Community and County Mental Health Programs of the Future

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Introduction

Community Mental Health Centers also referred to as County Mental Health Centers treat patients usually with no or limited insurance in a domiciliary setting versus an inpatient state or community facility. Both children and adults are eligible to receive such assistance. These programs provide a wide range of psychiatric and counseling services to the residents in their community as well as other types of assistance such as:

- treatment services related to substance abuse;
- housing, including halfway hours;
- Full or partial supervision day centers;
- employment services;
- information and education service;
- referrals;
- consultative services to schools, courts and other agencies;
- self-help groups;
- after-care services; and
- other related activities.

The community facilities generally include outpatient clinics, community/county mental health programs, short-term psychiatric facilities, day-care centers, de-toxification centers, residential rehabilitation centers for substance abuse, vocational training, residential care, long-term care psychiatric facilities, and Veterans Affairs (VA) psychiatric centers. The community centers may be co-located with other county services such as social services, occupational rehabilitation services, information technology services, human resources, maintenance services, and others or may be independently located.

A. Description of a Community Mental Health Center

1. Staffing

Staffing levels at community mental health facilities depend on the size and funding of each clinic, and vary in number, qualifications, and mix. Many personnel hold or are working on Master's degrees and various professional certifications. Typical staffing would include:

- **Administrative or Mental Health Director —** This individual, working under general policy directives, is responsible for planning, organizing, coordinating, and directing delivery of a community's comprehensive mental health programs and services. This would include the development and implementation of goals, objectives, policies, procedures, budget, standard compliance, and work standards for mental health services. The Director is responsible not only for the services offered under the program, but also for extensive coordination with other county departments, public and private organizations, citizen groups, and the Board of Supervisors.
- **Case management staff —** These personnel are responsible for compiling all the services related to the treatment program.
- **Psychiatrists —** These individuals may work for a mental health center full or part time, and be Board-eligible or Board-certified in Psychiatry.
- **Psychologists —** These individuals will hold Ph.D., Psy.D. or Ed.D. qualifications and be licensed as clinical psychologists in the state.
- **Licensed Independent Social Worker (LISW) —** These individuals will have expertise in such services as family counseling, child psychology, geriatric dementia, psychological testing, and so on.
- **Licensed Marriage and Family Therapist (LMFT)** — These individuals are specialized in various fields and provide an array of counseling services to patients, dependent on the nature of their problem.
- **Clinical Nurse Specialists —** These personnel are certified in psychiatric nursing by a national nursing organization such as the American Nurses Association to practice within the scope of these services and are licensed in the state.
- **Support staff —** These staff members would include an administrative assistant to the Director, medical billers, transcriptionist, and possibly a receptionist.

- **Substance Abuse Counselor or Licensed Professional Clinical Mental Health Counselor (LPC or LPCC)** — An individual who takes a holistic approach where they exam a person's external environmental and societal influences while also monitoring inner emotion, physical and behavioral health.

  A licensed mental health counselor has met or exceeded the following professional qualifications:[1]

  – earned a Master's degree in counseling or a closely related mental health discipline;

  – completed a minimum of two years post-Master's clinical work under the supervision of a licensed or certified mental health professional; and

  – passed a state-developed or national licensure or certification examination.

2. Types of Covered Services

A variety of services is offered by each state and many times by different counties within the state. Because there are no federal standards, nor even statewide standards within any state, there is little uniformity in services offered. Each and every center can add, delete, or "carve-out" services they wish to include or exclude from their program based on funding allocation, resources, and available space.

Typically however, mental health services include treatments for some combination of the following disorders, among others:

- Alcohol/Drug Abuse
- Anxiety/Panic Disorders
- Attention Deficit Hyperactivity Disorder (ADHD, ADD)
- Autism Spectrum Disorders (Pervasive Developmental Disorders)
- Bipolar Disorder (Manic-Depressive Illness)
- Borderline Personality Disorder
- Crisis/Stress Disorders
- Depression
- Eating Disorders
- Generalized Anxiety Disorder
- Obsessive-Compulsive Disorder (OCD)
- Panic Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Schizophrenia

- Social Phobia (Social Anxiety Disorder)
  - Suicide prevention.

Some states, like South Carolina, based on population size and upon consent of the South Carolina Department of Mental Health, may provide grants to any county, city, town or political subdivision to establish a community mental health service program for its specific area.

Examples of traditional services provided in a typical community mental health program include the following:

- intake evaluations or assessments, which are usually performed by a staff psychiatrist;
- testing, which is performed by a staff social worker or psychologist;
- therapy such as individual or group, detoxification or narcotics treatment programs, which is performed by staff social workers and substance abuse counselors;
- case management, which may involve a combination of internal staff assessment and treatment as well as out-sourced community-based services. The treatment plan is a co-joint plan that is developed between the internal staff at the center and the external staff in the community. This combination of care is usually monitored through medical records to assure specific goals are addressed, treatment providers are complying with the state and federal regulations, in general terms, and the level of care is appropriate. Once the treatment plan and care are approved and provided, a community mental health center will bill collectively for all staff services — both internal and external — and traditionally submits the billing to the insurer. Once reimbursement is received, the center will usually deduct a case management fee based on a percentage of the billing and pay the remainder as fees to the out-sourced providers;
- medication clinics or checks, which are performed by a staff psychiatrist;
- Acute stabilization, crisis intervention or emergency services;
- referrals, which are made by the staff. Clients are directed to traditional medical services, rehabilitation, occupational therapy, housing, vocational, homeless services, and life skills services within the community;
- various support services, which are offered to clients by such organizations as the national foundations for specific diseases, support groups, etc.;
- Support and advocacy services where a team of volunteers and employees staff a 24 hour hotline offering peer counseling, hospital accompaniment, court advocacy, referrals for victims, sexual assault, and provide school-base prevention and education;
- integration of clients into non-medical support services, which includes arranging for clients to attend various 12-step support groups; and
- advocating for or against clients in family and criminal court.

The aggregate service feedback continuum for these mental health services may be visually depicted as:

NOTE: USE GRAPHIC INSTEAD OF ARROWS BELOW

Diagnostic assessment → Functional Assessment → Individual treatment plan (ITP) →

Service delivery → Reassessment

3. Sources of Clients

Community mental health centers receive referrals from a variety of sources, including the following:

- the medical community. These referrals are traditionally for patients without insurance, or who have limited income, or rely on Medicaid, and may come from private medical practitioners, psychiatrists, internists, family practitioners, gynecologists, emergency departments or urgent care centers;
- the psychiatric medical community that includes psychiatrists, psychologists, counselors, therapists, and a variety of social workers from private behavioral managed outpatient clinics;
- the non-medical community. For instance, physical therapy refers individuals facing life-changing problems (e.g., amputation). Osteopaths, chiropractors, and local private therapists all refer occasionally;
- acute private psychiatric centers;
- health departments at major local employers;
- local schools when teachers report suspected developmental problems, suspected abuse, and behavioral problems to the school's counselor;
- Social Services, which refer clients of all ages;
- non-profit agencies helping mental health patients and homeless individuals;
- family members and family support friends;
- some self-referrals or self-help clubs;
- courts, which send defendants for evaluations;
- police, who sometimes bring referrals as an option against arrest and who monitor the homeless;
- staff from the Sheriff's Department jail, which houses offenders, some of whom are assumed to have mental health problems;
- homeless shelters and missions;
- probation officers, who refer probationers for evaluation and monitoring;
- national foundations of specific diseases, which refer patients, like the American Diabetes Association;
- detox centers, which refer clients for evaluation and placement;
- domestic violence groups and protective services groups;
- 12-step recovery groups like Alcoholics Anonymous (**www.alcoholics-anonymous.org**), Narcotics Anonymous (**www.na.org**), Cocaine Anonymous (**www.ca.org**), Emotions Anonymous (**www.emotionsanonymous.org**), Overeaters Anonymous (**www.oa.org**), and Sexaholics Anonymous (**www.sa.org**);
- substance abuse rehabilitation centers, which refer Medicaid clients for evaluation of suspected co-morbidity and after-care;

- clergy who provide marriage and grief counseling;
- pharmaceutical companies that promote treatment, albeit indirectly, for depression, attention deficit disorder, etc.;
- bookstores (through their self-help manuals);
- web sites, such as Substance Abuse and Mental Health Services Administration (SAMHSA) referral site;
- bartenders;
- industrial and company medical departments, which may refer clients who have conditions that are less expensive to treat at a county center; and
- well-meaning individuals.

In addition, public awareness programs often result in increased referrals from various sources.

4. Regulatory Environment

Regulations from federal, state, and county governments have an impact on the day-to-day operations, procedures, and processes of a community mental health center.

