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Financing Mental Health Services for the Homeless Mentally Ill in New England

Margaret Stephens
Dominic Hodgkin

This paper examines how New England states pay for the mental health care of the homeless mentally ill. The focus is on how states choose providers, how they reimburse and monitor them, and how these arrangements may affect the incentives facing providers. Detailed case studies of Massachusetts, Rhode Island, and Vermont regulations are included. The studies reveal important differences in how states choose and reimburse providers, for both the homeless and nonhomeless mentally ill. The states also differ in the extent to which they have contracted with nontraditional providers, which many believe to be a necessary approach, given the frequent unwillingness of homeless persons to use the traditional mental health care system. The authors recommend investigation of the health, housing, and cost outcomes associated with these interstate differences in reimbursement policy, as the relationship may offer insights relevant to ongoing policy reforms.

During the 1980s, New England's strong regional economy allowed the states to develop new services targeted at the homeless mentally ill, whose numbers were surging partly as a result of deinstitutionalization policies. The regional fiscal climate in the 1990s is less favorable, due to the recession and voter hostility to taxes, as a result of which states are scrambling to improve the cost-effectiveness of their spending on human services. As a result, there is increasing interest in the effect of contract and reimbursement design on the delivery of human services. In this respect, the New England states provide a potentially instructive set of comparisons, given their historically widely divergent patterns of contracting and reimbursement procedures for human services.¹

Our aim is to examine in detail how mental health services for the homeless mentally ill are paid for in three New England states, and note where differences have implications for policy discussions. We explain why we think that the design of provider reimbursement is relevant to the delivery of human services, including care of the homeless mentally ill, note constraints common to all New England states, and

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present detailed case studies of provider reimbursement in Vermont, Massachusetts, and Rhode Island. Finally, we discuss our results and draw a few conclusions.

Issues in Provider Reimbursement

In analyzing the financing of mental health care and other human services, it is useful to distinguish the purchaser-provider relationship from the relationships among various purchasers (for example, federal government, state government, local mental health boards). Some previous research has addressed the issues involved in design of intergovernmental transfers in mental health,² and the sources of state mental health financing in New England.³ In contrast, we focus on purchaser-provider relationships building on earlier work on state contracting in mental health.⁴

A key question in evaluating human service contracts concerns the way the unit of service is defined and performance is evaluated. These questions arise because human service contracts typically pay providers according to their use of inputs rather than outputs, owing to the equity and incentive problems that could result if providers were paid solely by results. For an example of the incentive problems, consider the effect of a state policy guaranteeing to pay providers only for those homeless mentally ill persons successfully housed and placed in treatment. Rather than maximizing total outreach, this payment system would offer clear incentives for a provider to seek out those homeless people most likely to respond to outreach and ignore others, despite their possibly greater need. Although in principle the state could prevent such an outcome by adjusting provider payments for case severity, in practice the informational and administrative requirements for doing so would be prohibitive for many human services, including, presumably, treatment of the homeless mentally ill.

The alternative usually found in human services is to contract for inputs, that is, to pay providers based on hours of care provided or numbers treated or according to a set budget. Where funding is affected by the success or failure of the program, the effect occurs only with a lag, for example, through eventual nonrenewal of contracts if performance is deemed unsatisfactory. In turn, this choice of payment system means that one must pay extra attention to the incentive effects of how inputs are reimbursed and how performance is measured.

A second set of issues concerns the process by which the contract is awarded. Design issues include how the state decides who is qualified to bid, whether it makes regular use of requests for proposals (RFP), and how it selects the winning bid. Again, the risk of unobservable quality variation is one reason why states may not always choose the lowest bidder for a contract. Other reasons include the desire to keep a wide pool of potential bidders for future contracts, concern for continuity of care, or lobbying on behalf of particular bidders by legislators, human service professionals, and consumers.

A possible objection to the above approach would be that human service providers differ from, say, manufacturing subcontractors in that they are altruistically motivated. By implication, they would not respond to apparent incentives in a profit-maximizing way, if this would harm patient care. This argument has some validity, but there is also evidence of providers avoiding hard to treat or disruptive mental patients in the absence of special subsidies for treating them.⁵ The best research

strategy is probably to treat this as an empirical question, with provider altruism (no effect of incentives) being one possible hypothesis to test against others.

Although our focus is on homeless-specific reimbursement issues, the case studies also provide some background on mental health reimbursement in general. One reason this is important is that the homeless mentally ill are likely to be affected by the design of mental health contracts in general, not only those targeted to the homeless. For example, poorly designed performance incentives in general contracts may lead mental health providers to avoid the homeless mentally ill.

