment for services will be on a capitated basis with separate and fixed rates for three tiers of service. There will also be an exceptional care option. Authorization for payment will be done by the MHD directly. Provider payments will be based on the authorized number of recipients by tier rate. Crisis response services for those not, or not yet, authorized for Tier services will be paid through a separate mechanism. The rate and payment structure will be jointly developed by the MHD and providers.

There will be separate payment streams from the State to the PHP for Medicaid and non-Medicaid populations. The MHD will assure, through its contract negotiation with DSHS, that priority non-Medicaid populations retain some access to services in the new managed care system. (All populations will be subject to utilization management to assure most appropriate use of available resources.)

Special care will be taken to assure that definitions of medical necessity, benefits packages, service standards, and quality indicators all take into account the diversity of the service population and assure that access and appropriateness of care for traditionally underserved populations are maintained or enhanced. Methods will include minimum targets of service for underserved groups at each tier. Efforts will be made to develop measures of relative need per underserved population group.

Medical necessity will be determined through a combination of diagnosis and level of functioning. For the adult system, the level of functioning tool will be the Problem Severity Scale (PSS), now in limited use in KCRSN and developed by Community Psychiatric Clinic in collaboration with the University of Washington School of Social Work and other KCRSN enrolling agencies. For children, the level of functioning scale will be the Global Assessment Scale for children (GAS) now being piloted in the EPSDT assessment/certification process. Providers will recommend tier assignment and develop and implement ISP/ITP.

Authorization for payment will be based on medical necessity criteria established for each tier, for children and adults, for Medicaid and non-Medicaid populations. For adults, authorization will be required only for Tier 2 and 3 (for Tier 1, retrospective review of authorizations will be done). For children, all tiers will be authorized through the EPSDT process. Crisis response services will NOT require authorization for children or adults. The MHD will assure a 48-hour turnaround for authorizations. Appeals will follow an established grievance procedure. There will be an

ombudsperson function at the RSN/PHP level. For Medicaid recipients, the final step in the grievance process will be the Fair Hearing Process administered by DSHS.

Individual and system outcomes will be defined at the RSN/PHP for all participating providers. Individual outcomes will initially be focused on: 1) measures of consumer satisfaction, and 2) improvement in one or more elements identified in the PSS or GAS and defined as a goal in the ISP/ITP. Consumers, parents, and family advocate involvement will be essential in developing approaches to measuring satisfaction.

System outcomes will initially focus on current policy to: 1) control use of involuntary hospitalization; 2) assure stable housing for recipients of services; 3) increase number of adults in prevocational and supported employment; 4) assure appropriate access to traditionally underserved populations; and 5) increase collaborative service delivery cross systems.

Quality Assurance/Utilization Management advocates will be guided by the definitions of medical necessity by tier and the benefit packages for each tier. Utilization standards will be set for each benefit package, quality indicators will be defined to include outcome expectations, and monitoring practices and feedback loops will be established. The RSN/PHP will establish all of the above in collaboration with providers and consumers. A QA/UM plan will be approved through the Quality Council, an arm of the KCMHB.

The locus of control for implementation of QA/UM will be at the service provider level. Improvements and corrections will be made and managed at the provider level. Regular reports on QA/UM monitoring and action resulting from it will be reviewed by the RSN/PHP. QA/UM reports will be reviewed by an arm of the KCMHB, the Quality Council. Changes in benefits packages, utilization standards, or quality indicators will be recommended by this group.

Financial management systems will require a common vocabulary/chart of accounts to build cost assumptions and track performance. New IS capability will be developed to track eligibles, users, services used, and fee for service charges (the latter during the transition period only) by provider by subpopulation groups. Source of fund support will also be tracked by agency, by subpopulation group. Forecasting models and early warning systems for over-expenditures will be designed.

Measures to manage risk will have to be developed by the RSN/PHP and by service providers. Strategies under consideration at the RSN/PHP level include establishment of operating reserves, consideration of reinsurance mechanisms (perhaps jointly purchased by participating RSNs across the state), contract reopeners if caseload

growth significantly exceeds contract assumptions, stop-loss provisions for catastrophic events, etc.

Policy changes at the County level may be required to establish operating reserves, streamline processes to pay service providers, facilitate frequent changes in state contract dollar amounts, etc.

