DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

REPORT TO
THE COUNCIL OF THE DISTRICT OF COLUMBIA
REQUIRED BY THE

FISCAL YEAR 2009 BUDGET SUPPORT ACT OF 2008,
Title V, Subtitle I, Sec. 5022

RECOMMENDATIONS FOR THE GOVERNANCE OF THE DISTRICT OF COLUMBIA COMMUNITY SERVICES AGENCY

September 26, 2008

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I. Introduction

The Fiscal Year 2009 Budget Support Act of 2008 (the "Budget Support Act") requires the Department of Mental Health ("DMH") to submit a report about recommendations for the new governance structure for the District of Columbia Community Services Agency ("DC CSA") by October 1, 2008. The Budget Support Act also requires DMH to submit a plan for the implementation of any recommendations about the DC CSA (the "Implementation Plan") by December 31, 2008. Finally, the Budget Support Act requires completion of the Implementation Plan by September 30, 2009.

II. Background Information

In 1974, a lawsuit was filed against the Federal Government and District Government on behalf of a class of individuals civilly committed to Saint Elizabeths Hospital, demanding community based treatment alternatives to hospitalization. The class included former, current and future patients. The lead plaintiff was William Dixon. The case is now captioned as *Dixon, et al. v. Fenty, et al.* (the "*Dixon* case").

On October 1, 1987, operational responsibility for Saint Elizabeths Hospital officially was transferred from the Federal Government to the District Government. As a result of the transfer, the District Government became the sole defendant in the *Dixon* case. In 1997, the U.S. District Court appointed a receiver to operate the District's public mental health system. The District's mental health system remained in receivership for five (5) years.

In 2000, the U.S. District Court appointed a Transitional Receiver to work with the District and the plaintiffs' counsel on a plan to transition the daily operation of the public mental health system back to the District. On April 2, 2001, the U.S. District Court adopted the Transitional Receiver's Final Court Ordered Plan (the "Court Ordered Plan"). Among other things, the Court Ordered Plan required the District to enact legislation establishing DMH as a cabinet-level agency reporting directly to the Mayor. It also set forth requirements for the organization, structure and functions of the newly-created department. In addition, the Court Ordered Plan recommended that DMH function primarily as a state mental health authority, with responsibility for managing and monitoring the provision of community-based services. The Court Ordered Plan considered the question of whether DMH should continue to provide direct services in the community.

The Court Ordered Plan describes a three-part test for assessing the need for government operated mental health services. Specifically:

- Is the private sector is willing and able to provide a given service;
- Can these services can be provided more efficiently through the private sector; and
- Is there is adequate capacity in the community to provide the necessary volume of quality services in the community.

At that time, the Court Monitor concluded that because there was a lack of capacity in the community or viable alternatives to contract through the private sector to provide the needed mental health services, it was necessary for the District to directly provide mental health services. Therefore, the Court Ordered Plan mandated that DMH deliver direct government-provided services through a single core services agency that would be responsible for a range of adult and child and youth services based on a unified service delivery and administrative infrastructure. The government–run core service agency was to operate under the same rules and conditions as the certified private providers under contract with the government to provide services.[1] *See* Court Ordered Plan, pages 24 - 25.

At the same time, the Court Ordered Plan recommended an evaluation of the structure of the District's core services agency after operations stabilized. *See* Court Ordered Plan, page 25. In addition, legislation enacted by the Council in 2001 that established the Department of Mental Health mirrored the language in the Court Ordered Plan and required that DMH "directly operate a core services agency for three years from the effective date of this act, or longer as needed, to address the community mental health needs of the District." *See* D.C. Code §7-1131.03 (6).

It has been seven years since the adoption of the Court Ordered Plan and the enactment of the DMH enabling legislation. Beginning with his July 2005 report, the *Dixon* Court Monitor has continually raised concerns about the viability of the government run business model and strongly recommended that DMH review the service delivery model.