The Overall Environment

It is worth noting a few issues common to all states. First, all program planners face problems in determining the size of the population for whom they are developing programs. Estimates of homelessness in the United States range from 250,000 to 300,000 (U.S. Department of Housing and Urban Development) to 735,000 (National Alliance to End Homelessness). To further compound the problem, surveys report that anywhere from 10 to 47 percent of the homeless are mentally ill.⁶ The difficulty arises partly from the lack of a standard definition of homelessness (currently or at risk of; chronic or episodic) and partly from a lack of staff at shelters who are trained to diagnose mental illness. Surveys may report number of homeless individuals on any given night, over the course of a year, or served in shelters. All our estimates are subject to this imprecision. While they are the best guesstimates of knowledgeable state officials, these numbers should in no way be considered as definitive counts.

Another common theme is the difficulty of persuading the homeless mentally ill to accept treatment from traditional providers such as a community mental health center (CMHC). For the homeless mentally ill population, CMHCs may appear unattractive because there is a certain amount of pressure to follow a full treatment plan. For example, if medication is prescribed for an individual but not taken, there may be pressure in counseling or other treatment sessions to take the medication. Day treatment programs may combine homeless individuals with others with whom they feel they have little in common.

This has obliged states to make use of alternative providers such as shelters or food banks, which often operate outside the formal mental health system. In turn, the states' use of such providers poses a separate problem of how far to integrate their reimbursement and contracting arrangements with those used for traditional mental health providers.

Another constraint shared by all states is the existing organization of federal financing for care of the mentally ill homeless. Because of the federal system's critical importance for the states' own efforts, we describe it in detail.

The federal government currently awards funds to states for the provision of services to persons with severe mental illness who are homeless or at risk of homelessness through the Projects for Assistance in Transition from Homelessness (PATH) formula grant program. This program is a replacement for and an expansion of the McKinney Mental Health Services for the Homeless block grant program (MHSH) and is administered by the National Institute of Mental Health (NIMH). Under this program, Congress is authorized to appropriate \$75 million through 1994; the fund-

ing level for fiscal year 1991 was \$33.1 million and \$30 million has been appropriated for 1992. A state submits an annual application to NIMH and designates a state agency to administer the program. For every \$3.00 it receives in federal funds, a state must make a \$1.00 contribution in cash or in kind. Table 1 provides a comparison of the PATH and MSHH programs.

Table 1

Comparison of PATH and MSHH Federal Programs

	PATH	MSHH
Appropriation	\$33 million (FY 1991)	\$28 million (FY 1990)
Target Population	Individuals with serious mental illness and those with serious mental illness and substance-abuse disorders who are homeless or at imminent risk of becoming homeless	Individuals who are chronically mentally ill and homeless
Forms of Assistance	Formula grants to states, District of Columbia, Puerto Rico, and the U.S. territories	Block grants to same
Eligible Entities	States, which must make payments to political subdivisions of the state, and nonprofit private entities, including community-based veterans organizations and other community organizations	States, which must use funds to provide community mental health services to homeless individuals
Matching Funds	For every \$3.00 of federal funds provided, a \$1.00 match in public or private non-federal funds; match may be in cash or in kind	Same
Required Services	Same as MSHH, plus screening and diagnostic treatment services; habilitation and rehabilitation services; alcohol or drug treatment services; housing services; other appropriate services	Outreach; community mental health services; referrals; staff training; case management; supportive services in residential settings
Housing Assistance	Up to 20 percent of payment may be used for housing services, including minor renovation, expansion, and repair; planning for housing; technical assistance in applying for housing assistance; coordination of housing and services; security deposits; cost of matching individuals with appropriate housing situations; one-time rental payments to prevent eviction.	None
Restriction on Funds	No more than 20 percent for housing services; no more than 4 percent of total allocation for administrative expenses. Payments may not be expended for emergency shelters, housing construction, inpatient psychiatric or substance-abuse treatment, or cash payments to recipients of mental health services.	State agency may not spend more than 4 percent for administrative expenses. Payments may not be made for inpatient services, cash payments to clients, purchase or improvement of property, purchase of medical equipment, or to satisfy required nonfederal match.
Allotment of Funds	Minimum allotment: \$300,000 for states, District of Columbia, and Puerto Rico; \$50,000 for U.S. territories. Allotment determination formula: based on percentage of population living in urbanized areas of the state versus percentage of population living in urbanized areas of United States.	Minimum allotment: \$275,000 for states, District of Columbia, and Puerto Rico; \$50,000 for U.S. territories. Allotment determination formula: same as PATH.

Source: Access 3, no. 1 (January 1991): 5.

Two major differences are worth noting. First, individuals with a dual diagnosis of mental illness and substance abuse may not be excluded by any agency that receives PATH funds. Second, additional services, including housing services, are authorized under PATH. Housing services may include planning and coordinating housing services; providing technical support to those applying for housing assistance; matching people with appropriate residential programs; minor renovation, expansion, or repair of residences; and one-time rental payments to prevent eviction.⁷

State Studies

The case studies of three New England states were chosen partly for their contrasting approaches to reimbursement and contracting. Where appropriate, similarities/differences with other New England states will be noted. Table 2 contains information on the three states we discuss in detail: Massachusetts, Rhode Island, and Vermont. For comparison, Table 3 provides the same information for the remaining New England states.

