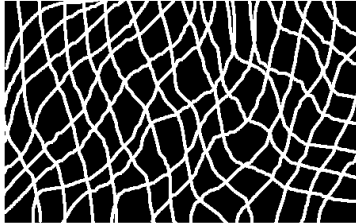


Tennessee's Mental Health Safety Net



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Executive Summary

Chapter 534, Public Acts of 1997, directs the Comptroller of the Treasury to evaluate Tennessee's mental health delivery system and report to the General Assembly on the extent to which there is a need for appropriate state actions to ensure that:

- a continuum of essential mental health services is readily available and accessible to citizens throughout the state not eligible for services through the Medicaid program or any waiver granted under the Medicaid program, specifically including the TennCare program; and
- mental health counseling, treatment, or support services are readily available to citizens throughout the state who are affected by disasters, catastrophic, or unforeseen events of great misfortune or public loss.

The policies and priorities of Tennessee's Master Plan reflect the national trend of moving the seriously mentally ill out of institutions and caring for them in the community. Since 1992, Tennessee has been moving toward the goal of community care for the seriously mentally ill. From 1992 to 1996, the average daily census of the regional mental health institutes decreased by over 24 percent from 1,321 to 1,016. Consequently, community providers play a greater role in mental health care than in previous years. The Tennessee Department of Mental Health and Mental Retardation indicates that community mental health center annual caseloads increased by 45,253 individuals, or by over one-third, from 1993 to 1996.

The community mental health centers were once able to provide services for individuals who were ineligible for Medicaid, but they are now struggling financially to do so. The centers' total revenues dropped 24 percent between fiscal years 1996 and 1997. During that same time period, government funding to the centers dropped 23 percent. Before the creation of TennCare Partners in 1996, the centers received state block grant funding sufficient not only to provide services for the seriously mentally ill, but also to provide services to individuals with mild or moderate mental disorders. Many relied on the centers to provide care to those with less serious disorders and perceived that as part of their mission. With the creation of TennCare Partners, grant funding declined.

Grants had few accountability measures before the TennCare Partners program. The community mental health centers received block grant funding intended to treat the seriously and persistently mentally ill. The centers then used portions of those grant funds to treat individuals with mild or moderate mental disorders. Advocates of managed care state that the Partners program has increased accountability by ensuring that mental health funds are tied directly to those for which they are intended: the priority population.

The seriously mentally ill compete with the less seriously mentally ill for state funding. Advocates for the seriously mentally ill argue that the state should first fulfill its obligation to that population. Others argue that the state should once again provide the community mental health centers with sufficient block grant funding to serve both the seriously mentally ill as well as those with lesser needs.

Alternatives to the community mental health centers provide care in some parts of the state. Both TennCare enrollees and uninsured individuals who are ineligible for TennCare can access these alternatives. For example, the Mental Health Cooperative in Nashville offers mental health services to TennCare enrollees. In addition, the Church Health Center in Memphis, Interfaith Health Clinic in Knoxville, and nonprofit health centers, such as the Friends in Need Clinic in the Tri-Cities area, provide mental health care to the working poor, elderly, children, and uninsured homeless. In addition, pastoral counselors offer sliding fee scales similar to those offered by community mental health centers to individuals not eligible for TennCare. Local schools also offer some mental health services to their students.

The number of Tennesseans needing a mental health safety net is difficult to estimate. Estimates range from 11,000 to 38,000 individuals with mild or moderate mental disorders. Those advocating a safety net for these individuals argue that treatment for the less seriously mentally ill prevents the deterioration of mental health and eliminates or delays the need for future mental health care. Scientific debate continues regarding the benefits of preventive action in the case of mild or moderate mental illness.

Almost 14,000 seriously and persistently mentally ill adults and severely emotionally disturbed children are automatically eligible for TennCare, but are not enrolled. Some providers state that many TennCare recipients lose benefits for reasons such as not paying premiums or changing addresses without contacting the TennCare Bureau. Numerous community mental health centers insist that they could enroll more individuals in TennCare, but are discouraged by low case and capitation rates. The TennCare Bureau used a consultant to review the payment calculation methodology and capitation payment rates for the program, but concerns about the rates persist.

An estimated 175,000 Tennesseans have no access to behavioral or medical health benefits. Reopening enrollment in TennCare would provide these Tennesseans a full spectrum of health benefits. However, this could cost the state up to \$111 million annually, if all eligible persons enrolled.

Other states have a more comprehensive safety net than Tennessee. Arizona, for example, partially subsidizes mental health providers' sliding fee scales for their clients who are ineligible for Medicaid. Colorado, Minnesota, and Massachusetts work to provide services to persons who are ineligible for Medicaid. Tennessee first provides funds for the TennCare population and offers over \$16 million in grant funding for other psychosocial services including housing assistance, drop-in centers, and vocational skills training.

Tennessee appears to have adequate resources for mental health services in case of a disaster. For presidentially declared disasters, Tennessee receives funding from the Federal Emergency Management Agency. The Tennessee Emergency Management Agency and the American Red Cross respond with a network of 30 licensed mental health professionals to disasters and catastrophic events. Coordination could be improved, however, by implementing a program similar to the Kentucky Community

Crisis Response Board. That program includes a network of mental health professionals who respond to crises ranging from school violence incidents to natural disasters.

Alternatives

This report offers several alternatives that may lead to improved community mental health services.

Legislative Alternatives

- The General Assembly may wish to clarify the state's mission and allocate appropriate funding to provide mental health services to seriously and persistently mentally ill adults and seriously emotionally disturbed children or those with mild or moderate mental disorders, or both groups.
- The TennCare Oversight Committee should continue to provide a forum that is conducive to public discussion and debate of issues surrounding the TennCare Partners Program. The committee has been successful in raising many issues, including concerns of reimbursement and access, to both the behavioral health organizations and providers.
- The General Assembly may wish to consider using its existing community resources and statutorily create a coordinated mental health disaster response system modeled after the Kentucky Community Crisis Response Board. The Kentucky system is a coordinated network of 150 volunteer mental health professionals who respond to disasters around the state.

Administrative Alternatives

- The TennCare Bureau should ensure that the community mental health centers receive timely and complete reimbursements from the behavioral health organizations. This would provide greater incentive to enroll people in TennCare and allow the community mental health centers better fiscal health and thus more flexibility in offering services to those ineligible for TennCare.
- The Department of Mental Health and Mental Retardation should conduct an annual actuarial study to determine the adequacy of funding for the TennCare Partners program. The community mental health centers have experienced a 23 percent decline in government funding since the implementation of the Partners program.
- If the state chooses to disburse additional money for mental health services, the Department of Mental Health and Mental Retardation should encourage accountability by tying grant funding to identified recipients.
- The Tennessee Department of Health should consider reopening TennCare enrollment. The state dollars spent by reopening TennCare enrollment would offer both behavioral and medical health care, but could result in state expenditures of up to \$111 million.