III. Assessing and Evaluating the DC CSA

DMH retained KPMG LLP ("KPMG") to assist with an analysis of options and alternatives for the governance and future operation of the DC CSA. DMH asked KPMG to consider five (5) options for the governance and future operations of the DC CSA. These five (5) options were not mutually exclusive. The five (5) options were:

1. Continue to operate the DC CSA or parts of it as a core services agency;

2. Create a new non-profit organization to assume responsibility for operating some or all of the DC CSA;

3. Transition the DC CSA to a public benefit corporation;

4. Expand services currently purchased through the current service delivery system and dissolve the DC CSA; and

5. Privatize the DC CSA operations.

[1] The Court Ordered Plan also considered the question of whether DMH should continue to operate Saint Elizabeths Hospital. The same test applied to the need for DMH to provide direct services in the community was applied with regard to Saint Elizabeths. The Court Monitor recommended that DMH continue to operate Saint Elizabeths as a tertiary care and forensic facility, with most secondary or acute care services provided in the community. *See* Court Ordered Plan, pages 22 – 24.

DMH posed seven (7) questions to KMPG and asked KPMG to address those questions within the context of five (5) considerations. The seven (7) questions were as follows:

1. Is there any difference in the populations served by the DC CSA and private providers?

2. Is there any difference in the service array offered by the DC CSA and private providers?

3. Is there any difference in access to care and timeliness of services between the DC CSA and private providers?

4. What are the safety net functions performed by the DC CSA and whether they can be replicated by the private providers?

5. Are there any services performed by the DC CSA that need to be retained?

6. Would a change in governance structure result in cost savings?

7. Should the DC CSA continue in its current structure?

Finally, KPMG was asked to analyze the data collected and make recommendations in the context of five (5) considerations:

1. Access to care;

2. Clinical;

3. Programmatic Issues;

4. Population(s) served; and

5. Costs.

As part of its analysis, KPMG conducted thirteen (13) focus groups that included over eighty (80) stakeholders. Stakeholders included consumers, DC CSA managers, DC CSA employees, union representatives, community members, advocates and other interested persons. The information gathered during the stakeholder focus groups was used to inform the data analysis. KPMG also analyzed data obtained from the DMH claims processing system (eCura), the DC CSA practice management system (Anasazi) and selected private providers with similar data management capabilities. A copy of the KPMG Report on the Governance Options for the DC CSA (the "KPMG Report") is attached as ***Appendix A***. A list of the acronyms and defined terms used in this report is attached as ***Appendix B***.

A. Key Observations from the KPMG Assessment

KPMG made ten (10) observations regarding the DC CSA. *See* KPMG Report pages 5 – 6. These observations are based on the data analysis completed and consideration of the five (5) areas identified at the outset of the analysis. The observations are as follows:

1. The consumer population served by the DC CSA is similar to the consumer population served by the private provider network. There is no appreciable difference between the demographics or clinical presentation of consumers served by the DC CSA when compared to those served by the private provider network. *See* KPMG Report, Section 5.1, page 37.

2. The services delivered by the DC CSA are similar to the services delivered by the private provider network. *See* KPMG Report, Section 5.1, page 37.

3. Although the capacity of the provider network is enhanced by the DC CSA, the current fee-for-service payment structure and funding mechanism of the DC CSA were reported to create an impediment to private providers creating additional service capacity. Private providers have a difficult time competing with the DC CSA to retain clinicians. *See* KPMG Report, Section 5.1, pages 37 – 38.

4. The source of funding for DC CSA services is not as predominantly non-Medicaid as presumed by most stakeholders. In fact, the DC CSA uninsured population is only 10% larger than the uninsured population served by the private provider network. *See* KPMG Report, Section 5.1, page 38.

5. The timeliness of service provision by the DC CSA is similar to the timeliness of service provision by the private provider network. *See* KPMG Report, Section 5.1, page 38.

6. The DC CSA and the private provider network served clients whose location, based on address zip code, and were similarly distributed across the District. *See* KPMG Report, Section 5.1, page 38.

7. The DC CSA tended to deliver more services in an office based setting. *See* KPMG Report, Section 5.1, page 38.

8. The DC CSA provides several unique services that are not delivered through the private provider network. Specifically, these services are: pharmacy, ACT to the extent they are the predominant ACT provider[2]; multi-cultural services, psycho-education in school based settings and outpatient competency restoration services.

[2] The DC CSA is one of three providers of assertive community treatment or ACT. Currently, the DC CSA operates three (3) ACT teams. DMH has proposed to increase the reimbursement rates for ACT, counseling, community-based intervention ("CBI") and medication management services effective November 1, 2008. DMH anticipates that the rate increases will result in increased capacity by private providers. One of DMH's planned FY 2009 initiatives is the increase of ACT capacity in the community through the issuance of an RFP.

