

# The Riverwood Centers Closure: A Systems Analysis

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Chemical and Mental Health Services Administration  
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## 0. Executive Summary

On March 17, 2014, Riverwood Centers Community Behavioral Healthcare (Riverwood), a six-site community mental health center in east central Minnesota, closed its doors. The abrupt closure severed client/agency relationships, displaced employees, and created a hole in the mental health safety net in the five-county Adult Mental Health Initiative region 7E. Several steps were immediately taken by county social service departments, the Minnesota Department of Human Services (DHS), mental health services providers, advocacy organizations, and consumers to address the most immediate impacts of the closure, but the longer term effects are still being worked through.

This report presents a system analysis of the closure, exploring how and why the closure occurred and explicating some of the larger system implications of the closure. It is based on about 25 interviews by DHS staff with those closest to the events, including the director and some staff of Riverwood, county staff (supervisors, directors, and a commissioner), other providers in the region, consumer advocates, directors of other community mental health centers in Minnesota, and DHS staff. It also includes information from two community meetings held in Cambridge, Minnesota in the weeks after the closing, and from several written documents: media reports about the closing, Riverwood's Board of Directors meeting minutes from January 1, 2013-March 11, 2014, a DHS audit report on Riverwood released March 31<sup>st</sup>, 2014, and written comments by the Chairman of the Board of Directors of another service provider in the region.

The main points of this analysis can be summarized as follows:

- Due to problematic reimbursement rates and processes for some mental health services, community mental health centers operate with very small financial margins, leaving them vulnerable to unforeseen financial problems.
- Prior to its closing, Riverwood had struggled financially for years with narrow margins, increasing debt and inadequate financial recordkeeping and reporting. The agency experienced increasing cash flow problems in the two years before the closing, going deeper into debt as they tried to make changes that were intended to ultimately put the agency back on firm financial footing.
- The closing was described by many interviewees as a “perfect storm” of factors; no single factor should be identified as *the* cause of the closure. While a lack of cash is what ultimately precipitated the closing, the agency's longer term financial difficulties were what led to the cash flow crisis. Those difficulties were supported by a range of non-financial factors.
- The abrupt closure of Riverwood was shocking and traumatic for clients of Riverwood and for the employees who were displaced. Clients' chief concerns were about the temporary lack of

mobile crisis services, the security and confidentiality of their medical records, and the loss of long-term therapeutic relationships with their providers at Riverwood. Employees shared those concerns and also faced uncertainty about their final paychecks and back vacation payouts as well as whether they would be able to find new jobs.

- The system reaction to the closure was swift and responsive, and continues to this day. Essential services were quickly transferred to other providers, medical records were secured, and meetings were held to coordinate and communicate about the response and to begin healing from the trauma. Most clients were quickly connected to other providers and many employees were soon hired by other providers in the region. However, the fallout of the closing is still being felt.
- There were mixed opinions among interviewees about whether the Riverwood closure was a bad event that should have been prevented. There was unanimous agreement that *how* it happened was wrong and should be avoided in the future.
- The closing raised dozens of policy-related questions that should receive future attention by all of the stakeholders involved, including the Department of Human Services, providers, clients and advocacy organizations, payers, counties and tribes.

## I. Introduction

On March 12, 2014, the Executive Director of Riverwood Centers Community Behavioral Healthcare (Riverwood), a six-site community mental health center in east central Minnesota, notified its employees, stakeholders, and clients that it was closing. The agency closed its doors 3 business days later (March 17, 2014), severing client/agency relationships, displacing employees, and creating a hole in the mental health safety net in the five-county Adult Mental Health Initiative (AMHI) region 7E. Several steps were immediately taken by county social service departments, the Minnesota Department of Human Services (DHS), other mental health services providers, advocacy organizations, and consumers to address the most immediate impacts of the closure, but the longer term effects are still being worked through.