Other Alternatives

- Mental health providers may want to seek other funding sources and lessen their dependency on state funds. Community mental health centers are nonprofit entities whose 501(c)(3) federal tax status allows them to raise funds or create partnerships with for-profit organizations for capital support.
- If the behavioral health organizations violate their contracts with untimely and incomplete payments, the community mental health centers should seek contractual remedies with the behavioral health organizations. Timely and complete payments may encourage mental health providers to increase their efforts to enroll people in TennCare.

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Introduction

Tennessee Code Annotated 33-2-601 mandates that the Department of Mental Health and Mental Retardation develop a system to assure the most appropriate and effective care for individuals admitted to and discharged from state-supported mental health institutes. *T.C.A. 33-2-602* establishes the procedures and requirements to implement this system.

In 1997, state legislation was proposed that would create catchment areas around Tennessee's community mental health centers. Senate Bill 107 would have directed the Department of Mental Health and Mental Retardation to establish procedures and requirements necessary to implement a system to assure that a continuum of essential mental health services shall be made available to: those Tennesseans who are not eligible for services through the Medicaid program or any waiver granted under the Medicaid program; and those affected by disastrous, catastrophic, or unforeseen events of great misfortune or public loss. The bill also would have directed the Department to contract for the provision of such services in each catchment area, with either the community mental health center or other providers. Furthermore, the Department would have been required to develop a statewide system of disaster-related care and support services by contracting with the centers or other providers.

The bill was amended, which deleted all its original language, passed into law and published as Chapter 534, Public Acts of 1997. The resulting legislation directed the Comptroller of the Treasury to evaluate the mental health delivery system in Tennessee and report to the General Assembly on the extent to which there is a need for appropriate state actions to ensure that:

- (a) a continuum of essential mental health services is readily available and accessible to citizens throughout the state who for any reason are not eligible for services through the Medicaid program or any waiver granted under the Medicaid program, specifically including the TennCare program; and
- (b) mental health counseling, treatment, or support services are readily available to citizens throughout the state who are affected by disasters, catastrophic, or unforeseen events of great misfortune or public loss.

Methodology

The conclusions and recommendations in this report are based on:

- interviews with personnel from federal, state, and local agencies and private entities
- site visits to four community mental health centers and three community mental health providers
- information received from federal, state, and local agencies and private enterprises
- review of survey data from the Tennessee Association of Mental Health Organizations
- review of journal articles, books, and reports
- review of pertinent statutes, rules, and regulations
- review of other states' programs

Background

History of Mental Health Care¹

The care of the mentally ill in the United States has evolved and changed dramatically in the past 200 years. Tennessee's history of care reflects national trends.

Late 1700s to the mid-1800s The mentally ill lived in the community, where their families, poor houses, or private charities cared for them. Many individuals, however, received no care.

Mid-1800s to the 1940s Institutional care, primarily through asylums, was the prevalent treatment of the mentally ill.

1940s to 1970s The emphasis in this era was on community mental health care. The 1963 Community Mental Health Centers Act provided federal subsidies for construction of community mental health centers to serve as alternatives to inpatient residential facilities. The legislative history of the Act reveals that Congressional intent was to “develop the quantity and quality of community services which [would] ultimately replace these institutions or [they would] have to undertake a massive program to strengthen the state mental hospitals.”² The community mental health centers were created to treat the most seriously mentally ill.

1970s The federal government shifted its focus to substance abuse, believing that the 1963 act had ensured care for the seriously mentally ill.

1980s Under the Omnibus Budget Reconciliation Act of 1981, federal funding shifted to block grants to the states. The grants were to provide for substance abuse and mental health services for the seriously mentally ill population.

Tennessee in the 1990s – From the Master Plan to TennCare Partners

In 1992, the Tennessee Department of Mental Health and Mental Retardation created the Master Plan to align Tennessee's mental health system with the national priority of caring for the seriously and persistently mentally ill population in the community. The Department concluded³ that the community mental health system lacked adequate funding for services for Tennessee citizens classified in the priority population. The priority population is made up of seriously and persistently mentally ill adults and seriously emotionally disturbed children. In 1989, a Comptroller's performance audit asserted that community mental health services did not meet the needs of the priority population. At that time, over two-thirds of the 18,000-member priority population did not have their needs minimally met in at least one of nine service areas.⁴

¹ Gerald N. Grob, “The Paradox of Deinstitutionalization,” *Society*, July-Aug. 1995, v. 5, p. 51(9).

² *United State Code Congressional and Administrative News*, 88th Congress, First Session, 1963, p. 1065.

³ Master Plan for Mental Health Services in Tennessee, A Report to Commissioner David Manning, Tennessee Department of Finance and Administration and Commissioner Evelyn Robertson, Tennessee Department of Mental Health and Mental Retardation, prepared by Yearwood, Johnson, Staton and Smith and Consultants for Community Change, Inc., April 15, 1992, p. iv.

⁴ State of Tennessee Comptroller of the Treasury, Division of State Audit, Performance Audit of Department of Mental Health and Mental Retardation, April 1989, p. 25.

Currently, there are 25 community mental health centers in Tennessee. A map of the community mental health centers is included in Appendix B.

A primary goal of the Master Plan was to move individuals, specifically the seriously and persistently mentally ill, from institutions to community settings as quickly as possible.⁵ Tennessee has been moving to meet that goal: from 1992 to 1996, the average daily census of the regional mental health institutes decreased from 1,321 to 1,016.⁶ Consequently, community providers play a greater role in mental health care than in previous years. Community mental health center annual caseloads increased by 45,253 individuals, or by over one-third, from 1993 to 1996.⁷

In 1992, the Department estimated that over 36,000 adults and over 9,000 children made up the priority population.⁸ The priority population is eligible for enhanced mental health benefits under the Partners Program.

- The clinically related group assessment categorizes adults into five groups. Persons who are determined to be a member of clinically related groups one, two, or three are considered to be seriously and persistently mentally ill.
- The target population group assessment categorizes children into four groups. Children who are assessed target population group two are considered seriously emotionally disturbed, and are included in the priority population.

In January 1994, Tennessee replaced its Medicaid program with TennCare. TennCare is a statewide section 1115 demonstration project⁹ to provide health care benefits to Medicaid beneficiaries, certain uninsured state residents, and individuals whose medical condition classifies them as uninsurable. TennCare is a managed care program offering medical and mental health benefits, with all care financed through capitation payments¹⁰ to managed care organizations. As a Medicaid waiver project, Tennessee receives matching federal dollars. The federal match for 1998 is almost 64 percent.¹¹

In July 1996, the Department of Mental Health and Mental Retardation implemented the Partners Program as part of TennCare. Mental health and substance abuse services previously offered by the managed care organizations were “carved out” to be provided

⁵ Master Plan for Mental Health Services in Tennessee, April 15, 1992, p. xv.

⁶ Department of Mental Health and Mental Retardation, “Breakthrough,” 1995-96 Annual Report, p. 11.

⁷ Information provided by Jim Cate, Computer Operations Manager, Tennessee Department of Mental Health and Mental Retardation.

⁸ Master Plan for Mental Health Services in Tennessee, April 15, 1992, p. iv.

⁹ An 1115 waiver is a waiver provided by Section 1115 of the Social Security Act. Under this section, states can deviate from many standard Medicaid requirements to test new ideas.