The information on states' contracting practices was collected primarily through conversations with officials in the government agency responsible for overseeing the mental health service system in each state and through examination of sample documents supplied by the officials. Our analysis has not been reviewed by anyone within these agencies. We take full responsibility for any errors or omissions in this article.

Table 2

State Comparisons

	Massachusetts	Rhode Island	Vermont
Population (1990)	6,016,000	1,003,000	563,000
Area (square miles)	10,555	1,545	9,615
Percent of Population in Metropolitan Areas	90.4%	92.5%	23.4%
State Mental Health Agency	Department of Mental Health	Division of Mental Health and Community Support Services	Division of Mental Health
Community Mental Health Service System	State-operated CMHCs; contracts with private providers	Contracts with private providers; CMHC responsible for specific area	Contracts with designated private providers; CMHC responsible for specific area
PATH funding	\$862,751 (FY 91) \$706,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)
Services to Homeless Mentally Ill	Shelters: 2 DMH, 1 contracted; DMH-operated outreach team; contracts for psychiatric nurses at shelters and for detox center	4 CMHCs offer outreach, mobile treatment; non-CMCH operates drop-in center	Contracts fund staff positions at generic, antipoverty organizations
Funding Process (private providers)	Five-year RFP cycle	Annual budget – negotiations with existing contractors; RFP for new services	Annual budget negotiations with designated providers; annual funding application for providers of homeless mentally ill services

Sources: *Statistical Abstract of the United States*, 1991; state mental health plans as referenced in text; state mental health agency officials.

Table 3

State Comparisons

	Connecticut	Maine	New Hampshire
Population (1990)	3,287,000	1,228,000	1,109,000
Area (square miles)	5,544	35,387	9,351
Percentage of Population in Metropolitan Areas	92.4%	35.9%	56.1%
State Mental Health Agency	Department of Mental Health	Bureau of Mental Health	Bureau of Mental Health Services
Community Mental Health Service System	State-operated CMHCs; contracts with private providers	Contracts with private providers	Contracts with approved private providers; CMHC responsible for specific area
PATH funding	\$449,325 (FY 91) \$366,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)
Services to Homeless Mentally Ill	State CMHCs offer outreach and case management; contracts for case management and outreach to shelters	Contracts for outreach and supportive services at shelters; intensive case management in most areas	CMHCs provide outreach, case management, shelters; local groups operate housing and loan programs
Funding Process (private providers)	Annual budget negotiations with existing contractors; RFP for new services	Current — annual budget negotiations with existing contractors; RFP for new services; 1996 — six-year RFP cycle	Annual budget negotiations with existing contractors; RFP for new services

Sources: *Statistical Abstract of the United States*, 1991; state mental health plans as referenced in text; state mental health agency officials.

Massachusetts

The commonwealth of Massachusetts covers an area of approximately 10,500 square miles and has about 6 million inhabitants (1990 estimate). The Department of Mental Health (DMH), a subdivision of the Executive Office of Human Services, oversees the provision of mental health services to children and adults in the commonwealth. In 1990, the administrative structure of DMH was reorganized; separate area, regional, and inpatient administrative offices were consolidated into nine service delivery areas.⁸

The DMH had a fiscal 1991 budget of over \$450 million, of which 50.53 percent was allocated to purchased and contracted services, with the remainder funding services operated by the state. Private contractors provide virtually all residential services and more than three quarters of emergency services and skill development/employment services. Case management and adult inpatient services are almost completely provided by the state. As of April 1991, DMH had approximately 1,400 contracts totaling \$199 million. Of these, approximately 1,000 contracts were for mental health services, with the remainder covering such varied services as laundry and medical laboratory services.⁹

At the beginning of 1991, the regular DMH service delivery system included sixteen DMH-operated facilities: seven state hospitals for adults, one facility for children, and eight community mental health centers. In June 1991, the Governor's

Special Commission on Facility Consolidation submitted a report recommending the closure of three of the hospitals and the restructuring of acute inpatient services. The commission plans to submit its recommendations on the community mental health centers and the children's facility later in 1992.¹⁰

DMH has begun to act upon these recommendations: closure of one of the hospitals has been completed, and DMH is currently evaluating the responses to a request for proposals for the development of acute care inpatient units in community and private hospitals. Some patient advocates and providers have charged that the numbers of homeless mentally ill are increasing sharply as a result of the facility closures and the recent elimination of General Relief welfare benefits for the mentally ill.¹¹

It is estimated that there are between 2,500 and 3,000 homeless mentally ill individuals in Massachusetts, with 1,500 to 2,000 in the Metropolitan Boston area alone.¹² DMH has focused on improving the collaboration between shelters and the existing mental health system in order to reach the homeless mentally ill population and improve their access to the service system. Each DMH area is required to have an agreement with every shelter within its boundaries which describes the provision of clinical, case management, crisis, and educational services to the shelter. In addition, it is DMH policy that homeless individuals be given priority for case management services.¹³

In the Boston area, the Department of Mental Health operates two shelters for homeless mentally ill individuals and contracts for a third. The aim of these shelters is to stabilize clients rather than provide temporary shelter; staff are clinically trained. DMH also operates a homeless outreach team in the Boston area whose function is to visit area shelters and provide case management services for mentally ill residents. This team also performs street outreach.