Contracts with service providers would change from the current minimum caseloads and program requirements (deliverables) to a more performance-based structure. Contract elements would include benefit packages, utilization standards, quality indicators, outcome expectations, and anticipated number of users by tier. There would be separate exhibits for Medicaid and non-Medicaid populations and for crisis response services for persons not authorized for tier services.

While the current DSHS waiver is limited to outpatient services, KCRSN will begin to develop the basis for inclusion of inpatient voluntary hospitalization. This addition is key to the success of the overall system. Data will be collected on current utilization and payment by hospital. KCRSN will solicit hospital interest in more active participation. This policy direction is supported by current language in the House and Senate budgets regarding RSN control of voluntary admissions and costs for Medicaid patients.

In summary, for the MHD (RSN/PHP) the primary resource management roles are to establish financial and management systems; operationalize the medical necessity definition; design benefits packages; develop standards for quality and utilization; set rates; authorize entry and exit from the system; project need; advocate for required resources, and allocate available resources based on need; and negotiate fair contracts with the State and with service providers which appropriately share risk.

For service providers, the primary resource management roles are to recommend individuals for service authorization based on definitions of medical necessity and required level of care; develop with consumer and family the Individual Service Plan/Individual Treatment Plan; implement, on a continuous basis, quality assurance and utilization management systems and feedback summary results to the RSN; and build a system to manage appropriately assigned risk.

The primary resource management responsibilities for consumers, parents, and family advocates are to: recommend outcomes; design and participate in the design and implementation of approaches/tools to monitor satisfaction; and design and implement an ombudsperson function.

To translate these basic principles of the KCRSN resource management plan into a detailed implementation plan will require substantial additional work. That work is proposed to be supported through the one-time-only expenditures detailed in the following sections. Ongoing dollars for this phase are proposed only as necessary for an adequate base on which to build the managed care system. No proposals are made in this phase to build ongoing capacity at the RSN or service provider level for activities solely related to a TXIX managed care system.

Resource Requirements for MHD, Step 1

Ongoing Dollar Impact:

A. Centralize financial and contract oversight in Managers Office.

1) Increase the time of the program analyst from .5 FTE to 1.0 FTE (by transferring existing position from Crisis and Commitment Services) and convert the position to a financial officer. The responsibility of the new position will be to maintain the division spending plan of over $41 million to reflect revenues and planned expenditures on a biennial basis in six month increments; develop and maintain the three year financial plan; prepare monthly expenditure reports for section coordinators that balance to the County ARMS system; prepare necessary budget revisions; reconcile actual expenditures with the spending plan and financial plan on an annual and biennial basis; coordinate the preparation and submittal of the annual division budget; assist with financial projections associated with converting to a managed care system and Title XIX; and assist in the development of biennial resource allocation formulas.

2) Add a full time Contract Compliance Officer to the Manager's Office. The Compliance Officer will have responsibility to develop a systematic approach to contract compliance, including development of policies and protocols, determining sources of information to independently verify contract compliance, and setting an annual review schedule; participation in on-site agency reviews including verification of prior year billings; write up contract compliance reviews; and monitor corrective action plans. In addition, the contract compliance officer will monitor State contract requirements, including Federal Block grant and ensure requirements are incorporated in to agency contracts as appropriate; draft biennial quarterly performance reports for the State; and review agency audits that are submitted annually to the RSN.

3) Add .5 FTE technical and clerical support Office Technician II (OTII) to the Manager's Office to support new and reassigned staff.

4) Request special duty/lead worker pay for the Confidential Secretary for assuming supervision responsibility of the Division Receptionist and half-time OTII.

Cost = $29,334 for July 1 - December 31, 1993

B. Expand capability for authorization and continuity of care in Community Support Services by creating a new 1.0 FTE position. The position will oversee the Western State Hospital (WSH) working agreement, risk pool agreement, and cross-system working agreements (Division of Developmental Disabilities, Division of Alcohol and Substance Abuse, Aging and Adult Field Services, AIDSNET, and Division of Vocational Rehabilitation). This position will also coordinate development of service authorization procedures for adult consumers. In addition, this position will maintain active linkage with primary agencies and organizations providing consumer referrals to KCRSN, including Evaluation and Treatment facilities, local psychiatric hospitals, and Crisis and Commitment Services. This position will also serve as primary contact for inquiries and complaints registered with the RSN by enrolled consumers, advocates, family members, and agency staff; convenes the Community Support Section Problem Assessment and Resolution Committee (PARC); and manages the Community Support Services Flex Fund, which is expended on recommendations from PARC.