The DC CSA also operates a Residents Clinic, staffed with psychiatry residents (third year) from the Saint Elizabeths Hospital psychiatry residency program. *See* KPMG Report, Section 5.1, page 38.

9. The current funding model for the DC CSA has a negative impact on the functioning of the overall provider network.[3] The DC CSA is not subject to the funding constraints applicable to the rest of the MHRS provider network, because the overhead costs for operating the program are built into DMH's base budget. Therefore, the DC CSA is currently able to impact the professional labor pool available to private providers by retaining staff at a higher rate, paying staff higher salaries and providing a larger benefit package. On a general level, the current funding model for the DC CSA impacts the private provider community by decreasing the overall funds available for local reimbursements. *See* KPMG Report, Section 5.1, pages 38-39.

10. Services are being delivered by the DC CSA at significantly greater cost to the District. The same services delivered in FY 2007 by the DC CSA could have been purchased through current fee-for-service arrangements with the private network for approximately $11-$14 million less. *See* KPMG Report, Section 5.1, page 39.

B. KPMG Recommendations

KPMG made the following eight (8) recommendations:

1. Discontinue the delivery of all direct services through the DC CSA with the exception of pharmacy services, outpatient competency restoration, psycho-educational services[4], multi-cultural services coordination and the Residents Clinic. Consumers should be transferred to the private provider network on a phased basis, under the prevailing fee-for-service schedule. The specific services to be transitioned to the private provider network include ACT, rehabilitation/day services (adults), community support (adults, children & youth), medication management (adults, children & youth), counseling (adults, children & youth) and community-based intervention (children & youth only). *See* KPMG Report, Section 5.2, page 40.

2. Continue direct government provision of the pharmacy,[5] the psycho-educational program,[6] the outpatient competency restoration program and the Residents clinic,

[3] The DC CSA is subject to the District's requirements regarding salaries and benefits.
[4] DMH believes that it may be more cost effective to contract with a private provider for psycho-educational services. This option will be explored during the development of the Implementation Plan.
[5] Stakeholders across all groups identified the DC CSA Pharmacy as an importance service for which there is no equivalent structure in the private provider network. In fact, it provides an important support to both private provider consumers without Medicaid or other insurance as well as DC CSA consumers. In addition, the Department of Defense ("DOD") contractual mechanism through which the DC CSA acquires medications is available only to governmental entity. As a result, the DC CSA Pharmacy provides an important service to District mental health consumers that should be maintained.

which are unique, specialized services currently provided by the DC CSA. These specialized services, which are provided only by the DC CSA, should be maintained as direct government provided services. They should be linked to, and incorporated into a direct services entity under the direction of the DMH Authority that could also include current Authority functions/programs such as Comprehensive Psychiatric Emergency Program ("CPEP") and school based services. *See* KPMG Report, Section 5.2, page 38.

3. Broaden the provision of multicultural services across the private provider network. The multicultural mental health services provided by the DC CSA are the same as those delivered by the private provider network to a unique set of consumers. This function should be transitioned to private providers based on the common service set, in conjunction with establishing a stronger language access co-ordination and cultural competency function at the Mental Health Authority. *See* KPMG Report, Section 5.2, page 40.

4. Develop increased capacity to deliver ACT services to adults. *See* KPMG Report, Section 5.2, page 41

5. Utilize the resources that will become available from the DC CSA transition to properly fund aspects of the mental health system redesign. Significant resources will become available to be reallocated to the initial transition and then the strengthening of the overall public mental health system. *See* KPMG Report, Section 5.2, page 41.

6. Develop and implement a detailed transition plan to support the termination of services currently provided by the DC CSA. The transition plan needs to move consumers, by team, on a staggered or staged basis, to new clinical homes. The transition should be staged in accordance with plans to implement any redesign of the public mental health system. *See* KPMG Report, Section 5.2, page 41.

7. Establish enhanced accountability mechanisms to sustain and increase private provider accountability and monitoring. These mechanisms should include regular fidelity reviews of District funded mental health programs. *See* KPMG Report, Section 5.2, page 41.