DMH contracts with five non-DMH shelters in the Boston area for the provision of a total of 10.2 full-time equivalent (FTE) psychiatric nurses who function as stabilizing forces at the shelter sites. The nurses refer clients to the homeless outreach team and confer with them on case management decisions. They are responsible for general health care issues as well and network with other shelters and providers; due to the numerous providers of different services to the homeless, networking is necessary to maintain the flow of information to all caregivers involved with an individual. Nurses often have input into policy and program development decisions as well.

DMH and the Department of Public Health jointly fund a contract with an organization that operates an intensive care detoxification center for substance-abusing homeless mentally ill individuals.

Federal MSHS funds have been used to support 19.5 FTE shelter specialists in shelters throughout the state. In addition to providing direct care, shelter specialists refer clients to entitlement, training, and education programs and to community mental health centers or substance-abuse treatment providers. For the current year, DMH hopes to use 2.5 FTE to fund housing services advocates who would act as consultants to the shelter specialists, provide technical assistance to clients referred by them, and seek out available existing housing.¹⁴

DMH has made development of housing a priority, which is evidenced by the fact that within the last five years, in the Boston area alone, 400 units of housing (500 if independent-living apartments are included) have been developed and there are agreements for the development of over 400 more units within the next eighteen

months. Also in Boston, 215 residential beds have been set aside for the homeless mentally ill with half the individuals coming from DMH shelters and half from inpatient facilities. DMH has contracted with a variety of private nonprofit organizations to provide these beds and gives the local community mental health center the responsibility for programmatic oversight. The problem DMH faces is being able to provide the funding for the necessary supportive services.

This problem was reported in Maine as well. In 1989, Maine voters approved a \$7 million housing bond referendum, which has since been leveraged into a \$12 million mental health facility fund being used for acquiring and rehabilitating residential program sites. A request for proposals was sent out in 1991 for the development of residential projects in nine areas of the state, which will result in at least 54 additional places for mentally ill adults. However, funds for operating costs and supportive services are not adequate to allow financing of all the proposals the Bureau of Mental Health would have liked.¹⁵

The Code of Massachusetts Regulations, Chapter 808.200, details the procedures state agencies must follow when purchasing social services. Contracts for all services performed by private providers must be opened to rebidding at least once every five years. A request for proposals is developed which describes the services sought and the evaluation criteria and must include price information — the schedule of prices or price methodology.¹⁶

The Massachusetts five-year RFP cycle is unique within the New England area. As will be discussed in more detail below, the RFP process is used in Rhode Island to develop new programs; however, once chosen, the contractor becomes a sole source provider. In Connecticut, a similar process requests grant applications for the development of new programs. After the initial year of operation, however, the program is funded through a separate process. Funding is requested through plans submitted by area directors to the Connecticut Department of Mental Health, which separates programs into two categories: continuation and expansion or new programs. The legislature specifies funding levels for each category. Thus, again, the contractor becomes a sole source provider. In further contrast, the Connecticut Department of Mental Health is under no obligation to put out contracts for competitive bidding for new or expansion programs as is the Massachusetts DMH.

The Massachusetts request for proposals process begins with publication of a notice in the *Goods and Services Bulletin*. The notice includes a brief program description, deadline information, and a contact within the contracting state agency. The department seeking to purchase services is required to “disseminate notices of availability of the RFP in a manner designed to obtain the widest possible competition at least 20 calendar days prior to the deadline for submission of proposals.”¹⁷ A bidders’ conference is held at which bidders may ask questions about any aspect of the RFP or the RFP process. Prior to submission of a proposal, all bidders must be qualified by their principal purchasing agency, that is, the agency within the Executive Office of Human Services which has awarded the greatest total contract dollars to the provider in the most recent fiscal year. Qualification requires the submission of financial and organizational data that demonstrates a bidder’s ability to meet minimum administrative and fiscal standards.

In general, proposals must include a description of the program, a proposed budget, an agency and/or program organizational chart, job descriptions for all program staff positions, proof of license, if required, and certification from the State

Office of Minority and Women Business Assistance (SOMWBA), if applicable.¹⁸ Further qualifications and/or requirements may be specified in the RFP itself. Contents of the proposal may become part of the final contract.