- **Federal Regulations** — The United States healthcare system is guided by programs such as those established under the Centers for Medicare and Medicaid (in the case of community mental health programs, Medicaid is especially important), Substance abuse and Mental Health Services Administration (SAMHSA) for community health block grants, Americans with Disabilities Act (ADA), Occupational Safety and Health Administration (OSHA), Health Insurance Portability and Accountability Act (HIPAA), and others. In addition, various Federal regulations have had or will have an impact on community mental health centers such as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Americans with Disabilities Act, The Patient Protection and Affordable Care Act, and others.[2]
- **State Regulations** — These include general legislative guidelines and laws from over 49 states and the District of Columbia, state management of benefits and reimbursement of the Medicaid program, and state allocations of budgets, which impact the centers' operations.[3]
- **County Regulations** — Each county defines its own Community Mental Health Program and decides which services will be provided or excluded.

5. Types of Revenue

Community mental health services are usually paid for with a mix of state, local, and federal funds. In addition, many of those receiving services (approximately 38%) are uninsured and another 35% are covered by Medicaid.[4] Revenue is received from a variety of sources, including the following:

- cash from patients;
- co-pays, sliding scale payments, etc.;
- health insurance payments, primarily Medicaid and some Medicare which does not cover all mental health services;

- direct state funding (available in many states, but not all);
- indirect state funding via the county (available in some states);
- general tax and fee revenues;
- Federal Stimulus dollars;
- county or local levy funding (available in some states) funded largely by state appropriations; and
- direct and indirect grants from various national foundations.

As part of a prior transfer of mental health program responsibilities from the state to counties, in most states some state revenues are automatically set aside for the support of community mental health programs and thus may not be provided through the annual state budget act. Other state support for community mental health programs is provided through the annual state budget act and thus is subject to change by actions of the Legislature and Governor of that state.

The primary source of revenue, however, is Medicaid with the secondary being supplemented by state general funds. Medicaid is a combined state and federal health insurance program administered by the states. Medicaid often provides broader mental health benefits than those provided by private insurance including employment-related services, as well as therapy and medications.

Medicaid operates as a vendor payment program, with payments made directly to the providers. Providers participating in Medicaid must accept the Medicaid reimbursement level as payment in full. Each state has relatively broad discretion in determining (within federally imposed upper limits and specific restrictions) the reimbursement methodology and resulting rate for services, with three exceptions:

1) for institutional services (payment may not exceed amounts that would be paid under Medicare payment rates);
2) for disproportionate share hospitals (DSHs) (different limits apply); and
3) for hospice care.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such copayments. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy health maintenance organization (HMO) enrollees. For the latter, an example would be those individuals who enroll in a Medicaid Managed Care Program with the state and whose income is below a state- or federal-designated poverty level.

The amount of total federal outlays for Medicaid has no set limit (cap); rather, the federal government must match whatever the individual state decides to provide, within the law, for its eligible recipients. However, reimbursement rates must be sufficient to enlist enough providers so that Medicaid care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area.

The portion of the Medicaid program that is paid by the federal government, known as the Federal Medical Assistance Percentage (FMAP) and the Enhanced Federal Medical Assistance Percentages (eFMPA), is determined annually for each state by a formula that compares the state’s average per capita income level with the national average. By law, the FMAP cannot be lower than 50% nor greater than 83%. Wealthier states have a smaller share of their costs reimbursed. More information on FMAP rates by state is available at http://aspe.hhs.gov/health/fmap12.shtn.

The federal government also shares in the state's expenditures for administration of the Medicaid program. Most administrative costs are matched at 50% for all states. However, higher matching rates (75, 90, and 100%) are authorized by law for certain functions and activities.

Most Medicaid plans provide a broad range of professional mental health and substance abuse services, including evaluations, therapy, tests, and reports. Typical covered services under Medicaid for mental health include the following:

- inpatient treatment and psychiatric evaluations;
- outpatient or clinic therapy services to include evaluations, testing, medication management, psychological testing, rehabilitative services, and individual, group, or family therapy;
- therapy in partial hospital settings for patients under 21;
- injections that are primarily used to treat the mental health condition; and
- counseling and recovery programs aimed at treating substance abuse.

In summary, external factors such as government regulations, insurance reimbursement methodology, insurer's limitation of benefits for mental health and ever-increasing cost of medications or limitations of certain medications, and internal factors such as staffing issues, shortage of qualified mental health providers especially in rural areas, increased patient volumes, and managing the day-to-day operations of the center, all negatively impact the future viability of community mental health centers. These situations are causing community mental health centers to consider alternatives to their existing operational structure in order to survive.

6. Other Resources

National Mental Health Information Center
P.O. Box 2345
Rockville, MD 20847
Telephone: 800-789-2647
(TDD): 866-889-2647
E-mail: nmhic-info@samhsa.hhs.gov
http://mentalhealth.samhsa.gov

American Association of Pastoral Counselors
9504-A Lee Highway
Fairfax, VA 22031-2303
Telephone: 703-385-6967
Fax: 703-352-7725
E-mail: info@aapc.org
www.aapc.org

American Self-Help Clearinghouse
Saint Clare's Hospital
100 E. Hanover Avenue
Cedar Knolls, NJ 07927

Telephone: 973-401-2121
Fax: 973-989-1159
E-mail: wrodenbaugh@saintclares.com
www.mentalhelp.net/selfhelp

National Alliance for the Mentally Ill
Colonial Place Three
3803 N. Fairfax Drive, Suite 100
Arlington, VA 22203
Telephone: 800-950-6264
Fax: 703-524-9094
www.nami.org

National Empowerment Center
599 Canal Street
Lawrence, MA 01840
Telephone: 800-769-3728
Fax: 978-681-6426
www.power2u.org

National Mental Health Consumer's Self-Help Clearinghouse
1211 Chestnut Street, Suite 1100
Philadelphia, PA 19107
Telephone: 800-553-4539
Fax: 215-636-6312
E-mail: info@mhselfhelp.org
www.mhselfhelp.org

National Council for Community Behavioral Health Care
1701 K Street, N.W., Suite 400
Washington, DC 20006
Telephone: 301-984-6200
Fax: 301-881-7159
www.nccbh.org

B. Issues Impacting Community Mental Health Programs

Maintaining the goal of the community mental health is difficult due to changing social priorities, funding deficits, and the increasing need of treatment. Just alone in the 21st century, there has been nearly a four-fold increase in the number of patients seeking care at a community mental health center which is not mirrored by a rise in physicians.[5] These issues create incorrect allocation of resources to meet the needs of the patient population, poor coordination and communication both internally with the staff and externally with the medical community, staff attitude problems, access to care in a timely manner, and a host of other inequities, which cause organizational and operational discord. However, most importantly, these issues have an impact on the financial viability of the centers.

The following provides an overview of several of the major issues impacting the community mental health programs and includes the impact of the newly approved health reform bill, the Patient Protection and Affordable Care Act which was signed into law on March 23, 2010 (http://www.healthcare.gov/law/full). It needs to be noted that these issues are not prevalent in every mental health program, but represent the typical sampling of issues. In addition, these issues may vary in intensity from one location to another, or may be totally different.

1. Fragmented Entry Process into the Mental Health System

In a community program, no single gatekeeper refers patients to the center. Referrals come from a multitude of providers and services within the county in a non-coordinated manner. The typical referral patterns were referenced in Section A.3, Sources of Clients, above.

2. Shortage of Qualified Mental Health Providers

Due to the increase in volumes and the majority of rural and urban mental health centers, there is a shortage of qualified behavioral or mental health providers to serve the populations at hand, especially in the rural areas. With a local presence of specialty behavioral health providers, primary care providers play a large role in behavioral health care, even though many have not been specifically trained in this specialty. The Patient Protection and Affordable Care Act is planning on addressing the provider shortage by establishing grant programs to train and educate new providers, especially those that would be co-located in rural areas, special needs populations, and schools and colleges.

Impacting the provider community roles and responsibilities are the clinical social workers who are providing a higher volume of mental health services. Their scope of services is quite broad and many times overlaps the fields of psychiatry, professional psychology, psychiatric nursing, and marriage and family therapy. Several state laws have enabled these same individuals to diagnose mental disorders, testify in court as expert witnesses, and even admit crisis patients to mental facilities. Because of this broadening scope of duties, many of the higher paid psychiatrists are either finding their duties and responsibilities limited or are seeking other positions outside the boundaries of community mental health centers.

3. Administrative Challenges

Community mental health programs may be staffed by personnel supplied by the state, personnel hired independently, and contractors (for services that have been outsourced). This patchwork arrangement creates management issues, including diminished authority and lack of compliance, discipline and attitude problems, potential salary discrepancies among similar staff functions, bureaucracy that hinders transitioning to emerging mental healthcare treatment trends or new services, denial of services and resulting labor-intensive appeal processes, and many more.