¹⁰ A capitation payment is a method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time, usually a year.

¹¹ Information received from Health Care Financing Administration, Federal Medical Assistance Percentages, as of November 26, 1997.

by one of two behavioral health organizations,¹² Premier Behavioral Health Systems of Tennessee and Tennessee Behavioral Health. Under their original contracts, Tennessee Behavioral Health paid the community mental health centers a monthly capitation rate—a fixed per-enrollee payment. Before paying the centers, Tennessee Behavioral Health deducted payments to other providers for pharmaceuticals and transportation. A July 1997 amendment to the behavioral health organizations’ contracts prohibits the passing of unmanageable financial risk to subcontractors or providers.¹³ Premier pays a case rate for each priority client who actually uses services.

¹² A “carve out” is an arrangement whereby coverage for a specific category of services, e.g. mental health services, are eliminated, and a separate set of providers are contracted with for those services according to a predetermined fee schedule or capitation arrangement.

¹³ Information provided by the Bureau of TennCare to the TennCare Oversight Committee, July 30-31, 1997. Amendment 5 also set capitation rates for the priority population at \$319.41 per member per month, decreasing the capitation for all other enrollees from \$22.93 to a variable rate of \$10.00 per member per month, depending on the number of enrollees.

Analysis and Conclusions

The community mental health centers were once able to provide services for individuals who were ineligible for Medicaid, but now struggle financially to do so. The centers receive state and federal block grant funds designated for the seriously mentally ill or priority population.¹⁴

At one time, the grant funding was sufficient to allow the centers not only to provide the services for which they were paid but also to provide other services.¹⁵ The centers provided services to persons who were ineligible for TennCare by subsidizing care completely or seeing patients on an ability-to-pay basis according to a sliding fee scale. Many persons across the state perceived that the centers' mission was to provide services for the less seriously mentally ill and relied on that care.

With the implementation of TennCare Partners, capitation payments from the behavioral health organizations almost entirely replaced the block grant funding. The centers still receive limited block grant funds from the Department of Mental Health and Mental Retardation (over \$16.8 million for year ending 1996-97) and the Department of Children's Services.¹⁶

The centers' revenues have declined under TennCare Partners. A 1997 Comptroller of the Treasury report confirmed that the centers' revenues,¹⁷ from June 30, 1996, to the projected revenue for June 30, 1997, decreased approximately 24 percent.¹⁸ Data from the Department of Mental Health and Mental Retardation and the two behavioral health organizations confirm that government funding for the community mental health centers declined 23 percent between fiscal years 1996 and 1997.¹⁹ (See Exhibit 1.)

In addition to the funding and revenue reduction, the centers have not received timely payments from the two behavioral health organizations. The Comptroller's report noted the claims payment problems. The report recommends that the Partners program require the behavioral health organizations to process claims filed by the centers at least within the contractually agreed time frame or be assessed the penalties specified in their contract with the state.²⁰ In a report released in February 1998, the Tennessee Department of Commerce and Insurance and the Comptroller of the Treasury found that one of the

¹⁴ Dr. Ron Manderscheid, "Estimation of the 12-month Prevalence of Serious Mental Illness," April 1997, p. 1; Department of Mental Health and Mental Retardation, "Breakthrough," 1995-96 Annual Report, p. 11 and 1995 Annual Report, pp. 4-5.

¹⁵ Testimony to the TennCare Oversight Committee, October 25, 1995.

¹⁶ Information provided by Lisa Faehl, the Director of Planning and Research for the Department of Children Services, Chris Gingles, Department of Mental Health and Mental Retardation; Bob Waters, Premier Behavioral Health Systems; and Chris Paterson, Tennessee Behavioral Health.

¹⁷ State of Tennessee Comptroller of the Treasury, Division of State Audit, Special Report, "Status of Community Mental Health Centers Under TennCare Partners Program," June 1997, p. 2.

¹⁸ Ibid. Schedule 1 – Selected Financial Data.

¹⁹ Based on information received from Chris Gingles, Department of Mental Health and Mental Retardation; Bob Waters, Premier Behavioral Health Systems; and Chris Paterson, Tennessee Behavioral Health.

²⁰ State of Tennessee Comptroller of the Treasury, Division of State Audit, Special Report, June 1997, p. 3.

behavioral health organizations wrongly denied almost 28 percent of provider claims.²¹ In March 1997, the federal Health Care Financing Administration expressed concern that the behavioral health organizations were not adhering to their contract by paying claims in a timely manner.²² Timely and complete reimbursements by the behavioral health organizations would improve the centers' fiscal health and allow more flexibility to offer services to those ineligible for TennCare.

Because of the funding change with TennCare Partners, most community mental health centers have raised their sliding fee scales and priced many of the uninsured individuals out of care.²³ Some center officials assert that for many patients, the Partners program places excessive resources in case management at the expense of services, such as doctor visits. In addition, community mental health centers claim the program has placed undue administrative burden on clinical staff. Several center officials stated that they had experienced problems in obtaining reimbursement. Employees at one center date stamped individuals' admissions and expected payment from the time of admission. The center was only reimbursed for services from the time of enrollment, however.

The Tennessee Association of Mental Health Organizations conducted a survey in October 1997. A sample of the survey is included in Appendix C. In response to the survey, some community mental health center officials expressed concerns with the program. Concerns included increased waiting lists, elimination of day treatment and therapeutic nursery programs, shifts from individual to group therapy, and a decrease in the frequency of contacts between patients and providers. In addition, one center claimed to provide the same level of services by spending its reserves.

Overall, the centers insist that even if they are able to serve the same number of people, the depth of services has decreased. However, it is important to note that the Partners program and the Health Care Financing Administration consider decreases in day treatment an accomplishment.²⁴

In March 1997, the Health Care Financing Administration confirmed many of the centers' concerns about the Partners program. The Health Care Financing Administration's report as explained to the TennCare Oversight Committee²⁵ asserted:

- Access to mental health and substance abuse services had been impaired.

²¹ Tennessee Department of Commerce and Insurance, TennCare Division, and Comptroller of the Treasury, Division of State Audit, "Special Review of Claims Processing Operations of Tennessee Behavioral Health, Inc.," November 6, 1997, p. 5 and Exhibit C.

²² Based on information provided by Commissioner Nancy Menke, Commissioner, Department of Health, to the TennCare Oversight Committee, April 1997, "Tennessee Mental Health Site Visit," p. 3-4.

²³ Office of Research staff interviewed staff at a number of the CMHCs. Also, the Tennessee Association of Mental Health Organizations conducted a survey in October 1997. Twenty of the 25 centers participated in the survey.

²⁴ Based on information provided by Commissioner Nancy Menke, Commissioner, Department of Health, to the TennCare Oversight Committee, April 1997, "Meeting between HCFA and Tennessee, March 17, 1997, Washington, D.C." p. 1.

²⁵ Based on information provided by Commissioner Nancy Menke, Commissioner, Department of Health, to the TennCare Oversight Committee, April 1997, "Tennessee Mental Health Site Visit," pp. 2-4.