Proposals are required to be evaluated according to the priorities and programmatic guidelines specified in the RFP. Proposals are initially screened to ensure that they meet the minimum requirements and conditions contained in the RFP. A selections committee, whose members must include at least three state employees, is formed to review these proposals and make a recommendation to either the area director or the central office, whichever level is purchasing the services, who may then accept or reject the recommendation. An RFP may be withdrawn at any time during this process and a new RFP issued.¹⁹

The department may also initiate competitive negotiations with all qualified bidders, during which the original specifications in the RFP may be modified as long as it is reasonably believed that organizations which did not bid on the original RFP would not have bid had the modifications been included.²⁰

Contract negotiations are limited to terms and conditions that were not specifically addressed in the RFP or the proposal. If the division cannot reach agreement with the first prioritized bidder after a reasonable time, it may disqualify that bidder and begin contract negotiations with the next prioritized bidder.²¹ Unsuccessful bidders may request a meeting with the department to discuss the reasons a competitor's proposal was selected and may appeal the decision to the head of the department, and if still dissatisfied, may appeal the department head's decision to the assistant commissioner of the Division of Purchased Services.²²

There are two additional methods of procuring services: prequalified services procurement and noncompetitive procurement. If a department is unsure of the amount of services that will be required over the course of the year or cannot determine when services will be required, it may instead award a contract through a prequalified services procurement process. The department defines in its request for qualifications the time frame in which services may be required and a plan selecting qualified bidders during this period.²³ Noncompetitive procurement is permitted if (1) there is an emergency, (2) the department determines, after a thorough investigation, that only one provider is qualified to perform the services, (3) a change in a contractor's administration, staffing, or facility has made it unable to perform the services, (4) a secondary purchaser wishes to purchase a portion of a program, or (5) the funding appropriation for the services specifically identifies a provider or type of provider. The department must keep on record a written justification for all noncompetitive contracts and must file a list of all such contracts with the Division of Purchased Services quarterly.²⁴

The terms of the contracts themselves are governed by the Code of Massachusetts Regulations 808.100: Prices, Reporting, and Auditing for Social Service Programs. A department may use two types of contracts: cost-reimbursement and fee-for-service. A cost-reimbursement contract includes a detailed budget specifying the total anticipated expenditure per line item, offsets per line item such as third-party payments or payments from other state departments, and the maximum amount DMH agrees to reimburse during the contract period. The contractor is reimbursed for costs documented and submitted to DMH each month and has a full year to reach the maximum. Cost reimbursement contracts may be used only if it is a start-up year, the program is available for purchase only by the department and utilization cannot be

predicted, or payment on a fee-for-service basis would be detrimental to the quality or effectiveness of the program.²⁵

Fee-for-service contracts include those purchased for negotiated prices, component pricing, or unit rate. There are two types of unit rate contracts: class rate and individual rate. Class rates, established by the state's Rate Setting Commission, are not discretionary. Historical expenditures of the providers of a specific type of service are examined and a form of weighted average is computed to set the rate per unit of service. These rates are reexamined every few years and after extended negotiations between the commission and the providers and a public hearing, new rates are set. DMH contracts for most outpatient services, psychiatric day treatment, and certain types of hospitalization in this manner. Individual rates occur if the service is different and meets a specific DMH need. The provider documents its projected costs and a special rate is negotiated. In general, residential programs fall into this rate category. In all cases, the Division of Purchased Services must approve the price to be paid under a contract and notify the state comptroller of the authorized price.

Contracts are monitored by requiring providers to submit a Uniform Financial Statement and Independent Auditor's Report to the Division of Purchased Services before the fifteenth day of the fifth month after the contractor's fiscal year has ended.²⁶ Providers are asked to submit the following audited basic financial statements: balance sheet, statement of revenues and expenses and changes in fund balances, and statement of functional expenses. They must also submit the following supplemental schedules: supplemental revenue, supplemental expense, supplemental employee, and supplemental program statistics.

Despite Massachusetts's elaborate array of regulations designed to encourage competition, some studies have found a lack of takers for mental health contracts. In a 1986 study, Schlesinger et al. found that almost two thirds of "competitively" bid contracts only attracted one vendor, and only 15 percent attracted more than two.²⁷ More recently, a Suffolk University study has argued that there is a lack of competition in the private sector with the implication that contracting out mental health services could actually raise costs to the state.²⁸ These results highlight the importance of understanding market structure for any evaluation of proposed reforms to contracting in mental health.

Rhode Island

Rhode Island covers approximately 1,500 square miles and has just over one million inhabitants (1990 estimate). The Division of Mental Health and Community Support Services (DMH), a subdivision of the Department of Mental Health, Retardation, and Hospitals, oversees the provision of community mental health services in Rhode Island. The planning emphasis is primarily on adults with a severe mental illness, whom the division terms "community support clients." The Rhode Island Department for Children and Their Families has the primary responsibility for the provision of mental health services to children.