As part of the response to the closure, the Commissioner of DHS requested a system analysis of the events leading up to the closure in order to better understand how and why the closure occurred and to understand the larger system implications of the closure. This report presents that system analysis. It is based on about 25 interviews by DHS staff with those closest to the events, including the director and some staff of Riverwood, county staff (supervisors, directors, and commissioners), other providers in the region, consumer advocates, directors of other community mental health centers in Minnesota, and DHS staff. It also includes information from two community meetings held in Cambridge, Minnesota in the weeks after the closing and from several written documents: media reports about the closing, Riverwood's Board of Directors meeting minutes from January 1, 2013-March 11, 2014, a DHS audit report on Riverwood released March 31<sup>st</sup>, 2014, and written comments by the Chairman of the Board of Directors of another service provider in the region.

The purpose of this report is not to assign blame for the closing or even to identify one primary reason for the closing. Many interviewees used a common metaphor to describe the closing: a perfect storm. In a perfect storm, a rare combination of meteorological circumstances occurs, leading to a weather event of unusual magnitude. In the Riverwood closing, the rare combination of circumstances identified by interviewees included ongoing financial struggles that led to Riverwood's precarious cash flow position, inadequate health insurance reimbursement rates, decade-old dysfunctional relationships between Riverwood and counties, the nature of the oversight provided by the agency's Board of Directors, agency management decisions, personality conflicts, and DHS actions. Interviewees presented a range of perspectives about which circumstances were most responsible for the closing, but almost all agreed that multiple factors were involved.

To capture the range of perspectives on the closing, this report begins with an overview of Riverwood and a recounting of the events in 2012-2014 that were most mentioned by interviewees as culminating in the closing. It then identifies several contextual factors that contributed to the closing and the policy issues raised by each of those factors. The report tries to balance the need for enough detail to understand a complicated situation with the commitment to focusing on system-level factors that were involved in the closing. The use of acronyms was kept to a minimum, and a list of acronyms appearing in the report is included in an Appendix.

## II. Background

### A. Overview of Riverwood Operations

Riverwood began its organizational life as Five County Mental Health Center, Inc., a community mental health center established in 1968 to serve Chisago, Isanti, Kanabec, Mille Lacs, and Pine counties. The agency was certified as a Rule 29 Mental Health Center in 1999. The agency, incorporated as a nonprofit 501(c)3, changed its name to Riverwood Centers Community Behavioral Healthcare in 2010. To minimize confusion, this report will refer to the agency as “Riverwood” throughout.

More than a decade ago, Kanabec County pulled out of Riverwood, leaving just Chisago, Isanti, Mille Lacs, and Pine Counties as members. According to Riverwood’s Executive Director, when Riverwood closed it had 78 employees and served about 2,400 unduplicated clients per month. The agency was operating sites in Braham, Cambridge, Milaca, Mora, Pine City, and North Branch and it provided the following community mental health services:

- Community Support Program (CSP): skills training for clients with serious and persistent mental illnesses
- Adult and children’s mobile crisis services, adult residential crisis services, and crisis lines
- Adult Rehabilitative Mental Health Services (ARMHS): skills and symptom management training for adults with serious mental illnesses
- Day treatment: Skills training and psychotherapy for adults with serious mental illnesses who are at risk for hospitalization or who have recently been discharged from an inpatient psychiatric hospital.
- Children’s Therapeutic Services and Supports (CTSS): Skills training and psychotherapy for children and their families in clinics, schools, and family homes
- Individual, group, and family outpatient evaluation and therapy
- Forensic evaluation and treatment of sex offenders

### B. Riverwood Governance and Oversight

At the time it closed, Riverwood was managed by an Executive Director who was hired in December of 2011. It was overseen by a Board of Directors that consisted of the County Commissioners of Chisago, Isanti, Mille Lacs, and Pine Counties and a lay community representative from each of the four counties. The Directors of Health and Human Services from each of the four counties were also invited to Board meetings, but they were not voting members.