At the executive level, a Director may hold the title, may have a Master's in Healthcare Administration, and may function as a Chief Operating Officer (COO), but may have little experience in working in a government-run facility managing an archaic governmental accounting system. Also, a Director may work in parallel with a Medical Director, who is usually a psychiatrist, but who may only be interested in clinical services, not in regulatory or administrative matters, creating managerial or staff conflicts.

Recruitment — hiring and retention of qualified and culturally competent staff — is a significant problem, especially for small community mental health centers or areas that are sparsely populated. These centers usually are unable to compete with pay, benefits, professional growth opportunities, and working conditions of larger counties. As a result, smaller centers often have unfilled positions and limited patient care.

Community mental health programs yield no profitability and many times the Director must arbitrarily reallocate funds in order to finance various internal projects or services. This incremental budgeting, or "use it or lose it" funding does not promote cost savings, but instead is merely a money-shuffling exercise that keeps a center functioning on a day-to-day basis.

Another challenge for most mental health centers is the cultural diversity of the patients. Many speak multiple languages and may not be proficient in English causing mis- or poor communications and difficulty in providing follow-up care. Additionally, these same individuals because of the cultural stigma and/or the difficulty in communicating may never return for additional care, and instead will seek assistance from clergy or a general health provider who may not have the training or education needed to treat the behavioral issue.

In addition, many of the funding models will not work for small counties, and in fact, may end up penalizing themselves. The amount of available funds is often so small that the administrative cost of applying for, tracking, and justifying the use of the funds is far greater than the allocation itself. Consequently, many smaller counties "leave the money" that, in turn, will be collected and used by larger county programs. The result is a widening of the gap between resources and program availability between smaller and larger counties.

Increasingly, the cost of upgrades is a challenge. Many centers cannot afford the investment required to purchase modern computer equipment and software, nor to provide the necessary continued maintenance and technical support. Thus, as technology becomes increasingly sophisticated, the community mental health centers drop further behind. In addition, the cost of renovation of physical facilities to meet evolving program needs has become-prohibitive.

4. Medical and Mental Health Parity

There has been a difference between the benefits covered under medical insurance for providers and facility charges compared to the benefits covered under mental health benefits. In addition, there have been caps on the annual number of visits allowed, higher co-pays, higher deductibles, restrictions of medications on the Preferred Drug List (PDL), and reduction of covered benefits such as partial hospitalization and number-of-treatment limits for mental health. Further managed care systems, like Medicaid Managed Care, focus on limiting costs by either keeping the total number of patients using services low or reducing the cost of the service itself.

Congress touched on this issue in 1996 with the Mental Health Parity Act. This federal law prevented group health plans from placing annual or lifetime dollar limits on mental health benefits that are lower — less favorable — than annual or lifetime dollar limits for medical and surgical benefits. However, the law did not require group health plans and their health insurance issuers to include mental health coverage in their benefits package — it only applied to group health plan insurances that already did include mental health benefits in their benefit package.

In 2003, Senators Pete Domenici, Edward Kennedy, and Representatives Patrick Kennedy and Jim Ramstad introduced S. 486 and H.R. 953, called the Mental Health Equitable Treatment Act. In March 2005, the Mental Health Equitable Treatment Act was passed and with the passage of this bill a loophole — that insurers may no longer arbitrarily limit the number of hospital days or outpatient treatment sessions for people in need of mental health care — was closed. The law also eliminated separate and unequal deductibles and out-of-pocket costs for mental health and substance abuse services. It required a single deductible and the same out-of-pocket co-payments or co-insurance for mental health and substance abuse services and all other covered health services. It also removed separate yearly and lifetime visit limits and dollar maximums. Although the law required insurers to provide coverage for mental health and substance abuse services at the same level as other health services covered under the plan, insurers are allowed to offer benefit options with different out-of-pocket costs as long as one of the options provides the same coverage for mental health and substance abuse as other covered health services.

On October 3, 2008, the Emergency Economic Stabilization Act (HR 1424) passed Congress and was signed into law. It included a major mental provision, was entitled the “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act”, was attached to the economic bill and became law. This federal mental health law required health insurance plans that offer mental health coverage to provide the same financial and treatment coverage offered for other physical illnesses but again does not mandate that group plans must provide mental health coverage. This law is extremely protective of state law. Only a state law that “prevents the application” of this Act will be preempted - This means that stronger state parity and other consumer protection laws remain in place. Many states still have not enforced the law and insurers will still continue to limit mental health benefits.

None of the aforementioned laws mandates the coverage of any specific mental health condition; rather, where an insurer chooses to cover both mental health and medical and surgical benefits, they are required to do so in compliance with these parity requirements.

The new Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as modified by P.L. 111-152 of the health care and Education Reconciliation Act of 2010) and approved by the Supreme Court on June 28, 2012 (in the case of National Federation of independent Business v. Sebelius) contains a number of provisions that general combine to extend the reach of existing federal mental health parity requirements. The ACA contains a number of provisions which achieve two key goals with respect to mental health parity: 1) they expand the reach of the applicability of the federal mental health parity requirements; and 2) they create a mandated benefit for the coverage of certain mental health and substance abuse disorder services (to be determined through rulemaking) in a number of specific financing arrangements. The PPACA expands the reach of federal mental health parity requirements to three types of health plans: 1) qualified health plans as established by the ACA; 2) Medicaid non-managed care benchmark and benchmark-equivalent plans; and 3 plans offered through the individual market.

The PPACA will also:

- Bars insurance companies from considering pre-existing conditions or gender in coverage decisions

- Expands coverage to include 30 million uninsured

- Requires insurers to offer the same premium to all applicants of the same age and geographical location

- Commences the operation of a Health Insurance Exchange to offer individuals and small business policies and premiums. In addition, low income individuals and families above 100% and up to 400% of federal poverty level will receive federal subsidies on a sliding scale if they choose to purchase insurance via an exchange. Medicaid eligibility to those earning up to 133% of the poverty line

- Includes Medicaid eligibility to those earning up to 133% of the poverty line. However in states that choose to reject the Medicaid expansion, individuals and families at or below the 133% of the poverty line, but above their state's existing Medicaid threshold, will **not** be eligible for coverage.

- States that annual and lifetime coverage caps will be banned

- Eliminates Co-payments, co-insurance and deductibles for select healthcare insurance benefits considered to be part of an "essential benefits package for Level A or Level B preventive care or medical screening

The PPACA was effective June 21, 2010 but will be transitioned into place over the next eight years with various provisions enacted each year. The issues impacting today's and the immediate future of the community mental health centers are the defining of approved mental health benefits, handling the significant increase of potential new Medicaid patients who are now seeking mental health benefits, addressing the ratio of qualified mental health providers to the number of patients, and addressing the impact of continued cost to the mental health center. For now until 2014 the Medicaid health premiums will be paid by the Federal government from a variety of taxes and offsets, but will then revert to the States. Likewise, states may opt out of the expanded Medicaid eligibility requirements without losing pre-existing Medicaid funding from the Federal government. To date, five states have opted out Texas, Florida, Mississippi, Louisiana, and South Carolina.

More information for health plans subject only to federal law may be obtained from the U.S. Department of Labor toll-free by telephone at 866-275-7922, or by mail from:

U.S. Department of Labor
Employee Benefits Security Administration
ERISA/COBRA Office
JFK Federal Building, Room 575
Boston, MA 02203

5. Coding Classification

The classification and coding systems used by mental health insurers, both diagnosis-related groups (DRGs) through revenue codes for facility and program services and current procedural terminology (CPT) for in and out patient professional services and consultations, are still being defined through historical methodologies and are vague compared to the medical classification coding structure. As an example, mental health insurers classify Tourette Syndrome (TS) as a "mental disorder." In fact, TS is an inherited, neurobiological disorder, and both neurologists and psychiatrists treat TS with the same medications. If TS were reclassified under the medical coding structure, TS would not only receive potentially a better reimbursement but public perception of TS as a "mental disorder" would be changed.

The Diagnostic and Statistical Manual of Mental Disorders (4th edition, text revision), also known as the DSM-IV-TR, is a manual published by the American Psychiatric Association (APA) that includes all currently recognized mental health disorders. The coding system utilized by the DSM-IV is designed to correspond with codes from the International Classification of Diseases, commonly referred to as the ICD.

Since early versions of the DSM did not correspond with ICD codes and updates of the publications for the ICD and the DSM are not simultaneous, some distinctions in the coding systems may still be present. For this reason, it is recommended that users of these manuals consult the appropriate reference when accessing diagnostic codes. In addition, DSM5 is currently in consultation, planning and preparation and is due for publication in May 2013. For more information, contact the APA at (800) 368-5777.