The Rhode Island mental health service system is divided into eight catchment areas, each of which contains a single comprehensive community mental health center. The CMHC is a nonprofit agency that provides all the outpatient public mental health services in its area and is responsible for all admissions to and discharges from the Institute of Mental Health, the state inpatient facility. The service

system also includes three organizations that provide residential services to the severely mentally ill.²⁹ Contracts with these major providers totaled over \$24 million in fiscal 1991.³⁰

DMH also contracts with numerous small organizations for specific services; for example, in fiscal 1991, DMH funded a client literacy program, a refugee center, a mental health worker certification program, and others. The only non-CMHC contractor that provides services specifically aimed toward homeless mentally ill individuals falls into this category. Contracts with these small organizations totaled nearly \$3 million in 1991.³¹

It has been estimated that there are 4,400 homeless people in Rhode Island over the course of a year. A census done in April 1991 counted 471 individuals in shelters or visible on the streets; however, shelter operators report that the approximately 500 beds throughout the state are filled each night. DMH uses the following percentages to estimate the numbers of homeless mentally ill: 19 percent of all homeless individuals have a serious mental illness and an additional 27 percent are in need of mental health services.

In 1987, as part of the process of developing the state plan for mental health services, surveys of homeless individuals were conducted in Providence and Newport. The Providence survey was performed at eight sites (including shelters and the bus terminal) in addition to some street interviews. A total of 144 homeless people were interviewed. This survey found that 18.8 percent were judged to have severe and/or persistent mental disability.³²

The survey in Newport interviewed seven individuals looking for temporary shelter at a YMCA shelter. None of these were found to be "definitely severely mentally disabled." The results of this survey are not considered as valid as those of the Providence survey owing to the small sample size and lack of information on previous treatment.³³

As a result of these surveys, the mental health plan recommended the creation of aggressive outreach services focused on linking the homeless with mental illness with the necessary services; the plan states that the community support services it proposes were appropriate for these individuals and that the problem is more one of identifying and gaining service acceptance by this population. The plan proposed creation of the following programs: (1) an outreach and liaison program to operate on the streets, (2) a mobile care team to operate at shelters, soup kitchens, and similar sites, (3) drop-in center(s) located near homeless shelters, and (4) transitional residential beds.³⁴

Rhode Island funds four CMHCs to provide services specifically aimed at the homeless population. The services provided include homeless outreach teams and mobile treatment teams. Of the roughly \$300,000 allocated for services to the homeless, approximately \$200,000 is split among the four CMHCs. The remaining third funds a contract with a non-CMHC provider, Travelers Aid, which operates a drop-in center in Providence.

In an attempt to provide "light" services rather than the CMHCs' regular package of services, DMH funds the drop-in center, which is designed to be external to the CMHCs. Light services are social — having a cup of coffee together and talking. Because they are not structured, they are valuable in reaching individuals who are the most resistant to standard treatment, like many of the homeless population. The

drop-in center staff includes a full-time CMHC person to facilitate referral into the CMHC system, but referral is not the main focus of this service.

Contracts with community mental health centers result from sole source negotiations; there is no competition for these contracts. CMHCs must complete a plan for service development. This document defines DMH service priorities, standard program element definitions, planning guidelines, and service need data for each catchment area. CMHCs are required to prepare reports containing information on each of the program elements, which include the population served, service objectives and modalities, outcome assessment and quality assurance mechanisms, staff cost, units of service, and active clients and anticipated admissions and discharges in the previous year, current year, and as proposed for the coming year.³⁵ A separate budget application is prepared, which contains detailed expenditure and income data. Income data requested include income from federal grants, all state agencies, and local sources. Expenditure data include personnel and operating expenditure for each program as spent in the prior year, budgeted for the current year, and anticipated in the coming year.³⁶ The final contract amounts and service levels are negotiated between the contractor and DMH.

The contract with Travelers Aid for the drop-in center in Providence did go through a competitive process. Over two years ago, the division sent out an RFP for the provision of services of a more social, less treatment-oriented nature. CMHCs were not barred from competing for this contract even though the services requested were intended to get away from those of the standard CMHC package. Five proposals were submitted, three from CMHCs and two from other organizations.

Once awarded the contract, Travelers Aid became the sole source provider of these services and is annually re-funded in much the same manner as are the community mental health centers.

Each CMHC has one contract that covers the provision of all services. A non-CMHC contract, such as Travelers Aid's, is similar but would, of course, cover only the services specifically purchased from this provider. A general agreement contains general provisions; for example, equal employment opportunity requirements, termination and amendment terms, and language holding the state harmless from liability for any act of the contractor. Program descriptions and requirements are contained in addenda that cover broad categories of services such as community support services or acute alternatives. All program-specific information is found in these sections: the purpose of the service, the population to be served, and exact definitions of each service including how units of service are to be measured. Sections of the plan for service development that contain performance standards and targets which were agreed upon during contract negotiations are referenced and incorporated into the contract. Quality assurance and reporting requirements are included as well. Services to be provided to the homeless population, like mobile treatment teams, are contained in such an addendum.