Retain extra help dollars for 1993 to support the continued temporary placement of the State employee on rotation from Western State Hospital. Restructure job responsibilities of Social Service Coordinator/Liaison staff by reducing some aspects of contract compliance (transferred to Manager's Office) and management of CIS exhibits (transferred to CCS) and expanding responsibility to include clinical review, approval, rejection, and/or amendment of requests for authorization of client service based on appropriateness of proposed service package. These additional responsibilities will require clinical experience in the mental health field and extensive knowledge of the current and planned mental health and related (e.g., substance abuse, developmental disabilities, criminal justice, aging, HIV/AIDS, etc.) delivery systems. All liaison staff will be required to be at the Master's degree level. The cost is $21,471 for July 1 - December 31, 1993.

C. Designate a lead worker in the Community Support Services and Children's sections to assure that contract management and authorization functions are consistently and efficiently applied. The critical tasks assigned to lead staff will include: development of effective contract elements as KCRSN moves toward

performance-based contracts; deliverable worksheets, and documentation summaries; distribution of work assignments related to contract development and maintenance and program planning and development among the Social Services Coordinator liaisons in their section; technical assistance and consultation in contract negotiation activities; and provision of technical assistance in the resolution of difficult and/or contested service authorization decisions.

Cost = $2,013 for July - December 1993

D. 1. Add a full time MIS specialist and restructure assignments of current MIS staff to manage efficiency and cover new responsibilities. The tasks of MIS staff will be to develop, operate and manage the KCRSN MIS; develop and maintain the MIS Data Dictionary; operate maintenance and user support for the KCRSN office automation; develop and maintain required data bases; provide technical assistance and support to provider agencies in their development and operations of agency information systems; and develop and publish MIS management reports.

2. Designate a lead worker for MIS activities who will coordinate the day-to-day tasks of MIS staff.

Cost = $22,182 for July - December 1993

Total increase of ongoing dollars to complete step 1 is $75,000 for July-December, 1993.

One-time-only dollars:

A.. Consultation to refine contract management protocols and procedures as required by the State certification review. $5,000

B. Operation and maintenance support to set up new staff: $17,500

C. - Consultation/extra help for EPSDT implementation:
1. $7,000 to refine the assessment tool

2. $15,000 to support extra help to handle EPSDT authorizations. The EPSDT plan requires the approval of service plans for all children who receive services from more than one agency. The County will be responsible for assuring the plan meets the requirements of a service plan, is inclusive of other systems, and meets the range of needs of the child. The process will require re-approval of plans and re-authorization of services at a minimum of every six months. Growth in EPSDT program is difficult to estimate. Extra help staff should be available to assure that State contract requirement of 48 hour turnaround in authorizations is met. Depending on experience in second half of 1993, position additions may be necessary in 1994.

D. $20,000 for contract psychiatrist time to support the development of standards, quality assurance and utilization management goals, authorization criteria and review.

E. $75,000 for consultant's and extra help support in the following areas: medical necessity definition, service/benefits packages and authorization tools; cost/rate setting; standard setting and UM/QI processes; resource allocation/contract structures; risk management review, financial systems, actuarial review, and demographic review. See Attachment ____, TXIX development workplan for more detailed description of tasks.

F. $48,000 for MIS development: Dollars will support temporary staff, capital purchases, and staff training on MIS enhancements. Development of MIS support will be required for UM/QI, contract management, financial management. The overall goal is to create a flexible and lean information system which collects only essential information required for management of the system.

G. $15,000 for training for Division staff, Fiscal Management staff, Mental Health Board, Regional Policy Team, consumers, families, and advocates on managed care.

H. $12,500 to develop consumer outcome standards, consumer satisfaction approaches, ombudsman function (available only to consumers and/or family advocate groups).

I. $5,000 for translation and production of public information materials into five languages.

J. $7,500 for consultation support/training for Division cross-sectional standards team.

K. $7,500 to support travel for a minimum of three people to a minimum of two out-of-state sites to review operational managed mental health systems.

Total cost in one-time-only dollars for Step 1 is $235,000.