Besides the above coding manual, the International Statistical Classification of Diseases and Related Health Problems" produced by the World Health Organization (WHO) is another commonly used manual which includes criteria for mental health disorders.

6. Medication and Pharmaceutical Direction

To quote the Mental Health America Article on Access to Medication, "While medication is by no means the 'be all and end all' of psychiatric treatment, for many if not most people, medication has played an essential role. This treatment technology by abating symptoms has enabled people with mental illness to take advantage of and benefit from the many other technologies (such as community-based case management, wrap around plans, supported employment and housing, and peer-led services) to build or rebuild the type and quality of life they desire. It is for this reason that 'preserving open access' assuring that all medications for the treatment of mental illness are equally and easily available is so critical. Unfortunately open access has been under threat for a number of years and has intensified recently in many states."[6]

The community mental health programs are being impacted by the following:

- Medicaid Preferred Drug Lists (PDLs) formerly called Drug Formularies. Many of these drugs listed only contain one or two mental health medications and rarely include the newest or most effective drugs available. Providers must obtain prior authorization from the Medicaid agency which many times are denied.

- There is an emphasis on drug therapy and the derived benefits of an individual being able to return and function in the community.

- Pharmaceutical companies are marketing their newer, more costly drugs to the mental health centers, while insurers are constructing barriers to medication access. Insurers fail to take into account the complexity of mental illness and the fact that an individual may have more than one illness, mental and/or medical, that requires the prescribing of multiple medications, including newer more effective drugs.

In the past, psychiatrists focused on identifying the "cause of the problem" and developing associated treatment plans to treat the cause. With the increasing number of mental health patients, especially those with chronic mental illness conditions, psychiatrists do not have the time to focus solely on the treatment plan and the underlying cause of the mental illness. Instead, their focus has had to become intake evaluations, case coordination, and medication checks. Use of medication has replaced the treatment plan, and continues to play a much larger and more primary role in the treatment of most, if not all, patients. If medications are reduced, the end result is that these patients will require more costly treatment in the long run.

The Food and Drug Administration (FDA) lifted restrictions against direct pharmaceutical advertising several years ago, enabling the representatives of these firms to market and advertise their drugs. Advertisers target both medical and mental-related problems, including everything from depression, anxiety, attention deficit disorder, acid reflux disease, high cholesterol, erectile dysfunction, arthritis, allergies, over-active bladder, to asthma. With the advent of marketing, many drugs are now being over-prescribed and are becoming a component of spiraling healthcare costs.

In summary, these pharmaceutical issues are having an impact on community mental health centers — first, as a cost issue, second because of the change-in-direction treatment modality, and third from the perspective of potential ethical issues involved in provider/pharmaceutical company ties and relationships. There is a fine line between what is needed by the patient in the treatment of his/her mental health condition and what may result in an unnecessary, as well as costly drug interventions.

7. Decentralization

The shift to the outpatient setting including mental health centers has been evident for several decades and has been demonstrated by the continued volumes of patient seeking care in community mental health centers. This evolution has a positive impact on patients and their families as they are able to re-acclimate to society versus spending their waning years institutionalized. However, the associated increased volume of patients contribute to long wait times, increased cost, lesser quality of care, and limited interaction times between providers and patients. This issue persists and will continue to persist until different revenue dollars either from the Federal, State, County or insurance can offset the rising operational cost.

8. Increased and Diversified Patient Populations

Patient populations at community mental health centers are on the rise and this rise is associated with different groups or classifications of individuals. Some centers may or may not have experienced increases in these specific classifications previously; however, they are increasing in many centers today and will continue in the future. There is an unprecedented number of older adults who are experiencing substance abuse issues, depression, anxiety, or dementia-related behavioral and psychiatric symptoms along with a multitude of medical issues as well as complicated medication regimens that frequent these centers across the United States. The clinic healthcare workforce is not prepared to address this influx of patients and their associated special needs at these centers. Another category, children and teenagers, is also on the rise. This can be attributed to more schools referring students, more families seeking care for their children, more emphasis being placed upon mental health treatments and medications, or a combination of things. Minorities, such as Hispanics, Latinos, African American, and others are somewhat reluctant to seek behavioral health treatment because of the associated cultural stigma surrounding mental health. However, when these same individuals have a combined physical and mental healthcare related need, they are seeking care at community centers. Finally, others seeking care have had terrorism scares, are Veterans with Post Traumatic Stress Disorder (PTSD) and other affiliated behavioral symptoms, or have been afflicted with a long term mental or emotional issue from the impact of natural disasters that caused a lost loved one, home, pet, or job. Many of these individuals not only have mental health issues but also have one or many medical health issues creating a complex case.

9. Facility Payments

Federal per diem base payment rates for facility payments, i.e., free standing clinics or hospitals, are calculated by the Centers for Medicare and Medicaid Services (CMS) using a separate marketplace basket to update payments and reimbursement. This payment process is called the inpatient Psychiatric Facility Prospective Payment System (IPFPPS) and is determined by the following:

- Geographic factors based on geographic differences in wage levels
- Patient characteristics that includes Medicare's Severity Diagnosis Related Groups (MS-DRG) along with age, length of stay and co-morbidity

- Facility characteristics such as rural, teaching hospital, etc.
- Other factors such as Electro Convulsive Therapy (ECT) or other extraordinary high costs items

C. Future Options for Community Mental Health Centers

With all the issues, especially those related to diminishing financial resources that are having an impact on community mental health centers, state and county officials, and Directors of mental health centers are looking at options for survival. In general, public sector providers rely heavily on tax monies from state and federal governments, on health insurance, and to a lesser degree on private or self-pay funds. State appropriations for community mental health services are always among the first items cut in biennial budgets and are significantly reduced by administrative expenses at state and regional levels. Most insurance companies still find ways to restrict mental health benefits and/or the associated funding thereof. In addition, prior to the adoption of the PPACA, insurance reimbursement, such as from Medicaid, has always been inadequate and cuts were made in Medicaid reimbursement and in other state programs serving the poor — programs on which community mental health services are heavily dependent. As a consequence, the community mental health centers find themselves continually realigning internal cost priorities and struggle with financial viability, which has resulted in many program closures.

Throughout the years, even for private sector providers, the funding is no better and patients often have significant out-of-pocket expenses. Health insurance companies reimburse only licensed providers and severely limit the amount of service that can be provided (for instance, by limiting the number of psychotherapy sessions). Medicare funding is available only to older adults and to some disabled persons, and the elderly typically has not sought mental health treatment because of the stigma attached. As for Medicaid, many private practitioners have refused to accept Medicaid's reimbursement because it is so inadequate compared to Medicare, private insurance or managed care reimbursement.

There are four options available for the survival of community mental health centers. An internal re-organization is a solution that can create more operational efficiencies in some of the centers. Another solution is one that includes the provisions of the recently passed law – the PPACA. The more promising solution for survival is a combination of the PPACA benefits along with the either a new direction of a combined medical-mental health center or privatization. There is a potential fifth option which will be briefly described at the end. All options are detailed below.

1. Internal Reorganization

Internal reorganization is a solution, but one that requires the full support of every person within a community mental health center. Centers need to evaluate themselves internally and develop action plans that will organize, coordinate, direct, and manage all aspects of their internal operation.

The first step in this process is actually conducting interviews and gathering information. From this information, a center will need to focus on five things:

1) identification and location of services presently offered, and nature of clients served;

2) operational processes from the time the patient enters the door until they leave;

3) staffing capabilities, training, and qualifications;

4) funding sources; and

5) issues, problems and needs.

Checklist 1 presents a typical list of questions that should be addressed. Through these questions and others, a community mental health center will be able to develop a detailed action plan that will lend itself to improving day-to-day operations, standardizing treatment protocols, improving scheduling, recruiting and retaining qualified staff, improving collaboration and coordination, increasing funding options, and improving insurance qualification and reimbursement.

The internal reorganization option will take considerable amount of invested time, cost, and commitment from staff in order to make it truly effectual. Many centers are unwilling to invest the resources or cost in order to change; many staff is reluctant to change their routines. Therefore, many centers are appearing to head to other more immediate solutions.

2. Patient Protection and Affordable Care Act (PPACA)

As mentioned previously in this chapter, the new national health reform law enables many individuals who have previously been uninsured to obtain Medicaid coverage. In addition, this new law works towards more medical and mental parity where mental health providers would be paid comparable to medical providers, enabling more equality. This law also creates a mandated benefit for the coverage of certain mental health and substance abuse disorders that when adopted will require insurance firms – Medicaid, Medicare, Managed Care, and private insurance, to cover these services. Those individuals who would have been precluded in obtaining insurance because of a pre-existing condition will now be able to be covered. Likewise, certain preventive benefits will be included without associated restrictions, deductibles, coinsurances or annual or lifetime coverage caps.