8. Establish contractual mechanisms and obligations to solidify the public mental health system safety net. These requirements should be incorporated into provider agreements. *See* KPMG Report, Section 5.2, page 41.

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[6] The Psycho-Educational team provides counseling and diagnostic assessments to children and youth enrolled in the DCPS Psycho-Educational program.

IV. DMH Recommendation and Proposal.

DMH has reviewed the KPMG report and has addressed the results of the data analysis with respect to the Court Ordered Plan's three part test for assessing the propriety of continuing government operated services through the DC CSA.

A. *Dixon* Test Results

DMH concurs with the findings of the KPMG report and has made the following findings regarding the *Dixon* test.

1. Is the private sector willing and able to provide a given service?

The private sector is willing to provide the services required by consumers currently enrolled in the DC CSA. This is supported by the results of the stakeholder interviews and based upon the clinical and demographic profiles of the consumers currently receiving services from the DC CSA.

2. Can these services be provided more efficiently through the private sector?

Services can be provided more efficiently through the private sector. Cost analysis completed by KPMG shows that the same MHRS services provided to DC CSA consumers in 2007 could be provided more cost efficiently through the private sector.

3. Is there adequate capacity in the community to provide the necessary volume of quality services?

A transfer of DC CSA consumers to the private providers will require that the current public mental health system be restructured to ensure the provision of both the volume and quality of needed services.

B. DMH Proposal

Based on its findings regarding the Dixon test and to address the KPMG observations and findings regarding the DC CSA, DMH proposes to take three steps. First, DMH proposes to restructure the existing public mental health service delivery system by reallocating existing resources. The goal is to create a comprehensive, community-based public mental health system that increases accessibility and is administratively unified. Second, discontinue the delivery of direct services by the DC CSA that can be provided by the private provider network. Finally, continue direct government provision of only those unique services currently operated by the DC CSA. Specifically, those services are the pharmacy, the residency outpatient clinic and the outpatient competency restoration program.

The restructuring proposal or system redesign includes the following seven (7) major components.

1. Establish within the private provider community, Community Mental Health Centers ("CMHCs"). The CMHCs would be expected to provide the full range of community-based mental health services required by DMH including, but not limited to Mental Health Rehabilitation Services ("MHRS") and the clinic services currently funded through the Free Standing Mental Health Clinic program ("FSMHCs").

2. Use the DC Healthcare Alliance benefit as the primary eligibility criteria, to include a benefit for uninsured individuals throughout the system and have the Alliance mental health benefit managed by DMH.

3. Bring the full authority for managing and monitoring Free Standing Mental Health Clinics ("FSMHCs") under the auspices of DMH.

4. Establish the provision of rehabilitative services through the MHRS program and clinic-based services through FSMHCs to create a clinical platform for service delivery.

5. Require CMHCs to offer both services through MHRS and the FSMHC structures.

6. Encourage primary health care settings to provide both physical and mental health care by becoming certified FSMHCs and require all mental health service providers to coordinate with physical health care providers.

7. Establish an integrated medical records system for all mental health providers.[7]

The CMHCs will be responsible for service coordination for all enrolled individuals. DMH will also continue to certify specialty providers that offer one or some combination of MHRS services, as well as FSMHCs. A specialty provider offering one MHRS service may also be certified as an FSMHC, but not certified as a CMHC.

V. Proposed Service Delivery Structure

The core of the proposed restructuring of the District's public mental health delivery system is to establish eight (8) to ten (10) CMHCs to assume the lead role in the provision of a comprehensive range of services. The CMHCs will become the clinical home for consumers. The Core Services Agencies ("CSAs") are currently responsible for carrying out this function. CSAs will be eligible to apply to be to be CMHCs or become specialty providers.

[7] The integrated electronic medical records system for mental health providers could be included in the electronic medical records system recommended in the Rand Phase 2 report released by the District on June 27, 2008. *See* Phase 2 of the Rand Report "Assessing Health and Healthcare in the District of Columbia," Recommendation # 2, pages v and 20 – 22.