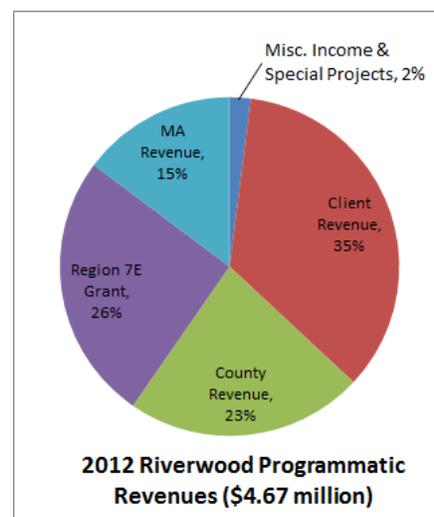
Another important element of regional decision making and oversight is the Region 7E Mental Health Initiative (AMHI), which includes Kenabec, Chisago, Isanti, Mille Lacs, and Pine Counties. The Region 7E AMHI is overseen by a Governing Board made up of the five mental health supervisors from each of the five counties (who are the only voting members), one social services director, a representative from DHS, and a case manager representative. Riverwood contracted with the Region 7E AMHI mainly for crisis services, which made up about a quarter of Riverwood’s overall revenue. The counties do not have a joint powers agreement, unlike some other AMHIs in Minnesota, and some interviewees reported that the Region 7E AMHI operates more as a collection of individual counties than as a

collaborative entity. The AMHI is required by DHS to prepare a community needs assessment and plan for meeting those needs using the AMHI funds allocated by DHS, and the AMHI serves as an important vehicle for inter-county collaboration. DHS provides technical assistance to the region through a mental health program consultant, a DHS employee who regularly visits the region and attends Governing Board meetings as the DHS representative. The purpose of the mental health program consultant is to be a liaison between the region and DHS.

### C. Riverwood's Business

Riverwood earned programmatic revenue from the following sources (percentages are from 2012):<sup>1</sup>

- Client revenue: Payments for services to clients that were paid by private insurance.
- County contracts: Riverwood contracted individually with four counties to provide community support programs to uninsured and underinsured people from the county. These contracts were known as "capitated" contracts by the counties. The amounts were about \$200K per county annually, and the amounts had not changed for at least a decade.
- Region 7E AMHI grant: Riverwood contracted with Region 7E to provide crisis services.
- MA revenue: Payments for services to clients covered by Medical Assistance (public health insurance).
- Miscellaneous: Mediation and custody review services, special projects, and misc. income.



Riverwood's expenses included all of the costs of providing the services listed on the previous page. Wages and benefits constituted about three-quarters of their total expenses in 2012.<sup>2</sup>

## III. The Financial Unraveling of Riverwood

Many interviewees emphasized that Riverwood had had financial difficulties for years. Most interviewees suggested that this was not uncommon for community mental health centers, which often operate with very little margin, but that Riverwood struggled more than most. In 2010 and 2011, Riverwood received permission from Pine, Isanti, Chisago, and Mille Lacs Counties to write off about \$217K of long-term debt to them, loans made years earlier to stabilize the agency's financial position.

A few interviewees attributed some of the difficulties to the agency's accounting manager who was dismissed by the agency in November of 2012. The agency's financial reporting system was in such disarray that the agency decided to hire an accounting firm to reconstruct the agency's books,

<sup>1</sup> Riverwood's Audited Financial Statements for the Year Ended December 31, 2012, p. 4. For clarity, this graph does not include revenue from increases in receivables or gain on sale of assets.

<sup>2</sup> Ibid., p. 5.

undertake agency audits for 2008-2012, and file tax returns for the previous three years. The agency also implemented a new accounting software system in January of 2013 in order to enable better financial analysis and reporting. Due to financial pressures, the accounting manager position was not filled.

The rest of this section lays out the financial events that interviewees described as leading to the Riverwood closing. The dollar amounts were provided by interviewees and confirmed or revised using the audited financial statements for 2008-2012 prepared by Riverwood's accounting firm.