The PPACA does not immediately address all the financial, staffing, or benefits issues but is a step in enabling patients without insurance coverage to have coverage and clinics and providers to receive equitable reimbursement. The financial picture of a community mental health center could improve within several years, but would still need State, Federal. Local, and grant subsidy.

3. Combined Mental and Medical Health Centers

As alluded to previously in this chapter, many individuals who seek care in community mental centers, emergency rooms, urgent care centers, or provider offices have a combination of mental and medical related conditions. It is well known that many private care providers don’t have the skills and training to treat psychiatric related problems nor prescribe associated medications; likewise, mental health providers are not familiar with the current treatment and medication protocols to treat medical problems. It is further well known that one condition could precipitate another and vice versa and that initial evaluations and preventive treatment could eliminate potential chronic conditions, whether mental or medical health.

One of the future recommendations for economies of scale and for integration of care is to co-locate the mental and medical health centers at one site. This will enable coordination of care plans between multi-specialties as well as enable patients to immediately see other specialties without having to obtain a referral with a provider across town. As everyone knows, if a patient has to wait to see another provider, that secondary visit may not occur. Secondarily with the existing process, providers are not sharing their findings nor communicating with other providers which have resulted in disjointed treatment efforts and poor outcomes. This newer model provides prevention and early intervention, coordination of care, improved patient outcomes and recovery, reduction or elimination of ongoing symptoms and/or mental/medical problems, and require less clinic re-visits. This represents a “total healthcare package” that includes both mental and medical components and can prevent the development of more serious mental health or medical conditions, improve quality of life, and are more cost effective to the community center.

Pros	Cons
• Shared overhead cost with combining two clinics • Both medical and mental care issues are	• Expense of time to plan, coordinate, move, and re-organize business processes

addressed at one site • Early prevention can reduce chronic conditions saving more expensive treatment cost • Providers collaborate on combined treatment plans • Cross specialty education occurs • Resources and systems are shared	• Staff may resist re-education and re-positioning of duties • The co-location may be cost-prohibitive to both the medical and mental clinic and not be a feasible option

4. Privatization

Privatization --where a private for-profit business takes over the processes of traditional public government provided service -- is a continuing trend and has been used for not only mental health centers but also other public services. This process shifts the funding and cost from the community-based organization to a private managed behavioral healthcare organization that have operated similar functions in the past.

In today's economy, the government, especially with community mental health centers, are being asked to do more with less money, which has increased the cost and decreased the revenues. It has been demonstrated from other privatization efforts that the private sector can deliver quality products and services more efficiently and at a much lower cost to taxpayers.

The components of privatization are:

- Alignment of expectations
  - What the agency though they were getting from the RFP
  - What the firm said they would do in the proposal
  - What the contract committed both to do
  - Original alignment of expectations and outcomes
  - Modifications where necessary
  - Quarterly and annual performance meetings
- Staffing
  - Full or part time
  - Training
  - Compensation and benefit structure
  - Defined performance methods
- Process and procedures
  - Written policies and procedures
  - Training on processes and procedures
  - Continual communication
- Structure
  - Internal reporting structure
  - Role of agency and customer
  - Role of team

- Defined roles and responsibility

Privatization can be accomplished in one of three ways:

- Outsourcing – The government agency delegates some or all of its in-house operations or processes to a third party. It is a contracting transaction where the government agency purchases services from a private firm while keeping ownership and ultimate responsibility for the underlying processes. They inform the private firm of what they want and how they want the work performed. The private firm can be authorized to operate as well as redesign basic processes in order to ensure even greater cost and efficiency benefits.

- Design, Build, Operate – The government negotiates with a private firm to design and construct a new facility that is fully operational. The project components are procured from the private sector in a single contract with financing secured by the public sector.

- Public/Private Partnership – This is a cooperative arrangement between both parties where each assume some responsibility for operating the program.

More specific techniques are outlined below:

Table 1: Privatization Techniques

Privatization Techniques	Description
Asset Sale	Ownership of government assets, commercial-type enterprises, or functions is transferred to the private sector through the selling of such assets.
Contracting Out	Government enters in contractual agreements with a private firm(s) to provide goods or services.
Franchising	Government grants a concession or privilege to a private-sector entity to conduct business in a particular market or geographical area.
Managed Competition	A public-sector agency competes with private-sector firms to provide public-sector functions or services under a controlled, or managed, process.
Public-Private Partnership or Joint Venture	A contractual arrangement is formed between government and private-sector partners that can include a variety of activities including development, financing, ownership, and operating of a public facility or service.
Subsidies	Government encourages private-sector involvement in accomplishing public purposes through direct subsidies, such as funding or tax credits.
Vouchers	Government subsidies are given to individuals for the purchase of specific goods or services from the private or public sector.

Source: Office of the Auditor, Report No. 99-11, Study of Privatizing Adult Mental Health Program Services.

Many states and counties are seeking to “out-source,” “privatize,” or “contract” with private entities especially when it is reasonable to believe that those private entities can provide equivalent or better quality services at lower cost than the government agency. Note, though, that equating cost efficiency with the lowest bidder may be a mistake.

D. An Examination of the Privatization Option

A key to the successful privatization of government services is the use of a systematic decision-making process to guide actions taken. Such a process includes an analysis of various factors that will determine the success of privatization efforts. These factors include the following:

- realistic and measurable goals and criteria;
- availability of qualified and capable competition;
- an accurate cost or business analysis;
- state employee and union decisions especially regarding current staff;
- safeguards to mitigate risks;
- adequate management controls, monitoring, and evaluation; and
- controls for maintaining and monitoring quality of service.

As with all shifts in services, there are pros and cons that need to be considered when contemplating privatization of a community mental health center.

Table 2: Pros and Cons of Privatization

Pros	Cons
Eliminates cost of staff, overhead, and operating cost to the community mental health center. This staff would be outsourced to the new firm.	May lack support from union or exclude unions and staff covered by unions in new arrangement. Affects morale of both patients and staff because they fear change. New firm may reduce level of care or services as a cost saving measure. A shift of cost and burdens to other agencies could occur.
Provides a managed care coverage concept. Efficiency of operations	Increases patient volumes per provider in managed care. Tends to limit patient/provider interaction and/or fragmentation of treatment services by eliminating multi-interdisciplinary teams
Assumes quality of care with a quality run firm.	May resort to older, cheaper medications because the newer, more expensive medications are too costly to dispense.
Outsourcing becomes a management tool for the mental health center oversight team	Limits the decision making of mental health professionals — authorizations, length of treatments, treatment protocols, and so on.
Lessens state and community liability.	Community will need to establish an oversight body and define performance standards in order to monitor private entity once contract is in place. There will be increased cost, both in terms of time and of personnel.
Improves organizational efficiency and eliminates overlap of services and specialties.	May result in questionable performance from contracted firm.
Private sector management flexibility (recruiting, hiring, compensation, etc.)	Existing staff may not be hired, resulting in potential unemployment.
Private sector management experience of similar projects	Qualifications may be stated, but company may not have quality

	performance requirements in place.
Improvements in patient outcomes and patient satisfaction	Projected outcomes may suffer based on clinical protocols and treatments

The components of privatization are:

- Alignment of expectations
    - What the agency though they were getting from the RFP
    - What the firm said they would do in the proposal
    - What the contract committed both to do
    - Original alignment of expectations and outcomes
    - Modifications where necessary
    - Quarterly and annual performance meetings
- Staffing
    - Full or part time
    - Training
    - Compensation and benefit structure
    - Defined performance methods
- Process and procedures
    - Written policies and procedures
    - Training on processes and procedures
    - Continual communication
- Structure
    - Internal reporting structure
    - Role of agency and customer
    - Role of team
    - Defined roles and responsibility

What are the pre-requisite characteristics of an ideal partner when considering privatization?