- Quality of care issues needed to be addressed.
- The Partners program may be underfunded.
- Data to assess the program was not available.
- Numerous contract issues needed to be addressed.
- The state’s monitoring efforts must be improved.
- A carve-in²⁶ would not be approved until the state demonstrates that it can effectively administer the current mental health program.²⁷

The block grants had few accountability requirements before the TennCare Partners Program. The community mental health centers received block grant funding intended to treat the seriously and persistently mentally ill. The centers then used portions of the grant funds to treat individuals with mild or moderate mental disorders.

In 1996, the Comptroller found that the Department of Mental Health and Mental Retardation had not monitored program quality of the community mental health centers,²⁸ citing “no uniform quality standards” and “no evaluation of services that would allow benchmarking and comparison of services and performance.” The report found that the Department had not compared the community mental health providers’ actual performance and the accomplishments related to outcome measures.

Centers’ officials contend that they were able to provide services to less seriously ill individuals by using grant funds²⁹ intended for the seriously mentally ill.³⁰ The Department of Mental Health and Mental Retardation asserts that they are now monitoring every block grant dollar.³¹

Consequently, if the state decides to disburse additional money for mental health services, that money should follow identified people. Regardless of the policy decision regarding which population additional funds are intended for—the priority or other—providers must be accountable for these funds.

The seriously mentally ill are competing for state funding with persons who are not seriously mentally ill. Advocates for the seriously mentally ill argue that the state should first fulfill its obligation to that population. Encouraging service of the non-priority

²⁶ A “carve in” can be defined as an arrangement whereby coverage for a specific category of services, e.g. mental health services, once provided by a set of providers, who were contracted with for those services according to a predetermined fee schedule or capitation arrangement, are now provided with other services under one or a joint set of providers.

²⁷ In July of 1996, mental and behavioral health services were “carved out” of the TennCare program, thus creating the Partners Program.

²⁸ State of Tennessee Comptroller of the Treasury, Division of State Audit, Performance Audit of the Department of Mental Health and Mental Retardation, February 1996, pp. 11-12.

²⁹ Testimony of Jeanne Richardson, Executive Director, Midtown Mental Health Center, to the TennCare Oversight Committee, October 25, 1995.

³⁰ Dr. Ron Manderscheid, “Estimation of the 12-month Prevalence of Serious Mental Illness,” April 1997, p. 1; Department of Mental Health and Mental Retardation, “Breakthrough,” 1995-96 Annual Report, p. 11 and 1995 Annual Report, pp. 4-5.

³¹ Interview of Melanie Hampton, Department of Mental Health and Mental Retardation, February 9, 1998.

population may discourage the community mental health centers from enrolling the priority population in TennCare.

Many community mental health center directors interviewed for this study believe that the state, through the TennCare Partners Program, has abandoned the mental health needs of persons ineligible for TennCare. They argue that the state should once again provide the community mental health centers with sufficient block grant funding to serve both the seriously mentally ill as well as those with lesser needs. The General Assembly should decide upon which population the state should focus its limited resources: the seriously mentally ill, those with lesser needs, or both.

In some parts of the state, alternatives to the standard community mental health centers provide care for individuals on TennCare as well as others. Besides private practice providers who accept the TennCare rate, other community mental health agencies exist. These include the Mental Health Cooperative, Inc., in Davidson County; nonprofit health centers; and pastoral counselors. Some of these providers offer sliding fee scales to persons who do not have insurance. However, alternatives to community mental health centers are scarce in rural counties.

The Mental Health Cooperative

Although it is easy to confuse the Mental Health Cooperative in Davidson County with a community mental health center, the two organizations are actually quite different. Although the Mental Health Cooperative offers clinical services, it is primarily a case management agency. The Mental Health Cooperative accepts only clients assessed in clinically related groups one or two, and therefore must offer each client case management services.³² Clients must accept case management services. The limitations that the Mental Health Cooperative places on the individuals accepted for treatment also ensures receiving the TennCare enhanced case rate for all patients. Unlike the Mental Health Cooperative, community mental health centers do not receive the enhanced case rate for all clients because not all are assessed in clinically related groups one and two.

The Mental Health Cooperative operates under an agreement with Psychiatric Management Resources, Inc., which shares in the revenues of the Mental Health Cooperative and provides ongoing capital support. The Collaborative Care model of case management, which is used by both the Mental Health Cooperative and Case Management, Inc. in Memphis, is also a proprietary interest of Psychiatric Management Resources, Inc. For a community mental health center to use the Collaborative Care model of case management, an agreement must be established between the community mental health center and Psychiatric Management Resources, Inc.

The Mental Health Cooperative staff prescribe drugs they consider more effective than the traditional antipsychotics like Haldol. According to the Executive Director, 57 percent of the Mental Health Cooperative's clients currently use non-traditional antipsychotics.³³

³² Interview of Pam Womack, President, Collaborative Care Corporation, and Executive Director, Mental Health Cooperative, Inc., November 18, 1997.

³³ Ibid.

Nonprofit Health Centers

Private, nonprofit health centers and other agencies often provide mental health services. The Church Health Center in Memphis, Interfaith Health Clinic in Knoxville, and the Friends in Need Clinic in the Tri-Cities area, for example, provide mental health care to the uninsured working poor, elderly, children, and homeless. These centers offer mental health services on a sliding fee scale. The scale is more generous than that offered by the community mental health centers, possibly because of aggressive fund-raising efforts and support from local medical and ecumenical communities. Not all low-income individuals meet eligibility requirements of the centers. For example, these centers generally require that adult patients be employed. These centers also require that patients reside in the metropolitan areas where the centers are located or in surrounding counties. Most rural areas in the state have no such facility.

Pastoral Counselors

Pastoral counselors provide one alternative to private-practice psychologists and licensed clinical social workers for individuals who do not qualify for TennCare as seriously and persistently mentally ill. Pastoral counselors are not necessarily less expensive than most other mental health professionals, however, and their sliding fee scales are generally similar to those of the community mental health centers.

The Samaritan Counseling Center in Shelby County provides pastoral counseling, educational programs, and consultation resources to individuals in the Memphis area, even if they cannot afford the sliding fee scale.³⁴ Informal counseling by a member of the clergy is also often an option for uninsured individuals. However, there is no guarantee that these ministers or preachers are licensed pastoral counselors. The American Association of Pastoral Counselors maintains strict licensure standards for its members, including education requirements, required counseling hours, and an examination process.³⁵ It is important to note that pastoral counselors, who are dually trained in psychology and theology, combine psychology and faith, taking seriously the spiritual dimensions of life.³⁶ In literature dispersed by the Samaritan center, Pastoral Counselor Dr. Carroll Wise is quoted as saying, "Pastoral therapy is...offering a quality relationship through which curative grace is mediated."³⁷ The religious connotations of pastoral counseling may not be desirable to some individuals who do not qualify for TennCare, thus possibly limiting the effectiveness of pastoral counseling as an alternative mental health resource for some.