For Provider Agencies:

Step 1 Ongoing Dollars

A. (Up to $60,000 to lead agencies in the adult system for July-December 1993 for existing capability required for residential screening, financial benefit coordination, and placement functions, and for existing capability required for developing, negotiating, maintaining, and monitoring residential sub-contracts. These functions are required of lead agencies, were added in 1992, but not fully reimbursed. These costs will be supported by existing residential funds allocated but not spent for residential services. Budgets are under spent annually because it is impossible to precisely determine occupancy levels and client participation. Residential contract terms will be amended to allow use of current unspent dollars for these resource management functions up to a maximum of $120,000 annually. There will be no reduction in rates paid to residential providers, minimum occupancy levels, or number of beds.)

B. $25,000 for children's providers for July-December to purchase increased tracking of EPSDT screening referrals through the system. EPSDT requires client tracking from the time of the request for service until service is received. It also requires connection to a primary health care provider for the purpose of

determining whether any identified health issues will impact meeting the child's needs.

Total additional cost in ongoing dollars for July-December 1993: $25,000 (excluding reprogramming of current unspent funds as described in "A" above.

One-time-only Dollars

A. $65,000 for 1993 currently approved but unfunded RSN training plan for provider agency staff. The plan covers training in the following areas:

- Children's Mental Health
- Geriatric Mental Health
- RSN Training Consortium
- Consumer/Advocate Training Fund
- Intensive Case Management
- Developmental Disabilities Cross-Agency Training
- AIDSNET Cross-Agency Training
- DASA/KCDASAS Cross-Agency Training

B. $50,000 to support training of provider agency staff to enhance skills in the area of implement continuous quality improvement techniques for managed care.

C. $100,000 to support enhancement of agency information systems including acquisition of hardware, software, and consultation.

D. $60,000 for refinement of the Problem Severity Scale to allow its use as an instrument for standardized assessment of individual service needs and to support recommendation of service level; facilitate development of individual ISPs; and support utilization management activities and allocation of resources.

E. $12,500 to support piloting of consumer satisfaction tools proposed by consumer and parent groups.

F. $10,000 to support a minimum of four people for a minimum of two visits to out-of-state mental health managed care programs.

Total one-time-only requirements for agencies for July-December 1993 is $297,500.

The resources required for Steps 2 and 3 would have to come from TXIX administrative match. The current estimate, based on 1993-95 budgets under consideration by the State legislature, is approximately $750,000 annually for King County.

SUMMARY OF REVENUE/EXPENDITURES

For 1993 as stated in proviso

Available ongoing dollars	$400,000/yr
Available one-time-only dollars	$300,000/yr.

Staff proposed revision in proviso based on projected loss of ongoing revenue of $200,000/year

Ongoing	$200,000
One-time-only	$400,000

For 6 month period (July-December 1993):

Available ongoing dollars:	$100,000
Available one-time-only dollars	$500,000

1993 Proposed Expenditures (July - December 1993)

MHD

Ongoing	$ 75,000
One-time-only	$235,000 *

Contract Agencies

Ongoing	$ 25,000 **
One-time-only	$297,500 *

* Additional $32,500 in one-time-only expenditures beyond $500,000 will be covered by unallocated fund balance.

** Excludes reprogramming of $60,000 of existing residential funds to support related resource management activities at the lead agencies.

DRAFT

TXIX WORKPLAN

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
1. INTERIM FEE-FOR-SERVICE CONTRACTS				
1a. Analyze extent/distribution of match shortfall	5/1/93	X		
1b. Assess accounting methods to assure maximum use of state funds	5/1/93	X		
1c. Explore new routes for County funds to increase match possibilities	5/1/93	X		
1d. Project new biennium revenues, start dates	5/1/93	X		
1e. Explore alternative methods to cover match requirement for 9 months	5/1/93	X	X	
1f. Determine strategies	5/1/93	X	X	
1g. Negotiate DSHS contract to support strategies	5/10/93	X		
1h. Negotiate contracts with providers	7/1/93	X		
1i. Refine contract management protocols/procedure	10/1/93	X		