• Understanding of agency needs and local community • Project approach • Same management and governance philosophies • Ability to provider services • Operational background and experience • Financial solvency • Understand political issues • Operations program strategy	• Long term, low cost solutions • Competitive pricing • A tailored or customized operational process, not an off-the-shelf one-size-fits-all model • Willingness to partner and consider long term arrangement • Open dialogue on issues • Not interested in cutting or restricting services • Service oriented

Successful privatization results cannot be guaranteed; however, strong leadership can ensure that privatization efforts are adequately planned, implemented, and evaluated. To this end, the leaders in any drive towards privatization must prepare a thorough analysis of both the costs and the benefits. On the one hand, what is the potential for cost savings? On the other hand, what new costs might be involved in writing bid and contract requirements, and developing monitoring and oversight requirements? The following table outlines the cost components to be considered:

Table 3: Cost Components of Privatization

Cost Component	Description
Total in-house (fully allocated) costs	**Direct costs** — 100% chargeable to service targeted for privatization. This can include salaries, wages, fringe benefits, supplies, materials, travel, printing, rent, utilities, communications, and other costs such as interest costs, pension costs, and facility and equipment costs. **Indirect or overhead costs** — benefit the target service and at least one other government service, program, or activity. This can include salaries, wages, fringe benefits, supplies, materials, travel, printing, rent, utilities, communications, interest, pension, and depreciation that benefit the target service and at least one other government service, program, or activity. State and local governments frequently develop overhead or indirect cost rates that are simply applied to the personnel or total direct costs of a target service.
Total contracting costs	**Contractor cost** — cost to perform target service. **Administration costs** — procurement, contract negotiation, contract award, amendment and change order processing, dispute resolution, contractor invoice processing, and contract monitoring and evaluation. **Conversions costs** — personnel, material and other costs resulting from the conversion from in-house to contracted service, and off-setting revenue (new or enhance revenue stream resulting from contracted service).
Total avoidable cost	Costs that will not be incurred if a target service or portion of a service is contracted out. All direct costs are avoidable; however, determining what portion of indirect/overhead costs is avoidable requires professional judgment and largely depends on three factors: 1) How effectively resources are reallocated; 2) The time period in which resource allocation will occur; and 3) The extent of the privatization effort.
Potential savings	Subtract "total contracting costs" from "total avoidable costs."

Source: Reason Foundation, Massachusetts Office of the State Auditor and Texas Council on Competitive Government.

A business case assessing privatization should include the following elements:

- Description of service to be outsourced
- Description and analysis of agency's current performance
- Desired goals and rationale for each goal
- Options for achieving goals and advantages and disadvantages
- Description of current market
- Cost benefit analysis
- Current and expected performance standards\
- Key benchmarks
- Contingency plan for contractors non-performance
- Transition plan

For assistance in preparing such an analysis, the following guidelines, studies, and reports may be helpful:

- *Annual Privatization Report 2010: State Government Privatization*, published by Reason Foundation in 2011
- Reason Foundation, *Privatization Blog*, 2012
- *Privatization: Lessons Learned by State and Local Governments*, published by the General Accounting Office in 1997.
- *Private Practices: A Review of Privatization in State Government*, published by the Council of State Governments in 1998.
- *Effective Bidding System and Monitoring System to Minimize Problems in Competitive Contracting*
  How to Compare In-House and Contracted Services
  Designing a Comprehensive State-level Privatization Program
  Social and Health Services Privatization: A Survey of County and State Governments
  all four published by the Reason Foundation in 1993.

Once the decision to proceed with privatization is made, the process should include, at a minimum, the establishment of a privatization oversight committee to assure systematic progress. The process should include implementation of a method for identifying potential privatization opportunities, development of privatization guidelines to promote accountability and the identification and analysis of what services should be privatized. Internally, staff must assemble necessary information, including the following:

- organization chart;
- job descriptions of all staff, including the Director;
- summary of patient volumes, by day, by month, by category;
- insurance distribution, including a reimbursement summary by month;
- budget versus actual summary of cash flows, monthly and annually;
- listing of any outsourced services;
- union regulations in place and information on whether the union agreed to privatization;
- detailed outline of treatment protocols currently in use;
- details of problems and issues;
- operations manual of policies and procedures;
- referral services

Community center/county officials must also determine the criteria for selecting a service provider and establish bid and contract requirements. Appendix 1 provides an example of a bidder evaluation form.

Finally, county officials should establish performance outcomes that are specific in terms of service quality, service levels, timeframe, reporting requirements, and tolerance ranges. Strong oversight of privatization efforts is critical. This would include periodic inspections, conducting citizen questionnaires, addressing any complaints, determining whether performance standards are adequately met, and conducting cost-benefit analysis to determine whether identified savings are realized and maximized.

Appendix 2 provides an outline for a Request for Proposal (RFP) form to be presented to private firms bidding on services that have been identified for privatization.

Once the RFPs are received, an evaluation process must be established. This process should be under the direction of the center's Director and the evaluation process and evaluation of RFPs should be done collectively by the oversight committee along with a report to the Director. The following list outlines the steps that should be followed in this process:

- Evaluation of mandatory requirements — have mandatory requirements of RFP been agreed to? Evaluate each RFP as pass or fail.
- Evaluation of technical proposal — evaluation of proposal by a team of qualified members using standardized evaluation tools and forms. The technical details should be scored using a point system.

- Evaluation of pricing/cost for each firm and comparison of each firm's cost to center's current operational cost.
- Oversight Committee review and recommendations — interview applicants and decide on a scoring process (probably a point system that assigns points to specific criteria such as background, experience, qualifications, scope of work, project organization and staffing, and project management).
- Rank the proposals — points for technical proposal are added to points for cost proposal and ranked highest to lowest.
- Announce the proposal award.
- Publicize the appeal process.

In summary, the important point to stress is that the community mental health center needs to define its criteria for an RFP, evaluate each firm against the criteria, and select the firm that aligns most closely with those criteria and will provide the quality of services, operational structure, and efficiency that the center desires. Without this process in place, privatization may not be better for the center than their own reorganization.

Other Potential Option – Federal Qualified Behavioral Health Centers (FQBHC)

This is a concept that would replace the current criteria for a community mental health center and would be established out of SAMHSA as a block grant. Services include screening, assessment, diagnosis, risk assessment, person-centered treatment planning, outpatient mental health services, outpatient primary care services, crisis mental health services, case management, psychiatric rehabilitation and peer and family support. This would require that services funded by the block grant be provided through appropriate qualified community programs and would require an entity be certified as a FQBHC by the SAMHSA Administrator at least every five years based on specified criteria.

E. Conclusion

In conclusion, Community Mental Health Programs face financial, re-direction, morale, staffing, and organizational issues today and more so in the future. These issues will have an impact on the clinic's viability. Each Community Mental Health Program needs to determine if they can provide the quality of care needed for the community with their existing structure and budget; if not, changes *will* need to be made.

Those responsible for the management of these programs need to evaluate each of the critical components compared to one or both of the options presented to determine which one would provide the most positive outcome for the community it serves.

Acknowledgements

To Hope Rachel Hetico RN MHA CMP™ of the Institute of Medical Business Advisors Inc, of Atlanta, GA

End Notes

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Mental Health Support Groups

American Association for Marriage and Family Therapy
American Counseling Association
American Group Psychotherapy Association
American Psychoanalytic Association
American Family Therapy Academy
American Nurses Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
Clinical Social Work Federation
National Association of Social Workers
National Association of Alcoholism and Drug Abuse Counselors
National Depressive and Manic-Depressive Association
National Mental Health Association
Therapeutic Communities of America

Mental Health Professional Publications

Academic Psychiatry
American J of Psychiatry
American J of Psychotherapy
Applied and Preventive Psychology

Archives of General Psychiatry
Behavior Research Methods, Instruments, & Computers
Behavior Therapy
Biological Therapies in Psychiatry
Biological therapies in Psychology
British Medical J
Bulletin of the Canadian Psychiatric Association
Bulletin of the Canadian Psychological Association
Canadian J of Psychoanalysis
Canadian J of Psychiatrics
Clinical Psychology: Science and Practice
CyberPsychology & Behavior, catchword
CyberPsychology & Behavior, liebertpub
Int J of Psychopathology, Psychopharmacology, and Psychotherapy
J of Addictive Diseases
J of American Academy of Child & Adolescent Psychiatry
J of the American Pharmaceutical Association
J of the American Psychoanalytic Association
J of Behavioral Health Services & Research
J of Clinical Psychiatry
J of Health Politics, Policy and Law
J of Information Technology in Medicine
J of Internet Law
J of Law, Medicine & Ethics
J of Neuropsychiatry and Clinical Neurosciences
J of Psychiatry & Neuroscience
J of Telemedicine and Telecare
Morbidity and Mortality Weekly Report
Psychiatric Services
Psycoloquy
Social Science Computer Review
Studi di Psichiatria
US Pharmacist
Clinical Psychiatry News
J of the California Alliance for the Mentally Ill
J of Virtual Environments J of Addictive Diseases
J of the American Academy of Child & Adolescent Psychiatry
J of the American Pharmaceutical Association
Psychiatric News
Psychiatric Times
PsychNews International

Mental Health Professional Organizations

Administrators in Academic Psychiatry
Adult Children of Alcoholics
Alliance for Psychosocial Nursing
American Academy of Child & Adolescent Psychiatry
American Academy of Experts in Traumatic Stress
American Academy of Neurology