A separate addendum defines the financial terms and conditions of the contract and includes a budget summary, payment terms, budget amendment procedures, and financial reporting requirements. Terms specific to service types may include required occupancy levels for residential services or penalties for overutilization of the state hospital for the mentally ill.

Provider performance is monitored by requiring periodic reporting of service and

financial data. Program reports must be submitted monthly. Required financial reports include the following: quarterly report of income and expenses, six-month income and expenditure detail, projection of year-end income and expenditure report, final expenditure report, and a year-end audit.

Vermont

The state of Vermont covers an area of approximately 9,600 square miles and has an estimated population (1990) of 563,000. The Division of Mental Health (DMH), an arm of the Department of Mental Health and Mental Retardation, has the responsibility for assuring the provision of mental health services to both children and adults.

The general service delivery system in Vermont consists of ten private, nonprofit community mental health centers, which are the designated providers of mental health services in the state; there is one CMHC in each of Vermont's ten catchment areas. The Division of Mental Health has contracts with these providers, but the contracts are not bid; instead, the CMHCs are annually re-funded. This service delivery system is not used to provide services specifically geared to the homeless mentally ill individual. It is, of course, true that all such individuals have access to the services offered by the CMHCs, but Vermont has decided not to give primary responsibility of reaching this population to the traditional service system.

This is similar to the situation in New Hampshire. The director of the Division of Mental Health and Developmental Services in that state has the authority to designate providers as "approved" for funding; the same ten CMHCs have been the approved providers since the 1970s. While in New Hampshire CMHCs are used to perform outreach and case management services, a large part of the services directed to the homeless mentally ill population is funded through contracts with local community action programs. These programs either supply housing themselves or monitor the availability of local housing. In addition, through a short-term cash infusion program, the division supplies funding that allows these programs to offer loans for initial rental costs like security deposits.

The Vermont Division of Mental Health estimates that there are approximately 1,200 homeless mentally ill individuals in the state. DMH funds all mental health services to the homeless through the federal PATH program. Vermont received \$300,000 from the program in fiscal 1991. State matching funds came from a variety of sources; for example, United Way, local municipal funds, state general funds, and volunteers. Only one organization received matching funds from the Division of Mental Health.³⁷

Due to the limited funds for services to the homeless, DMH has not attempted to create a statewide program but has targeted funds to areas where there are existing shelters or other homeless services programs. The policy is to tie the DMH program for homeless mentally ill individuals onto services that already attract these individuals. It is believed to be unlikely that a person involved with a community mental health center would become homeless, as services offered by all centers include housing subsidies (to cover the waiting period for Section 8 funds) and advocacy in addition to residential programs. Since people who are in the CMHC system are quickly housed, the majority of homeless individuals are those who are not using the CMHCs. In order to reach these individuals, the Division of Mental Health chose to contract with generic, antipoverty organizations not automatically associated with

mental health services. In the one case where services for the homeless are provided through a community mental health center, the services are provided at a drop-in center, not at the main office of the center.

The Division of Mental Health contracts with a variety of nonprofit organizations that provide services in six of the ten DMH catchment areas. The organizations include shelters, community action programs, a housing developer, and a consortium organization in Burlington that consists of a health center, a temporary shelter, and the community mental health center noted above.³⁸ The Division of Mental Health does not fund stand-alone programs but adds to existing ones. The type of organization that receives funding varies from location to location and depends on both the need for services and the existing providers. For the most part, DMH funds staff positions. For example, the division provides funds to shelters and community action programs to permit the hiring of an outreach person whose function is to identify and make initial contact with individuals exhibiting symptoms of mental illness. In Rutland, a neighborhood housing program, which provides assistance in locating housing, receives funds to identify individuals who need mental health services.

The services include outreach, case management, supportive counseling, assistance in locating housing and accessing housing benefits, advocacy, and referral; the emphasis is away from clinical treatment. The treatment philosophy is not necessarily to bring people into the traditional CMHC system. The services offered depend on the individual. If it makes sense to refer an individual to the standard system, this occurs. However, these people often have "fired" the CMHC. The intent is to reach the people who won't join the CMHC system.

The funding process begins when the DMH sends out notification of available funding. All existing contractors and other organizations that have expressed an interest in providing services geared toward individuals with mental illness are notified. In addition, there is an Advisory Board on Homelessness in Vermont whose members include shelter operators, representatives from churches, the Alliance of the Mentally Ill, mental health services consumers, legal aid providers, and community action program directors. This board is familiar with the organizations providing services to homeless individuals and can identify potential contractors. For the most part, however, the division has been working with the same core of providers since 1987, when the Mental Health Services to the Homeless block grant program began.

All organizations interested in receiving funding must submit an application and make a presentation to the advisory board. Organizations must specify both the services they propose and the budget necessary to provide them. The board annually reviews all submissions, then makes recommendations for funding to DMH. Funding is not automatically renewed; an existing contractor must submit an annual application and make a presentation regarding what has been accomplished in the current year and what is proposed for the following year.