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
2. DSHS PHP CONTRACT				
2a. Obtain additional Medicaid data including costs outside of present provider network	5/15/93	X		
2b. Assess adequacy of Medicaid data/ request reanalysis, if required	6/15/93	X	X	
2c. Capture Medicaid data by consumer ID	6/15/93	X		
2d. Analyze, by tier, definitions, for overall patterns of utilization/cost ---sort by Medicaid/non-Medicaid (M/NONM) --account for partial year activity --verify per episode cost --describe average service package utilized --establish baseline rates, average length of stay, days, visits/1000	7/15/93	X	X	
2e. Review general Medicaid caseload projections with local economists/demographers	7/15/93	X	X	
2f. Build a model of expected eligibles, penetration (users) and clinical mix by tier (M/NONM) --use historical tier costs to estimate $ needed --review model with actuary, revise --review model with providers, revise	8/15/93	X	X	X

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
2g. Resolve outstanding questions with DSHS regarding out-of-county recipients of service, out-of-county service by PHP clients, bed and board costs, relationship to Medicare program, etc.	8/15/93	X	X	
2h. Analyze impact of Medicaid changes on Medicare payments --idenfity Medicare elibibility --identify service/individuals impacted by changes	?	?		
2i. Negotiate preliminary contract assumptions with DSHS (enrollment, penetration, clinical mix), including process for managing risk (M/NONM) --risk options to include potential reinsurance mechanism, contract reopeners, stop-loss, etc. --cost assumption to include DSHS projections of additional administrative burden required of PHP --complete sensitivity analysis to determine impacts of variations on caseload/penetration/case mix	9/15/93	X X X	X X X	
2j. Make go/no go decision/requires Council action	11/1/93	X	X	
2k. Revise model based on medical necessity, service model and cost assumptions below	12/15/93	X	X	X
2l. Negotiate final PHP contract with DSHS for 4/1/94 effective date	1/1/94	X		

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
3. MANAGED CARE DEVELOPMENT/ EXTERNAL ASSESSMENT				
3a. Conduct informational interviews w/Behavioral Health Managed Care (BHMC) firms and medical directors	6/1/93	X	X	
3b. Review market products for UM/QA/outcomes	6/15/93	X	X	X
3c. Define PHP Medical Director scope of activity	6/15/93	X		
3d. Take field trips to review operational mental health managed care systems	8/15/93	X		

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS	
4. MANAGED CARE DEVELOPMENT/INTERNAL CAPACITY					
4a. Identify cross functional staff team	5/15/93	X			
4b. Develop team connection to assessment/LOF design	6/1/93	X			
4c. Provide initial team training CQI, managed care	6/30/93	X	X		
4d. Determine most appropriate administrative structure, i.e., what will be developed in-house, delegated to providers, and purchased from behavioral managed care firms	9/15/93	X	X		

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS	
5. MANAGED CARE DEVELOP-MENT/ASSESSMENT TOOLS					
5a. Convene Oversight Committee for adult assessment/LOF process (M/NONM)	5/15/93	X		X	
5b. Examine the 1992 PSS data set ?	5/15/93	X	X		
5c. Convene interagency expert group	6/1/93	X	X		
5d. Develop preliminary rules for ISP service levels	6/15/93	X	X		
5e. Pilot field test of ISP	7/1/93				
5f. Field test the ISP (sample)	8/15/93				
5g. Initial recommended service levels for groups	10/1/93	X	X		
5h. Initiate test of the ISP with enrolled consumers	7/1/93				
5i. Evaluate partial ISP data	12/1/93	X	X		
5j. Evaluate complete ISP data	2/1/94	X	X		
5k. Review and assign current Tier 2/3 enrollees for adult based on 5d - 5i					
5l. Convene Oversight Committee for children's assessment/LOF process (M/NONM)	6/1/93	X		X	
5m. Convene interagency expert group	6/15/93	X	X		

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
5n. Develop preliminary rules for ISP service levels	6/30/93	X	X	
5p. Begin test of ISP/authorizations	7/1/93	X	X	
5q. Expanded test of the ISP (sample)	8/15/93	X	X	
5r. Review and assign current Tier 1/2/3 enrollees for children based on 5n - 5s				
5s. Initial recommended service levels for groups	10/1/93	X	X	X

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
6. MANAGED CARE MEDICAL NECESSITY CRITERIA/BENEFIT PACKAGES				
6a. Draft medical necessity criteria based on assessment rules/service levels (M/NONM)	10/15/93	X	X	X
6b. Draft benefit packages based on assessment rules/service levels (M/NONM)	10/15/93	X	X	X
6c. Medical director and actuary review	11/1/93	X	X	
6d. Analyze cost impact of draft benefit packages, review against available dollars	12/1/93	X	X	
6e. Submit to Quality Council for review	1/15/94	X		