American Academy of Psychiatry and the Law
American Academy of Psychotherapists
American Association of Community Psychiatry
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of Suicidology
American Board of Psychiatry and Neurology
American College Counseling Association
American College Health Association
American College of Mental health Administration
American College Personnel Association
American College of Neuropsychopharmacology
The American College of Psychiatrists
American Counseling Association
American Family Therapy Academy
American Foundation for Suicide Prevention
American Medical Informatics Association
American Medical Association
American Mental Health Counselors Association
American Neurological Association
American Neuropsychiatric Association
American Pain Society
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Therapeutic Recreation Association
American Psychological Society
American Psychotherapy Association
American School Counselors Association
American Society of Addiction Medicine
American Society of Clinical Psychopharmacology
APA Division 28 (Psychopharmacology)
APA Division 46 (Media Psychology)
Associação Brasileira de Psicólogos e Profissionais de Saúde Mental On Line
Association for Academic Psychiatry
Association for Advancement of Behavior Therapy
Association for Advancement of Philosophy
And Psychiatry
Association for Advanced Training in Behavioral
Science
Association of Psychology Postdoctoral and
Internship Centers
Association for the Study of Dreams
Association for University and College Counseling Center Directors
Biofeedback Foundation of Europe
Canadian Psychiatric Association
Centers for Disease Control (and Prevention)
Center for Mental Health Services Research
Chicago Institute for Psychoanalysis
Chicago Psychoanalytic Society
Citizens' Council on Health Care
Citizens for Responsible Care and Research
Depression and Bipolar Support Alliance
Albert Ellis Institute
Epilepsy Foundation of America

European College of Neuropsychopharmacology
Healthcare Information and Management Systems Society
Illinois Psychiatric Society
Illinois Psychological Association
Institute for Behavioral Healthcare
International Association of Counseling Services
International Association of Group Psychotherapy
International Association for the Study of Pain
International Medical Informatics Association
International Society for Mental Health Online
International Society for the Study of Dissociation
International Society for Traumatic Stress Studies
International Stress Management Association
International Transactional Analysis Association
Internet Healthcare Coalition
InterPsych
Mental Health America
Murray Research Center
National Alliance for the Mentally Ill
National Alliance for Research on Schizophrenia and Depression
National Association for the Advancement of Psychoanalysis
National Psychological Association for Psychoanalysis
National Association of Boards of Pharmacy
National Association of Cognitive-Behavioral Therapists
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Board of Certified Counselors
National Center for Complementary and Alternative Medicine
National Center for PTSD
National Chronic Fatigue and Immune Dysfunction Syndrome Foundation
National Council on Community Behavioral Health Care
National Depressive and Manic-Depressive Association
National Institutes of Health
National Institute of Mental Health
National Library of Medicine
National Mental Health Association
Obsessive-Compulsive Foundation
Obsessive-Compulsive & Spectrum Disorders Association
Pharmaceutical Research and Manufacturers of America
Physicians for Social Responsibility
Psychiatric Society for Informatics
K. Rice Institute
Royal Australian & New Zealand College of Psychiatrists
Royal College of Psychiatrists
Sociedad Española para la Investigación de las Diferencias Individuales
Sociedad Española de Psiquiatría
Società Italiana di Psichiatria
Società Psicoanalitica Italiana

Society of Biological Psychiatry
Society for Computers in Psychology
Substance Abuse and Mental Health Services Administration
Texas University & College Counseling Directors Association
UK Council for Psychotherapy
World Federation for Mental Health
World Psychiatric Association
World Health Organization

APPENDIX 1

BIDDER EVALUATION

Bidder Information

Name ____

Contact ______________________________________

Phone _______________________________________

Fax ____

Cell ____

E-Mail _______________________________________

Background

Years in business ____________________________

Years in mental health_________________________

Years Medicaid experience_____________________

Medicaid gross billings x 3y______________________

References	**YES**	**NO**
Nearest county mental health center	o	o
State board	o	o
Bank	o	o
Trade accounts	o	o
Financial		
Two years financial statements	o	o
Audited for accuracy?	o	o
Two years tax returns	o	o

Credit report	o	o
D & B report	o	o

Technical

Financial software used	o	o
Practice management software used		
	o	o

APPENDIX 2

REQUEST FOR PROPOSAL

Purpose of the RFP

____

____

Overview of the organization and operation of the County Mental Health Program

____

____

____

Scope of services to be outsourced or privatized —description of each service

____

____

____

Contract Duration —period of performance and option years______________________________

Non-discrimination statement____

____

____

Schedule of Events

- Date RFP issued____
- Due date for written questions____
- Due date for answers to questions____
- Closing date and time for receipt of proposals__________________________________

Date for opening proposals____

Oral presentations____

Award and contract start date____

Issuing Officer and address____

____

____

Targeted individual for questions and Internet address____

____

____

Proposal submittal guidelines

Format and content (specify font size, margins, spacing, etc.) ____

Preparation costs (specify responsibility of respondent) ____

Opening of proposals (specify date officially opened) ____

Criteria for acceptance of proposal (specify review and acceptance criteria) ____

____

Criteria for rejection of proposal (specify criteria for rejecting a proposal) ____

____

Disposition of proposals (specify that proposals will be on the public record unless designated as confidential) __

____

Incorporation into the Contract —record including, for disclosing and for using information incorporated in the proposal

____

Subcontracting guidelines (number of subcontractors, if any, that can be included in the response)

____

Minority business policy____

Prohibited solicitation —those rules following a breach of ethical standards, such as commission, brokerage fees, etc.

____

RFP amendments (specify the procedure for making amendments) ____

RFP rules of withdrawal (outline the withdrawal process) ____

Respondent's contact person (name and telephone number) ____

Awarding of contract (explain the process in detail) ____

____

Notification (how will respondents be notified of the results) ____

Rules of procurement (specify general rules) ____

Restrictions on communications with state staff (specify limitations on talking with state or county officials until RFP awarded)

____

Technical proposal requirements

Cover sheet (format and what to include, usually name and number of RFP and name and address of respondent)

Table of contents

Statement of acknowledgement to RFP (acknowledgement of key facts from the respondent such as minority vendor, no previous fraud, authorized individuals, use of subcontractor, no separate cost nor pricing data included, etc.)

Disclosure of litigation (acknowledgement of whether any existing litigation could affect the project or contract)

Approach and process to scope of service (respondent's plan for meeting the objectives of the contract)

Respondent's background
- date established
- ownership
- number of employees
- number of full time equivalents in similar contracts

Respondent's experience
- letters of recommendation
- right to contact references

Respondent's qualifications
- evidence of qualifications and credential
- number and description of similar projects worked on successfully
- responsibility and experience on each project, etc.

Technical proposal response

Executive summary (provide a condensed summary of the contents of the technical proposal)

Project organization and staffing
- organization charts
- lines of supervision
- identification of key personnel

Target population (specify area and patient population served)

Needs assessment (function proposed in project)

Incorporation of union support and staff

Project management (specify project control methods)

Financial disclosures (provide respondent's evidence of financial status and ability to carry out the project)

Reimbursement methodology (specify method of payment for services or whether private firm will independently bill insurers)

Vendor number ____

Proof of licensure____

Performance and outcome measurements (demonstrate success of program through qualitative and quantitative goals)____

Reports (required and ad hoc)____

CASE MODEL

THE DOWNHOME MENTAL HEALTH CENTER: POISED FOR PRIVATIZATION

Strong rumors about privatization of the Center abound, post PP-ACA. The Administrator sees this as a potentially good transition and decides to prepare the Center internally for the inevitable Request for Proposals (RFPs) that will be presented to the private sector.

Therefore, the Administrator establishes the following goals:

1. Maintain quality and scope of service to existing clients of the Center.
2. Maintain jobs and benefits for employees of the Center.
3. Extend Center mental health services to currently under-served classes of clients (e.g., Latino migrant population, rural shut-ins, etc).

She also requires the following financial analysis from her staff:

1. Translate governmental accounting:
   a. consider the impact of privatization on current revenues; and
   b. consider the impact of privatization on current expenditures.
2. Improve profitability:
   a. consider the impact privatization might have on increasing revenues; and
   b. consider the impact privatization might have on decreasing expenditures.

STRATEGIES AND SOLUTIONS

The Administrator sets out her long-term strategies for the Center:

1. Ensure strong financial standing of bidders. Although this is outside the Administrator's authority, she wants to be prepared to give input. Turnover is traumatic and Administrator wants to get it right the first time. The state may require "bidders" to be intra-state. She knows some of the local mental health organizations have financial problems. Startup or transitional reserves are an issue.
2. Ensure strong Medicaid experience of the bidders. The Center is not profit motivated and profitability under Medicaid takes existing expertise.
3. Ensure strong managerial track record of bidders in the mental health field. The bulk of the initial revenues for the bidder will be Medicaid at 84%. The county will probably keep the case management aspect of the Center intact for quality assurance. The successful bidder should provide the bulk of the currently out-sourced services, for which the Center gets a 16% case management fee. However, the current out patient revenue of the Center, not subject to the 16% fee by the Center, will also be subject to the 16% fee for the bidder.
4. Make the Center attractive, but realistic, for bidders by showing potential sources of increased revenues and potential cost-cutting strategies.