## 2011

In 2011, Riverwood's revenues exceeded expenses by about \$36K and on December 31, 2011, their \$100K line of credit balance stood at \$0. However, in 2012 it was learned that payments for Riverwood case management contracts with Isanti and Pine Counties in 2010 and 2011 had not been being passed back to the counties, resulting in debts of about \$50K to Isanti County and \$99K to Pine County. Riverwood made arrangements to pay back these debts in monthly installments of \$2K to Isanti County and \$4K to Pine County until paid in full.

## 2012

In 2012, Isanti County as the fiscal host for the Region 7E AMHI recommended to the AMHI, with Riverwood's agreement to change to a new reimbursement method for provision of crisis services in order to help Riverwood cope with its cash flow challenges. The AMHI would prepay the contract amount in 24 semi-monthly installments up to the award amount for services that Riverwood would provide rather than reimbursing Riverwood for services after they were provided. This method would eliminate the need for a settle-up process, which had previously been done twice per year to make sure that Riverwood's expenditures for the provision of crisis services matched the funding that had been prepaid. This new process was intended to improve Riverwood's cash flow, and was in place throughout calendar year 2012.

In December 2012, the DHS mental health program consultant learned that Riverwood was billing MA for reimbursement for crisis services provided under their contract with Region 7E, but not returning the money to the AMHI. The Executive Director believed that Riverwood's contract with Region 7E allowed it to keep those reimbursements and use them to support Riverwood's ongoing operations, but the contract between Riverwood and the AMHI stated that Riverwood would comply with this and all other Minnesota Rules. Based on the mental health program consultant's interpretation of Rule 9535.1740, she advised Region 7E that Riverwood's excess MA reimbursements needed to be returned to the AMHI and then managed according to the above Rule. She also advised that in 2013, all revenues collected from third party payers would need to be repaid to the Region, and that the agency could no longer keep any of the third party revenues collected for crisis services. . The total amount of repayments was approximately \$56K. Riverwood was able to pay three installments of \$3,000 on that debt, but the balance of \$45K remained. In addition, by mid-2013 Riverwood had collected an additional \$41K of MA reimbursements for services provided in 2012 that also now needed to be paid back to the AMHI. This was repaid by drawing \$41K from Riverwood's line of credit in December of 2013. Ultimately the AMHI

was allowed to use unspent 2013 AMHI funds to repay the \$45K to DHS, but Riverwood continued to owe \$45K to Region 7E (this debt remained when Riverwood closed).

During 2012, the Executive Director attempted to improve the agency's operations by instituting productivity standards and partial furloughs for staff who did not meet the standards. While this strategy did improve productivity, it also caused significant turnover. By February of 2013, the furloughs were discontinued but the relationship between the Executive Director and most remaining staff members was frayed and the agency faced the costs that accompany significant staff changes. The turnover also concerned county social workers, and interviewees reported that some social workers were reluctant to refer clients to Riverwood because they were concerned that the inconsistency in staffing would not be good for clients.

In 2012, Riverwood's expenses exceeded revenues by about \$64K, and on December 31, 2012, the line of credit balance was \$94K. Riverwood owed Isanti and Pine Counties about \$168K for the case management contracts and 97K (\$56K+\$41K) to Region 7E for the MA reimbursements. Because of her concern about Riverwood's financial stability, the DHS mental health program consultant recommended to Region 7E that for the 2013 crisis services contract with Riverwood, they shift to doing the settle-ups monthly, a change that was reluctantly adopted even though it would be time-consuming for both Riverwood and the region's fiscal host, Isanti County.

## 2013

In January 29, 2013 Board of Directors meeting, the agency's independent auditor reported to the Board of Directors that Riverwood's 2012 financial records were extremely problematic. The accounting firm had found no evidence that money had been taken from the agency, but the auditor reported that there was much evidence of efforts to cover up the fact that work had not been completed in a timely manner: they had found stacks of papers that had not been entered into the accounting software. The auditor reported that Riverwood's books were being reconstructed in Quickbooks and estimated that they would be able to provide information on Riverwood's revenue and expenses by program by April of 2013.