Specific unit prices for services are not exogenously set but rather contract amounts are negotiated between the organization and the advisory board. The members of this board are involved in the provision and use of services and are therefore knowledgeable about the costs of services and the current pay scales. No outside state agency determines the pricing of contracted services. This is in contrast to Massachusetts, where two state agencies — the Rate Setting Commission and the

Division of Purchased Services — both outside the state mental agency, have jurisdiction over pricing.

Contractors are required to submit quarterly reports regarding changes in clients or services, staff training, coordination with other agencies serving the homeless mentally ill population, expenses by budget line item, and client contact data. The DMH program director reviews the quarterly reports and inquires about any changes in client or service numbers in an attempt to solve any problems that arise and as a way of monitoring changes in need which may necessitate changes in plans for the coming year. In addition, a team from the advisory board visits the contractors' sites and reviews their quarterly reports.

From the above description, we may draw some preliminary comparisons between the states' approaches to provider reimbursement and note possible policy implications.

First, states differ in their commitment to encouraging competition among bidders. For example, although Rhode Island selected the provider of its drop-in center by RFP, there are no plans to repeat the process in future years, effectively giving the winner an indefinite contract. By contrast, the winner of an equivalent contract in Massachusetts would be subject to a standard five-year RFP. This is in line with each state's wider approach to mental health contracting, in which Massachusetts appears to be more procompetitive.

However, it is also true that the use of RFPs can have anticompetitive effects in that the time and effort needed to respond may become a barrier to entry by small providers. In this respect, Massachusetts has higher barriers because it imposes considerably more paperwork and other requirements on bidders. Kramer and Grossman discuss this problem and note that states can reduce its impact by offering technical assistance to bidders, which Massachusetts does, or by actively helping recruit or establish new provider agencies.³⁹ Another argument sometimes made against the RFP process is that there are few providers in small states and the government already knows their costs and utilization, so that the process does not offer efficiency gains to offset the additional administrative costs.

A second observation is that the need to include nontraditional providers has a different impact on states' contracting policies, depending on their approach to bidding. Vermont and New Hampshire, which traditionally organize most of their contracting around CMHCs, had to expand their approach to include nontraditional providers. By contrast, Massachusetts was already committed to seeking multiple bids and using non-CMHC providers, so presumably contracting with homeless shelters would not have required major readjustments. However, this advantage appears to have been pursued only slightly, since the majority of programs aimed at providing services to the homeless mentally ill population in Massachusetts are not contracted but are operated by the department.

A third issue is the way the states deal with agencies that do not serve the homeless mentally ill exclusively. Examples are how to structure financing the CMHCs so that they treat some homeless and how to pay homeless shelters/agencies so that the mentally ill benefit from the funding. Rhode Island addresses the first of these by identifying, within the annual plan for service development, clients who are homeless or at risk of homelessness as a high-priority group. Necessary services such as housing, case management, and mobile treatment team are identified as well. With

respect to structuring contracts with homeless shelters, both Massachusetts and Vermont require that state funds be used to support staff with specific duties and responsibilities.

One reason to study states' varying provider reimbursement arrangements would be to see which approaches are best suited to helping as many homeless mentally ill as possible, as cost-effectively as possible. This study is necessarily less ambitious, since the health, housing, and cost outcomes associated with the different reimbursement arrangements were not analyzed. Rather, one can only draw more limited conclusions about how different contract designs are likely to affect the number of potential providers and the incentives facing them.

A conclusion is that existing contracting systems appear to reflect considerations other than procompetitive ones, for example, the desire to ensure continuity of care. This familiar problem in the human service sector confronts anyone attempting to introduce contracting approaches developed for other sectors with different market characteristics. Second, states appear to need contracting schemes flexible enough to accommodate non-CMHC providers in the case of the homeless mentally ill, even if their other mental health contracting is largely channeled through CMHCs. Finally, coordination among state agencies is crucial, given the complementarities among services needed by the homeless mentally ill; for example, funding special housing will help only if the state also ensures that social support services will be funded.

A more general conclusion is that this is clearly an area in which further research would be of benefit to policymakers. Like deinstitutionalization, contracting reform may be an idea whose details of implementation matter a great deal, and ignoring them could lead to undesired results. More work needs to be done to examine the conditions under which the homeless mentally ill will be helped by contracting out, and whether current and proposed reforms meet those conditions. The natural diversity of states' existing approaches may provide valuable lessons for future reform efforts. ❧

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Notes

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 14. *Ibid.*, 64.
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 17. *Ibid.*, 2.04(2).
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 19. 808 Code of Massachusetts Regulations 2.04(10).
 20. *Ibid.*, 2.04(7).
 21. *Ibid.*, 2.04(8).
 22. *Ibid.*, 2.04(11), 2.04(12).
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 24. *Ibid.*, 2.06.
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