Each CMHC will have the capacity to serve between 1,000 and 2,000 adult and child consumers, either directly or through business arrangements with other qualified mental health providers. Although DMH would prefer to have a CMHC to serve all age groups, a CMHC could be certified to serve only children/adolescents or adults. One of the CMHCs may be a non-governmental outgrowth of the DC CSA.[8]

VI. Transition Planning

DMH has established a Transition Office to manage the transition of government-operated community services to the community. The Transition Office will be staffed by a full-time DMH employee with experience working in the provider community. DMH has established a transition planning work group that will be guided by a detailed project plan that is content and date driven. The transition activities will be guided by a detailed work plan that will address closing the DC CSA and simultaneously developing and implementing all the necessary requirements for the restructured provider network.

The transition plan will focus on ensuring that consumers currently receiving services from the DC CSA are involved in the transition process and have the opportunity to choose a new service provider. The Transition Office will develop various strategies for the consumer transition, including, but not limited to consumer fairs, face to face contacts and assertive outreach.

DMH recognizes that there are a very large number of extremely talented and committed individuals working at the DC CSA. The transition plan will focus on ensuring individuals employed at the DC CSA have every opportunity to locate employment with private providers as their skills and existing relationships with clients will be extremely valuable to the redesigned public mental health system. However, for retirement eligible employees who wish to leave government service the Office of the City Administrator may offer an incentivized early out program through December 31, 2008. The transition planning workgroup will explore the use of an incentivized early out program for eligible DC CSA employees.

By October 31, 2008, DMH will determine the following:

- Date to close enrollment for DC CSA;
- Date to freeze any new hires for DC CSA;
- Date to transition consumers to a new CSA; and
- Date when DC CSA stops delivering direct services.

Transition activities include, but are not limited to:

[8] DMH has begun discussing the policy issues involved in incubating a non-governmental outgrowth of the DC CSA and will resolve those issues during the next ninety (90) days.

- Developing a detailed work plan and milestones that would be used to stage individual work tasks and frequently assess and report progress;

- Documenting processes and protocols for implementing the detailed work plan; and

- Developing and monitoring key performance indicators to be assessed as the transition process progresses.

Transition activities fall into two main categories. The first, consumer and service change management, will develop the community capacity to provide clinically appropriate services to DC CSA consumers, while transitioning the retained DC CSA services to the mental health authority. Activities in this category will include the following:

- Transferring key administrative units that support DC CSA unique services to the Authority, potentially creating a new organizational umbrella for such services within the Authority structure;

- Evaluating deemed status for CMHCs to facilitate transfer of DC CSA consumers;

- Assessing the caseloads of individual DC CSA teams;

- Establishing transfer priorities and establishing the order in which cases will be transferred;

- Establishing and documenting transfer protocols and reporting, including processes for consumer choice, enrollment, and entering of appropriate authorizations;

- Implementing a focused clinical oversight and treatment monitoring structure for transferred consumers;
- Initiating transfer protocols and feedback reporting; and

- Identifying the full range of legal requirements to be met during the change process, including changes to the certificate of need law, mental health enabling legislation and various mental health regulations (MHRS, FSMHC).

The second category of transition activities is organizational change. Organizational change activities include personnel actions, legal requirements, infrastructure changes and development of accountability mechanisms. Examples of some of the organizational change activities include, but are not limited to:

- Developing plans for personnel incentives and buyouts as needed;

- Developing specific downsizing staff plans (keyed to consumer transfer plans);

- Working closely with union organizations throughout the process;

- Creating job opportunity mechanisms in conjunction with private providers and union organizations to be used by current employees;

- Developing facility down-sizing plan based on status of property (rental, owned); and

- Developing an equipment downsizing plan.

Other transition activities will be identified during the transition plan development. DMH will submit an Implementation Plan addressing all transition plan activities to the Council as required by the Budget Support Act.

VII. Transition Risks and Challenges

Transition risks and challenges include, but are not limited to:

- Minimizing disruption of services to consumers;

- Keep all affected individuals and groups informed;

- Meeting stakeholders' (consumer & families, advocates, courts) expectations; and

- Funding the costs of coordinating the transition of consumers to new providers while maintaining required staffing levels at the DC CSA.

VIII. Conclusion

DMH proposes to transition the majority of the DC CSA services to a network of private providers. A transfer of DC CSA consumers to the private providers will require that the current public mental health system be restructured to ensure the provision of both the volume and quality of needed services. The transition plan and the restructuring of the current public mental health system will be addressed in the Implementation Plan.