Also at the January 29, 2013 meeting, the Mille Lacs County Commissioner expressed concern that the financial statements provided to the Board by Riverwood did not indicate how much debt the agency was carrying, including the line of credit. He requested a special work session with the Board before February 9, 2013, stating that Mille Lacs County was considering whether they wanted to continue to participate with the agency. Other Board members encouraged Mille Lacs to give Riverwood more time to prepare better financial statements, and the Mille Lacs County director indicated that there were other concerns in addition to the financial ones. Mille Lacs County continued to push for the special meeting, but the other Board members resisted and ultimately the meeting was not held.

In March 2013 DHS conducted an audit of Riverwood's contract with Region 7E for crisis services. The audit was initiated by DHS's Adult Mental Health Division because of allegations about the MA reimbursements that had not been returned to DHS, Riverwood's inability to pay its bills, the possibility that Riverwood was co-mingling funds, and high rates of staff turnover. The audit raised concerns and

speculation among some people in the region about Riverwood's financial viability. Due to staffing shortages at DHS, the audit report was not circulated until a year after the audit was begun. The details of the audit and its findings are included in Section V, below.

For all of 2013, Region 7E and Riverwood were settling up the prepayments for crisis services on a monthly basis. This reimbursement method worked smoothly, it was labor-intensive for Isanti County (the fiscal host of Region 7E) and it left the Region in the uncomfortable fiduciary position of fronting funds to Riverwood. Their concern was heightened by the fact that Riverwood stopped making installment payments on the outstanding debts to Isanti and Pine counties after September of 2013. In November of 2013, Region 7E informed Riverwood that they would return to the original reimbursement method in 2014: Riverwood would bill for services after they were provided, and Region 7E would reimburse them accordingly. This presented a significant cash flow crisis for Riverwood, who now needed to cover 1-2 months of operating expenses to make the shift.

Another challenge to cash flow emerged in Riverwood's contracts with Mille Lacs, Pine, Isanti, and Chisago counties for outpatient services and the Community Support Program. The counties had agreed with Riverwood that they would pay Riverwood 20% of their annual contract upfront in January, 2014 as an administrative prepayment and split the rest of the monthly payments evenly over the rest of the year. This meant that each county would pay about \$30K for the 20% prepayment, and an additional \$19K for the Community Support Program per quarter. In November of 2013, however, Mille Lacs County informed Riverwood that they would not be renewing their contract for 2014 to provide outpatient or the Community Support Program services, a move that had been hinted at back in January of 2013.<sup>3</sup> This meant that Riverwood would not receive approximately \$47K in January that it was expecting from Mille Lacs County.<sup>4</sup> This decision left Riverwood with expensive excess capacity and an even larger hole in its 2014 operating budget.

## 2014

In January of 2014, Riverwood used the administrative prepayments from Pine, Isanti, and Chisago counties to cover their existing bills, but remained in an extreme cash flow position. At the January 29 Board meeting the Executive Director painted a dire picture of the agency's financial situation. Long-term liabilities had increased to almost \$400K, including a maxed out \$250K line of credit. Accounts payable totaled approximately \$80K. A cash flow analysis showed a \$138K discrepancy between billing and receipts for October-December of 2013. All of this was in addition to the loss of Mille Lacs County's contract for 2014, which had been \$216K in 2013. The Executive Director was concerned about being able to cover the second payroll in February. He reported that they would receive approximately \$40-

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<sup>3</sup> Interviewees said that reasons for Mille Lacs County's decision included concern for Riverwood's financial stability, dissatisfaction with the information they received from Riverwood about the clients being served, and Riverwood's lack of a prescriber.

<sup>4</sup> The amount of the initial impact of Mille Lacs County's decision is identified as \$47K in a report titled *End of 2013 Start of 2014 Cash Flow Analysis* that accompanied the January 29, 2014 Board meeting minutes. In the February 17<sup>th</sup> Board minutes, however, the amount is identified as \$56K in a letter to the bank requesting a mortgage and new line of credit. The reason for this discrepancy is unknown.