Local schools offer some mental health services to their students. For the 1996-97 school year, Tennessee's 138 school systems employed almost 1,600 guidance counselors, over 125 psychologists, and almost 90 social workers.³⁸ Additionally, each Tennessee high

³⁴ Interview of Ron Johnson, Pastoral Counselor at Samaritan Counseling Center in Memphis, and member of the governing board of the Tennessee Association of Pastoral Counselors.

³⁵ American Association of Pastoral Counselors, "General Information: Membership Requirements."

³⁶ As stated in literature from the Samaritan Counseling Center entitled "Hope, Healing, Wholeness, Insight."

³⁷ Ibid.

³⁸ Information provided by the Tennessee Department of Education, July 28, 1997.

school student must take a “Lifetime Wellness” course to graduate, which deals in part with mental health issues.

The mental health services provided in schools are paid for by a patchwork of funding streams, including TennCare, federal Title I, and state special education money. In addition, the Basic Education Program generates funding for guidance counselors, although systems do not have to spend it that way. Some school systems drop positions in an effort to create enough money to pay for mental health specialists. In Metro Nashville, therapists are provided in 26 schools and are funded in a variety of ways.³⁹

The Memphis City Schools Community Mental Health Center serves only school children. The center provides psychological services for all Memphis City School students, some Shelby County School students, and some private school students. The center receives no money from TennCare.⁴⁰

In 1990, the Vanderbilt School-based Counseling Program was established by the Vanderbilt Community Mental Health Center to increase access to mental health services for children and families from socioeconomically disadvantaged backgrounds.⁴¹ Trained and licensed mental health clinicians (master’s level social workers, psychiatric nurses, and psychologists) work in the school and provide services to referred students.

In 1993, a study of the program revealed that services offered in schools to children are more likely to be used than services offered in the community.⁴² Children from nine schools were randomly assigned to either the School-based Counseling Program or to individual academic tutoring (which served as a control group) and a matched group of children were referred to a local community mental health center. Only 17 percent of the children referred to the community mental health centers actually took advantage of the services offered, whereas 98 percent of the children referred to the School-based Counseling Program received treatment. Although the community mental health services were not offered without charge, transportation was provided for those students referred to centers and their parents were offered compensation for their time.

The number of Tennesseans needing a mental health safety net is difficult to estimate. The Tennessee Association of Mental Health Organizations reports that during the six-month period from January 1997 to June 1997, the community mental health centers turned away at least 964 persons ineligible for TennCare. During this same six months, the centers report serving over 19,000 TennCare ineligible/uninsured individuals. Thus, there

³⁹ Information provided by Dr. Jim Zerface, Director of Pupil Personnel, Metro Schools, December 30, 1997.

⁴⁰ Interview of Lynn Langston, Office Manager at the Memphis City Schools Community Mental Health Center, January 8, 1998.

⁴¹ Currently, the SBC operates in only one school. Interview of Dr. Thomas Catron, Executive Director, Vanderbilt Community Mental Health Center, January 9, 1998.

⁴² Thomas Catron and Bahr Weiss, “The Vanderbilt School-based Counseling Program: An Interagency, Primary-Care Model of Mental Health Services,” *Journal of Emotional and Behavioral Disorders*, October 1994, pp. 247-253.

may be an estimated 38,000 persons annually who could be served by a mental health safety net.

In numbers reported to the Department of Mental Health and Mental Retardation, however, the centers served only 11,303 individuals assessed in clinically related group four, who professionals do not consider seriously mentally ill, in the entire fiscal year 1996. Individuals assessed in clinically related groups one, two, and three are automatically eligible for TennCare Partners and individuals assessed in clinically related group five (substance abuse) are covered by grants from the Department of Health, Bureau of Alcohol and Drug Abuse Services. The disparity may exist because of service provided to individuals in clinically related groups one, two, and three who did not have or had lost TennCare coverage.

Some argue that a safety net is needed to prevent deterioration of mental health in individuals with mild or moderate mental disorders and that early intervention will eliminate or delay the need for future mental health care. However, scientific debate continues regarding the benefits of preventative action in the case of mental illness. Thus, it is uncertain whether providing mental health services to those with lesser needs will prevent them from progressing into a seriously and persistently mentally ill classification.⁴³ The genetic nature of serious mental illnesses such as schizophrenia and bipolar disorders augments the position that mental illness is hereditary and cannot be prevented. However, not all individuals who are genetically predisposed to mental illness actually succumb to it. Research shows that although identical twins share an identical genetic composition, there is only a 44 percent probability that both will be schizophrenic.⁴⁴ Facts like these cause belief that preventive action could have some effect on the onset of mental illness. Again, however, the assertion that formal mental disorders are preventable is unproven.

Almost 14,000 Tennesseans are eligible for TennCare, but are not enrolled. In February 1997, the Department of Mental Health and Mental Retardation estimated almost 14,000 seriously and persistently mentally ill adults and seriously emotionally disturbed children, who are automatically eligible for TennCare, were not enrolled.⁴⁵ Seriously and persistently mentally ill adults and children who are diagnosed as seriously emotionally disturbed are eligible for TennCare coverage.⁴⁶

In addition to untimely reimbursement issues, providers also claim that case and capitation rates are too low. The community mental health center officials insist they see little benefit in enrolling people in TennCare and that they lose revenue by treating those covered by TennCare. An annual actuarial study would determine the adequacy of

⁴³ Kenneth Heller, "Coming of Age of Prevention Science, Comments on the 1994 National Institute of Mental Health – Institute of Medicine Prevention Reports," *American Psychologist*, November 1996, p. 1124.

⁴⁴ I. I. Gottesman, P. McGuffin, and A. Farmer. "Clinical Genetics as Clues to the 'Real' Genetics of Schizophrenia," *Schizophrenia Bulletin*, Vol. 13, pp. 23-47.

⁴⁵ February 6, 1997, Department of Mental Health and Mental Retardation's fiscal note support form to Senate Bill 107.

⁴⁶ Interview of Joe Swinford, Director of Consumer Affairs, Bureau of TennCare, March 20, 1998.

funding for the program and either prove or disprove provider claims that rates are too low.

In 1997, the TennCare Bureau used a consultant to review the payment calculation methodology and capitation payment rates for the program. However, the consultant did not actuarially determine adequate funding for the Partners program. The consultant was told how much the state had to spend, and was asked to determine how the money could be allocated between capitation categories to better match payments to risk.⁴⁷

Information provided by the Department of Mental Health and Mental Retardation, Premier Behavioral Health Systems, and Tennessee Behavioral Health indicates a 23 percent reduction in government funding to the community mental health centers since implementation of the Partners program.⁴⁸ Improved funding of case and capitation rates may allow the community mental health centers the flexibility to offer a more generous sliding fee scale to individuals not eligible for services under the TennCare Partners program.

The centers contracted with the behavioral health organizations for these rates. However, the Bureau of TennCare did not provide adequate oversight of the contracting between the behavioral health organizations and the providers. The advent of managed care encompasses the notion of laissez-faire economics, allowing market forces to function without government intervention. This conflicts, however, with the federal Health Care Financing Administration directives that the state review contracts between the behavioral health organizations and the providers.⁴⁹

The Bureau of TennCare has set up a contract compliance division to comply with the Health Care Financing Administration's directive to review contracts. Also, an amendment to the behavioral health organizations' contracts prohibits the transfer of unmanageable financial risk to subcontractors or providers and revises the grievance and complaint procedures.