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
7. ACCESS TO SERVICES				
7a. Develop relationships with health care and insurance systems (AFDC pilots and Health Care reform)	11/1/93	X	X	
7b. Develop EPSDT screening/referral linkages	12/1/93	X		
7c. Develop medical necessity determination/ provider process (M/NONM)	12/1/93	X	X	
7d. Develop full authorization process for adults, children, crisis/inpatient services (M/NONM)	1/1/94	X	X	
7e. Finalize grievance process	1/1/94	X	X	X
7f. Initiate service request and assignment process	3/1/94	X		
7g. Initiate authorization processes for groups	4/1/94	X		
7h. Develop and produce public information materials in five major languages	1/1/94	X		
7i. Develop/distribute first client notice	2/15/94	X		X
7j. Develop/distribute second client notice	3/15/94	X		X

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
8. UM/QA PROCESS				
8a. Develop outcome standards and key indicators of consumer satisfaction	11/1/93	X	X	X
8b. Develop methodology for gathering consumer data	12/1/93	X	X	X
8c. Gather and analyze baseline data	3/1/94	X	X	
8d. Develop consumer ombudsman function	3/1/94	X	X	X
8e. Develop clinical standards/ guidelines, relate to assessments/LOF/ medical necessity/access	12/1/93	X	X	
8f. Develop key indicators to be tracked for service performance	12/1/93	X	X	X
8g. Develop key indicators to be tracked for PHP performance	12/1/93	X	X	X
8h. Establish a Quality Council via Mental Health Board	11/5/93	X		
8i. Review 8a -8g by Quality Council	1/1/94	X		
8j. Develop sampling method/review tools for providers	2/1/94	X	X	
8k. Develop MIS report templates, summary formats	2/1/94	X	X	
8l. Present formal QAP plan to Quality Council	3/1/94	X		
8m. Initiate UM/QA process	4/1/94	X		X

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS	
9. FINANCIAL PACKAGE/ PROCESSES					
9a. Define common accounting methodology/chart of accounts	8/15/93	X	X		
9b. Determine financial management approach for PHP (in- or out-house)	9/15/93	X	X		
9c. Compare costs to Medicaid billing assumptions (as in 6d)	12/1/93	X	X		
9d. Recommend provider rate structure	11/1/93	X	X		
9e Develop provider reimbursement method	11/1/93	X	X		
9f. Establish 1994-95 allocation scheme to support managed care	11/1/93	X		X	

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
10. MIS SYSTEM				
10a. Identify needed changes in State MMIS system	11/1/93	X	X	
10b. Assure MMIS changes in place	2/1/94	X		
10c. Develop RSN/M IS to support --forecasting models/needs assessment --automated billings/payment processes --UM/QA monitoring --contract management --public information	3/1/94	X	X	X

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS EXTRA HELP STAFF	CONSUMERS
11. TRAINING				
11a. Train line/supervisory management staff (provider and MHD) in managed care practice	11/1/93	X	X	
11b. Provide educational sessions for boards, consumers, advocates regarding managed care	11/1/93	X	X	X
11c. Train providers and MHD staff in PHP structure, process, tools	1/1/94	X	X	
11d. Train providers and MHD staff in MIS changes	3/1/94	X	X	
11e. Train providers and MHD staff in UM/QA methods	4/1/94	X		

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
12. 1994 PROVIDER CONTRACTS				
12a. Rollover 1993 contracts for first quarter 1994	1/1/94	X		
12b. Negotiate provider contracts based upon all of the above/streamline to minimize administrative cost while ensuring accountability	1/15/94	X	X	

ACTIVITY	COMPLETE BY	MHD STAFF	CONSULTANTS/ EXTRA HELP STAFF	CONSUMERS
13. OTHER				
13a. Develop contracts/working agreements with other RSNs/PHPs	3/1/94	X	X	
13b. Develop working agreements with major emergency rooms to establish appropriate access to mental health services	3/1/94	X	X	
13c. Develop contracts/working agreements with local voluntary hospitals --track voluntary hospital useage beginning 7/93 --determine voluntary hospital interest in serving PHP patients --establish utilization standards --develop process for authorization of care	3/1/94	X	X	
13d. Initiate briefings with elected officials, advocacy groups, and other systems	2/1/94	X		X
13e. Develop/implement proactive press strategy	3/1/94	X		