PROJECT

The Administrator and her staff gather information to put together an RFP, an auxiliary “help” list for bidders, and a form/process to evaluate bidders.

STATEMENT OF NET ASSETS

The Center does not have a significant amount of assets or even capital asset needs. The computers may or may not be part of the sale.

STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS

Last year’s “charge for services” consists of two lines: services rendered, for $2.6 million, and case management for $0.6 million. Case management fees are 16% of the Medicaid out-sourced reimbursement the Center monitored. Internal records show Medicaid totaled $1.8 million of the services rendered.

The total of out-patient revenues from last year, translated into bidder revenue is $2.3 million [($1.8 million Medicaid revenue x 84% = $1.5 million) plus ($0.8 million non-Medicaid sources)]. The 84% reflects the expected 16% fee the county will take for ongoing case management of previously non-fee Center (out-patient) revenue.

The Administrator estimates the bidder can perform in house 90%, of the currently out-sourced client services. Last year’s revenue, from performed services the Center out-sourced, is $2.8 million [($0.6 million/16%) x 90%].

The operating expenses section must be:

1. Reduced:
    a. By the salaries of the case managers: $180G [6 x $30G/y]
2. Increased:
    a. by the equivalent cost of county-provided rent. Space to accommodate the previously out-sourced client services must be added on, and the current space for the six case managers can be eliminated;
    b. by the equivalent cost of county-provided janitorial service;
    c. by the equivalent cost of county-provided printing;
    d. by the equivalent cost of county-provided utilities; and
    e. by the equivalent of county-provided technological support.

Expense	Estimated Current Amt (in $$)	By	Space/Volume Multiplier	Expected Amt (in $$)
Rent	1,475	Realtor	2.1	3,098
Janitorial	650/mon	3 estimates	2.1	1,366
Printing	1,200	Kinko's	2.6	3,128
Electric	625	By SF-county	2.1	1,391
Water	250	By SF-county	2.1	525
Rep/Main	3,180	By SF-county	2.1	6,678
Tech Support	22,600	County tech	1.0	22,600

The non-operating revenues (expenses section) must be:

1. Decreased:
   a. by interest expense — this expense is irrelevant to the bidder; and
   b. by depreciation expense — most of this is for the building. The Administrator assumes the county will charge a fair market rent if the bidder elects to stay in this location. The Administrator deems the remainder of the depreciation expense, for a few copiers and computers, to be immaterial.

Capital contributions and Transfers out are both irrelevant to the bidder.

STATEMENT OF CASH FLOWS

The Administrator feels the bidders will concentrate on the Statement of Revenues, Expenses and Changes in Net Assets and decides to forego proactive translation of the Statement of Cash Flows into bidder terms. The only item really affected is the interest paid, described above.

INCREASING REVENUES

The Administrator knows the local mental health care providers well. She does not feel the bidder would lose current non-Medicaid clients to these other providers. She feels the Center, after a bidder's upgrading, would attract additional non-Medicaid patients, pulled out of the existing providers and an increased awareness secondary to bidder's expectedly marketing.

In the past, the Center could not engage in HMO contracts because of logical county prohibition. Any bidder that can turn a profit at an 84% level of Medicaid reimbursement could probably afford to take on these potential contracts.

The Administrator feels there will be cost savings by increasing the efficiency of internal processes.

DECREASING EXPENDITURES

Because of the cost of technology, the Center uses manual systems for appointments, for billing private payors, and for performing and collecting transcription into medical records. Billing for Medicaid, Medicare and Blue Cross/Blue Shield uses their programs because they are free, but this results in a fragmented billing system. The Administrator feels any solid bidder would already have appropriate practice management and billing software.

SUMMARY

Despite multiple constraints, governmental mental health administrators can make a difference in how the facility is run, and thus more positively affect their community. A facility does not have to face privatization to improve in multiple parameters.

Governmental accounting focuses on stewardship of public funds. Public accounting focuses on performance. For internal purposes, the savvy administrator utilizes the best of both worlds.

KEY ISSUES:

1) Can the Administrator achieve all her goals?
2) How might these goals be achieved?
3) What strategies might be used?
4) What is the financial statement(s) impact on the Center?
5) Will the RFP meet the Administrator’s near- and long-term needs?

CHECKLIST 1: Analyze Your Mental Health Center	YES	NO
Have I determined the volume of patients using the mental health center?	o	o
What is the volume of patients on a daily basis? ___________________		
What is the volume of services for each of the specialty mental health services, such as marriage counseling? _______________________________________		
Is the volume of patients projected to increase in the next couple of years?	o	o
Do you have sufficient number of providers to cover care?	o	o
If not, is it financially feasible for others to be added?	o	o
Could any programs be outsourced?	o	o
Specialty mental health services?	o	o
Crisis services?	o	o
Residential services?	o	o
Other?	o	o
Could patients be referred to other comparable programs in the community?	o	o
Have I identified the social service organizations in the community that provide mental health services? (list services provided and hours of operation) ____ ____		
Have I identified all languages needed to converse with the patient population?	o	o
Are all providers' credentials in order?	o	o
Are providers continuing their professional education?	o	o
Do any of the providers in community private practice accept patients with Medicaid or without insurance?	o	o
Are detailed documented treatment protocols in place?	o	o
Are they used?	o	o
Have I identified and prioritized the major service needs for the mental health center?	o	o
What other services should be considered and how do they fit within the priority listing? ____ ____		
Is anyone your advocate to lobby the Legislature for additional mental health funds?	o	o

CHECKLIST 2: Analyze the Revenue Sources of Your Mental Health Center	YES	NO
Does the center receive funding from the following? If yes, write the percentage in the space provided: Federal government? _____ Direct state funding programs? _____ Indirect state funding (via county)? _____ County? ______ Medicaid? _____ Medicare? _____ Grants from national foundations? _____ Cash from patients? _____ Co-pays? ______ Private insurance? _____	o	o
Have you broken down your revenue by insurer? Is eligibility for insurance being identified at time of entry and pursued?	o o	o o
Is the state funding reimbursement for chronic patient care?	o	o
What funds, grants, etc. are currently being used? ____ ____		
Are any other grants being pursued to help improve revenue?	o	o
Can any of the patients qualify for Medicaid? Is that possibility being pursued?	o o	o o
Is the center aware of all the benefits, non-covered services, and/or required billing processes to improve reimbursement?	o	o
Are laboratory services a source of revenue?	o	o

CHECKLIST 3: Prepare for the RFP	YES	NO
Has an oversight committee been established?	o	o
Does the committee include a representative distribution of staff who can effectively evaluate various firms against the criteria set forth in the RFP?	o	o
Has a financial person been added to the oversight committee to evaluate and compare the cost of the firms, and the cost of the firms compared to the internal cost of the existing operations?	o	o
Are the job descriptions representative of the skill sets needed to be filled by the private firm?	o	o
Have the Director and the oversight committee agreed to all the criteria set forth in the RFP?	o	o
Does each member of the oversight committee know the steps in the evaluation process?	o	o
Has the Director developed a process for rescinding the RFP if none of the firms meets the criteria or cost?	o	o
Are all of the staff in the center aware of and knowledgeable of the RFP and the associated process?	o	o
Have the unions been contacted and made aware of the RFP process?	o	o
Have the unions agreed to the RFP?	o	o
Is a process in place to help current staff find new positions or new training once the RFP has been awarded?	o	o
Has an evaluation form been developed to record the oversight committee's evaluation of the RFP firms?	o	o

CHECKLIST 4: Prepare for Clinical Treatment Programs	YES	NO
Typically, mental health services include treatments for various disorders. Do you have programs available in your mental health center for the following disorders?		
Anxiety Disorders	o	o
Attention Deficit Hyperactivity Disorders (ADHD, ADD)	o	o
Autism Spectrum Disorders (Pervasive Developmental Disorders)	o	o
Bipolar Disorder (Manic-Depressive Illness)	o	o
Borderline Personality Disorder	o	o
Depression	o	o
Eating Disorders	o	o
Generalized Anxiety Disorders	o	o
Obsessive-Compulsive Disorder (OCD)	o	o
Panic Disorders	o	o
Post-Traumatic Stress Disorder (PTSD)	o	o
Schizophrenia	o	o
Social Phobia (Social Anxiety Disorder)	o	o
Suicide Prevention.	o	o
	o	o
	o	o
Are we familiar with the coding definitions and the system utilized by DSM-IV?	o	o
Are we familiar with The Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revision, also known as the DSM-IV-TR?	o	o
Are we familiar with, and track, emerging mental health parity laws?	o	o