In addition, the centers may want to lessen their dependency on state funds. Many have already engaged in partnerships with local governments and the United Way. Their non-profit 501(c)(3) federal tax status also allows them to raise funds.

An estimated 175,000 Tennesseans do not have access to either mental health care or medical care.⁵⁰ However, the cost of reopening TennCare may be prohibitive. Reopening TennCare enrollment would be consistent with the Master Plan in focusing the majority of mental health resources on the priority population: seriously and persistently mentally

⁴⁷ Letter from William M. Mercer to Theresa Clarke, Assistant Commissioner, Bureau of TennCare, dated June 17, 1997, and interview of Kevin Russell, William M. Mercer, February 27, 1998.

⁴⁸ Information provided by Chris Gingles, Department of Mental Health and Mental Retardation; Bob Waters, Premier Behavioral Health Systems; and Chris Paterson, Tennessee Behavioral Health.

⁴⁹ Based on information provided by Commissioner Nancy Menke, Commissioner, Department of Health, to the TennCare Oversight Committee, April 1997, "Tennessee Mental Health Site Visit," p. 3.

⁵⁰ Center for Business and Economic Research, University of Tennessee, "Health Care and TennCare: A Survey of Tennesseans" February 1997.

ill adults and seriously emotionally disturbed children. However, this could cost the state up to \$111 million, if all eligible persons enrolled.⁵¹

Currently 93.7 percent of Tennesseans have insurance. Researchers expect that figure to rise with open enrollment for the state's almost 70,000 uninsured children.⁵² In addition, the federal Mental Health Parity Act of 1996, which became effective January 1, 1998, and is applicable to all insurance plans offered by employers of over 25 employees, calls for mental health insurance benefits to equal medical benefits.⁵³ The high number of insured individuals, improving behavioral health benefits, and a state and national priority on the seriously and persistently mentally ill should all focus the General Assembly's attention on improvement and expansion of the TennCare program.

Programs in Other States

Other states have a more comprehensive safety net than Tennessee. Arizona, Colorado, Minnesota, and Massachusetts provide for persons who are eligible for Medicaid as well as those who are not. Tennessee first provides funds for the TennCare population and offers approximately \$16 million in grant funding for other psychosocial services including housing assistance, drop-in centers, and vocational skills training.⁵⁴

Arizona, the state whose managed care program is most similar to Tennessee's, also has a "carve-out" program for mental health care. The Arizona Department of Health Services/Division of Behavioral Health Services contracts with five private, nonprofit Regional Behavioral Health Authorities. The Regional Behavioral Health Authorities function like health maintenance organizations and are responsible for the needs assessment and provider network development in their respective geographic service areas. These Regional Behavioral Health Authorities provide care first for Medicaid-eligible citizens and pay for the uninsured, ineligible with any remaining funds. Medicaid eligible children and adults are entitled to any behavioral health services necessary to meet the behavioral health needs. The program provides services to non-Medicaid, uninsured individuals on a sliding fee scale after screenings to determine true need of behavioral health services. The Regional Behavioral Health Authorities partially subsidize the sliding fee scales if the funding is available after paying for the Medicaid-eligible population.⁵⁵

Colorado offers the Colorado Indigent Care Program. State and federal funds reimburse health care/mental health providers up to 30 percent of the cost of services to Medicaid ineligibles within 185 percent of the federal poverty level. The program costs, on average, \$18 million annually.⁵⁶

⁵¹ Calculations based in part from information received from Dr. Bill Fox, December 8, 1997.

⁵² Interview with Dr. Bill Fox, Center for Business and Economic Research, University of Tennessee, Knoxville. December 8, 1997.

⁵³ Public Law 104-204, United States Code Annotated.

⁵⁴ Information provided by Lisa Faehl, the Director of Planning and Research for the Department of Children Services, Chris Gingles; Department of Mental Health and Mental Retardation; Bob Waters, Premier Behavioral Health Systems; and Chris Paterson, Tennessee Behavioral Health.

⁵⁵ Arizona Department of Health Services/Division of Behavioral Health Services, "Overview of Managed Behavioral Health Care in Arizona," November 1997.

⁵⁶ Interview of Chrystal Burrell, Colorado Medically Indigent Care Program, August 22, 1997.

MinnesotaCare is a subsidized health care insurance program for uninsured adults and low-income children that fall within the federal poverty guidelines. Services covered include mental health and case management. Enrollee premiums and statewide taxes fund the program. Enrollees must be currently uninsured by any provider including Medicaid or Medicare and have no access to employer paid (50 percent or more) health insurance. Monthly premiums range from \$16 to \$222, depending on family size and income. Like Tennessee, Minnesota's goal was to increase insurance coverage, but the state receives *no federal funds* for MinnesotaCare.⁵⁷

In 1986, Massachusetts began the Uncompensated Care Pool, a \$345 million safety net to provide free health care (including limited mental health) to uninsured and underinsured individuals and to equally distribute the bad debt accumulated by providers. Funding for the pool is provided by the Commonwealth of Massachusetts (\$30M), hospitals (\$215M), and private third-party payers including commercial insurers (\$100M). A federal grant of \$70 million is reserved for supplemental payments. The program not only reimburses providers for free care, but it designates funds for employers of low-income workers to encourage them to continue insurance coverage for their employees.⁵⁸

Kentucky's program resembles Tennessee's before TennCare Partners. The state contracts with 14 nonprofit "comp-care" centers that provide care primarily to low-income mental health and substance abuse patients with long-term care needs. Payments go directly from the Kentucky Department of Mental Health and Mental Retardation Services to the centers and provide the core of the centers' funding.⁵⁹

Tennessee has sufficient mental health services in the event of a disaster. However, the program could be better coordinated. For presidentially declared disasters, the state receives assistance from the Federal Emergency Management Agency (FEMA). This money is paid to the Tennessee Emergency Management Agency (TEMA) for distribution to disaster victims and responders. To date, FEMA has granted all money that state officials have requested.⁶⁰ The issue for review, however, lies with non-presidential disasters and crises including tornadoes and school violence incidents. According to the community mental health centers and the Tennessee Association of Mental Health Organizations, the centers have responded to only three such disasters in the past ten years: a 1996 school shooting in Giles County, a 1996 naval F-14 plane crash in Nashville, and tornadoes that hit the middle Tennessee area in 1995. The infrequency of disasters and the past responses of organizations, agencies, and professionals indicate that there is a network in place to provide mental health services to victims of non-presidential disasters.

⁵⁷ Minnesota Department of Human Services, "MinnesotaCare Fact Sheet," July 1997.

⁵⁸ Information from and interview of Peter Murphy, Commonwealth of Massachusetts Office of Public Affairs, August 19, 1997.

⁵⁹ Information from Barbara Burns, Kentucky Department for Mental Health and Mental Retardation Services, December 1, 1997.

⁶⁰ Interview of Cecil Whaley, Director of Natural Hazards, Tennessee Emergency Management Agency, August 20, 1997.

The American Red Cross works both autonomously and with TEMA to respond to disasters with a volunteer network of licensed mental health professionals. The Red Cross is congressionally mandated to respond to events defined as: “an occurrence such as a hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, earthquake, volcanic eruption, drought, blizzard, pestilence, famine, fire, explosion, building collapse, transportation accident, or other situation that causes human suffering or creates human needs that the victims cannot alleviate without assistance.”⁶¹ In addition to a local network of volunteers, the Red Cross has Statements of Understanding with the American Psychiatric Association, American Psychological Association, and the American Counseling Association that encourage the development of disaster response volunteer networks and committees.⁶²

TEMA also uses a volunteer network called VOAD – Volunteers Active in Disasters – with 30 volunteer mental health professionals that will respond to non-presidential disasters. In addition, Tennessee schools have guidance counselors on staff to assist in school-related emergencies and disasters. Hamilton County Schools’ guidance counselors responded recently to two unrelated student deaths in Chattanooga.

Tennessee has an abundance of existing resources to aid in mental health services. To utilize those resources, create a coordinated response, and alleviate worries about the long-term emotional effect of disasters, Tennessee could implement a program similar to the Kentucky Community Crisis Response Board (KCCRB). The KCCRB includes a network of 150 mental health professionals that respond to all disasters, from school violence incidents to natural disasters. The program was implemented in response to a workplace violence incident and provides disaster and crisis counseling and critical incident stress debriefing to responders. Designed at no expense to the state other than two staff members, the program’s board consists of directors of agencies that typically provide first response in disasters. These include the state police chief, state fire marshal, and the American Red Cross director.⁶³

⁶¹ Statements of Understanding Between the American Psychiatric Association/American Counseling Association and the American National Red Cross.

⁶² Ibid.

⁶³ Kentucky Senate Bill 112, Enacted March 27, 1996.

Alternatives

This report offers several alternatives that may lead to improved community mental health services.

Legislative Alternatives

- The General Assembly may wish to clarify the state's mission and allocate appropriate funding to provide mental health services to seriously and persistently mentally ill adults and seriously emotionally disturbed children, those with mild or moderate mental disorders, or both.
- The TennCare Oversight Committee should continue to provide a forum that is conducive to public discussion and debate of issues surrounding the TennCare Partners Program. The committee has been successful in raising many issues, including concerns of reimbursement and access, to both the behavioral health organizations and providers.
- The General Assembly may wish to consider using its existing community resources and statutorily create a coordinated mental health disaster response system modeled after the Kentucky Community Crisis Response Board.

Administrative Alternatives

- The TennCare Bureau should ensure that the community mental health centers receive timely and complete reimbursements from the behavioral health organizations. This would provide greater incentive to enroll people in TennCare and allow the community mental health centers better fiscal health and thus more flexibility in offering services to those ineligible for TennCare.
- The Department of Mental Health and Mental Retardation should conduct an annual actuarial study to determine the adequacy of funding for the TennCare Partners program. The community mental health centers have experienced a 23 percent decline in government funding since the implementation of the Partners program.
- If the state chooses to disburse additional money for mental health services, the Department of Mental Health and Mental Retardation should encourage accountability by tying grant funding to identified recipients.
- The Tennessee Department of Health should consider reopening TennCare enrollment. The state dollars spent by reopening TennCare enrollment would offer both behavioral and medical health care, as opposed to grant dollars that would provide only mental health services.

Other Alternatives

- Mental health providers may want to seek other funding sources and lessen their dependency on state funds. Community mental health centers are nonprofit entities whose 501(c)(3) federal tax status allows them to raise funds or create partnerships with for-profit organizations for capital support.

- If the behavioral health organizations violate their contracts with untimely and incomplete payments, the community mental health centers should seek contractual remedies with the behavioral health organizations. Timely and complete payments may encourage mental health providers to increase their efforts to enroll people in TennCare.

Exhibit 1

GOVERNMENT FUNDING SUMMARY*									
COMMUNITY MENTAL HEALTH CENTERS									
FOR THE FISCAL YEARS:									
SOURCE OF FUNDING:	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997		
GOVERNMENTAL									
MENTAL HEALTH AND MENTAL RETARDATION									
MENTAL HEALTH SERVICES	\$ 36,607,700	\$ 36,293,200	\$ 50,777,242	\$ 53,465,494	\$ 37,514,862	\$ 30,818,452	\$ 16,887,262		
MENTAL RETARDATION SERVICES	\$ 234,100	\$ 139,900	\$ 115,864	\$ 356,630					
TRANSITIONAL PAYMENTS - NONTENNCARE**				\$ 21,535,606	\$ 32,467,292	\$ 23,509,891			
TRANSITIONAL PAYMENTS - TENNCARE***				\$ 32,707,000	\$ 67,226,454	\$ 78,574,912	\$ 6,225,000		
Subtotal - MHMR	\$ 36,841,800	\$ 36,433,100	\$ 50,893,106	\$ 108,064,730	\$ 137,208,608	\$ 132,903,255	\$ 23,112,262		
HEALTH - MEDICAID (STATE MEDICAID MATCH)									
	\$ 29,311,100	\$ 41,347,900	\$ 38,104,858	\$ 30,298,225					
Subtotal - state agencies	\$ 66,152,900	\$ 77,781,000	\$ 88,997,964	\$ 138,362,955	\$ 137,208,608	\$ 132,903,255	\$ 23,112,262		
PARTNERS PROGRAM									
TENNESSEE BEHAVIORAL HEALTH									
							\$ 29,611,000		
PREMIER BEHAVIORAL HEALTH SYSTEMS									
							\$ 50,612,809		
Subtotal - Partners							\$ 80,223,809		
TOTAL FUNDING	\$ 66,152,900	\$ 77,781,000	\$ 88,997,964	\$ 138,362,955	\$ 137,208,608	\$ 132,903,255	\$ 103,336,071		

Sources: Department of Mental Health and Mental Retardation, Tennessee Behavioral Health, and Premier Behavioral Health Systems.

*Chart excludes private pay and Department of Children Services grant information.

**Non-TennCare transitional payments adjusted providers' budgets after switch to TennCare.

***TennCare transitional payments provided mental health care for TennCare-eligible population after switch to managed care.

Appendix A Individuals Interviewed

Marlene D. Alvarez
Director, Administrative Services
Tennessee Department of Mental Health and Mental Retardation

Susie Baird
Director of Programs
Bureau of TennCare

Charles R. Blackburn
Executive Director
Tennessee Association of Mental Health Organizations

Brenda Blackmore
Programs Manager / Director
Emergency Social Services
American Red Cross

Gordon Bonnyman, Jr.
Tennessee Justice Center, Inc.

Matthew Bourlakas
Mental Health Association of Nashville

Ann Bowten
Consumer Advocate
Tennessee Behavioral Health

Pamela Boyd
Contract Administrator
TennCare Partners Program
Tennessee Department of Mental Health and Mental Retardation

Joseph Brenner
Attorney
Tennessee Department of Mental Health and Mental Retardation

Barbara Burns
Kentucky Department for Mental Health and Mental Retardation Services

Chrystal Burrell
Colorado Medically Indigent Care Program

Betty J. Carson

Clinic Administrator
Church Health Center

Dr. Thomas Catron
Executive Director
Vanderbilt Community Mental Health Center

Jim Causey
Executive Director
Professional Counseling Services

Jim Cate
Computer Operation Manager
Tennessee Department of Mental Health and Mental Retardation

Richard Cochran
Director of Special Initiatives
Alcohol and Drug Abuse Services
Tennessee Department of Health

Pat Cole
Guidance Coordinator
Metro Schools

Ben Dishman
Acting Commissioner
Tennessee Department of Mental Health and Mental Retardation

Cathy Dyer
Executive Director
Tennessee Academy of Family Physicians

Lisa Faehl
Director of Planning and Research
Tennessee Department of Children Services

Dr. Bill Fox
Center for Business and Economic Research
University of Tennessee

Chris Gingles
Fiscal Services
Tennessee Department of Mental Health and Mental Retardation

George Haley
Tennessee Alliance for the Mentally Ill, Inc.

Dr. Stephanie Hall
Knox County Health Clinic

Melanie Hampton
Assistant Commissioner
Tennessee Department of Mental Health and Mental
Retardation

James Harding
Executive Director
Cumberland Mental Health Services, Inc.

Ben Harrington
Greater Knoxville Mental Health Association

Craig Ann Heflinger
Vanderbilt Institute of Public Policy

Steve Hopper
Director of Contract Compliance
Bureau of TennCare

Dr. Ron Johnson
Pastoral Counselor
Samaritan Counseling Center

Joyce Judge
Executive Director
Tennessee Alliance for the Mentally Ill, Inc.

Carol Kardos
Mental Health Specialist
Tennessee Department of Mental Health and Mental
Retardation

Lynn Langston
Office Manager
Memphis City Schools CMHC

Bill Lyons
Social Services Research Institute

Dr. Ronald Manderscheid
Substance Abuse and Mental Health Services
Administration

Dr. Rob McDonald, Director
Interfaith Health Clinic

David McReynolds
Chief Operating Officer

Overlook Center

Nancy Menke
Commissioner
Tennessee Department of Health

Peter Murphy
Commonwealth of Massachusetts
Office of Public Affairs

Bill Nix
Tennessee Department of Mental Health and Mental
Retardation

Mary Ann O'Brien
Clinical Director
Overlook Center

Joe Osterfeld
Vice President
Management Services
Pinnacle

Chris Paterson
Vice President of Preferred Health Partnership
Tennessee Behavioral Health, Inc.

Kelly Lang-Rameriz
Director of Research and Policy Development
Tennessee Association of Mental Health
Organizations

Bob Rich
Nashville Union Mission

Reggie Roberts
Chief of Emergency Planning
Tennessee Emergency Management Agency

Jack Rudnick
Executive Director
Pathways

F. Kevin Russell
Actuary
William Mercer Company

Ellen Schmidt
Executive Director
Case Management, Inc.

Stephanie Shockley

Fortwood Center

Andrea Sheerin
National Technical Assistance Center for Mental
Health Planning

George Spain
Executive Director
Pinnacle
Janice Spillman
Director of Planning and Development
Tennessee Department of Mental Health and Mental
Retardation

Joe Swinford
Director of Consumer Affairs
Tennessee Department of Mental Health and Mental
Retardation

Dr. Robert Vero
Executive Director
Luton Mental Health Center

Robert M. Waters
Director of Planning and Evaluation
Premier Behavioral Health Systems of Tennessee

Cecil Whaley
Director of Natural Disasters
Tennessee Emergency Management Agency

Martha Gemstone Whitlock
Deputy Assistant Commissioner
Tennessee Department of Mental Health and Mental
Retardation

Gary Wilson
Interim Chapter Executive Officer
American Red Cross

Pam Womack
President
Collaborative Care Corporation
Executive Director
Mental Health Cooperative, Inc.

Chris Wyre
Executive Director
Guidance Center

Lynne Zager
Clinical Director of Psychology

Midtown Mental Health Center

Dr. Jim Zerface
Director of Pupil Personnel
Metro Schools

Appendix B

Appendix C

Tennessee Association of Mental Health Organizations

Safety Net Survey

October 1997

Safety Net Survey

Objective: To obtain a picture of how services are currently being provided to consumers not eligible for TennCare. Such vital information will aid efforts taking place with the Safety Net Study included in SB107/HB1758 currently being investigated by the State's Comptroller's Office.

Instructions: Please answer the following questions to the best of your ability. If at all possible, actual figures are requested. Please be aware that the Comptroller's office may follow up with respondents to further clarify or verify reported information. If actual figures are impossible to provide, estimated figures are acceptable. However, please note it when the figures are estimated.

This questionnaire is a follow up to the Sliding Fee Scale Survey you completed last January, therefore many of the questions may look familiar to you. Please note, however, that the dates for requested data have changed to provide the Comptroller's Office with an updated depiction of available safety net services.

If you have any further questions regarding the questionnaire, please call Kelly Lang-Ramirez at 1-800-568-2642. Return completed questionnaires to the TAMHO office by fax (615-254-8331) by **Friday, October 3, 1997.**

As always, your time and effort are greatly appreciated.

Persons Served:

- 1.) How many persons, not eligible for TennCare, received service from your CMHO from January 1, 1997 to June 30, 1997. (Please mark whether the figure given is an actual or estimated figure.)
_____ Actual _____ Estimate
- 2.) How many persons, not eligible for TennCare, requested but did not receive service from your CMHO from January 1, 1997 to June 30, 1997? (Please mark whether the figure given is an actual or estimated figure.)
_____ Actual _____ Estimate

Level of Service:

- 3.) If your CMHO has continued to provide services to persons not eligible for TennCare, has the type of services available to those persons remained the same

since January 1, 1997? Please explain. *(Please write N/A if your CMHO no longer provides services to non-TennCare consumers.)*

- 4.) In addition, has the quantity of services available to non-TennCare consumers remained the same since January 1, 1997? Please explain. *(Please write N/A if your CMHO no longer provides services to non-TennCare consumers.)*

Service Funding:

- 5.) Does your CMHO still offer a sliding fee scale for non-TennCare consumers not able to pay full fee?

Yes No

If yes, briefly describe your sliding fee scale.

If yes, what revenue source(s) does your CMHO utilize to fund the sliding fee scale? Please describe below.

- 6.) Please list in dollar figures the total amount of revenue collected for services rendered to non-TennCare clients between January 1, 1997 and June 30, 1997. *(Again, write N/A if your CMHO no longer provides services to non-TennCare clients. Accurate figures are needed if possible. However, please write "estimate" in the column next to the figure if an estimate is provided.)*

Self Pay	\$ _____
Grant Dollars	\$ _____
CMHO Reserves	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____
TOTAL:	\$ _____

- 7.) Additional Comments:

Thank you for your participation! Please return by October 3, 1997.