\$50K of start-up funding for their recently-awarded DHS school-linked grant in March, and that productivity and billing were up.

The Board discussed several options for responding, including cutting staff and other expenses, extending the line of credit, seeking a bank loan, and closing satellite offices. Ultimately, the Board authorized the Executive Director to close Riverwood's Milaca office and ask the bank for an extension of the credit line or for a short-term loan.

At a February 17<sup>th</sup> special Board of Directors meeting, the Executive Director described another cash flow challenge: a disagreement with Region 7E about how the administrative prepayments for outpatient services and the Community Support Program for 2014 would be accounted for. The fiscal host wanted to reconcile them in the February payment; the Executive Director wanted them to be reconciled in the December 2014 payment. The Executive Director mentioned the possibility of consulting an attorney about the contract language, saying that it might be necessary to close some services if the dispute could not be worked out. The Board decided to mortgage Riverwood's building in Braham to pay off the line of credit and establish a new \$150K line of credit to cover payables and payroll.

These decisions were communicated to the Region 7E AMHI Board on February 24, 2014. By then, however, the bank had denied Riverwood's request for a new loan and the Executive Director told the Governing Board that the agency may be facing dissolution.

At the February 26<sup>th</sup> Riverwood Board meeting, the Executive Director reported that Accounts Payable had increased to \$135K, the line of credit remained at \$250K, and there had been no resolution of the disagreement regarding the reconciliation of the 20% administrative pre-payments. He offered five options for consideration:

1. Continue operating the agency, making staff cuts, closing two offices, and discontinuing Day Treatment services, and assuming that capitated funding from counties could be secured and maintained
2. Continue operating the agency but closing crisis services.
3. File for Chapter 7 bankruptcy.
4. File for Chapter 11 bankruptcy.
5. Informal dissolution: begin negotiated settlements (buyouts) with other providers.

The Executive Director recommended that the agency pursue the first option, and the Board voted to follow that recommendation. They also voted to send a letter of demand to Mille Lacs County for the foregone revenues for the first two quarters of 2014, in keeping with their understanding of the contract requirement to provide six months' notice for a change to the contract.

On March 11, 2014, the Board called a special meeting. Accounts payable stood at \$166K, long term liabilities remained at \$400K, and payments for critical infrastructure were in such arrears that some utilities were on the verge of being disconnected. The Board considered the five options discussed at the previous meeting, and the Executive Director reported that due to lack of cash to continue

operations, Chapter 7 bankruptcy was really the only option for the agency at that point. The Executive Director reported that the final payroll would include \$95K of salary/benefits and an additional \$110K of vacation payouts. The Board agreed to a plan for closing the agency that included:

- The Executive Director would notify staff of the closure in the morning of March 12 and notify community stakeholders in the afternoon.
- The agency would close at 5 p.m. on March 17, at which time staff would receive lay-off notices. A small skeleton staff would be kept for a few hours per week to help with the closure.
- The County Commissioners agreed that their counties would pay Riverwood for services up until the close date in order to cover the costs of the final payroll.
- The Executive Director would file for bankruptcy as soon as the final payroll was paid, within 2-3 weeks.
- The bankruptcy trustee would determine how clients' medical records would be handled.

These actions were carried out basically as planned, although the Executive Director did not file for bankruptcy until April 24, 2014, by which time the agency's medical records had been secured through collaboration among the involved counties and DHS. As of May 10, 2014, employees had still not received their final paychecks or vacation payouts and had become parties in the bankruptcy process.

#### **IV. Response to the Closing**

By the time Riverwood closed on March 17, county officials, DHS, and local providers were already working on solutions to the loss of services. Riverwood staff and county social workers had been calling clients to explain the closing and connect clients to new providers, and county leaders had begun meeting to re-establish services lost in the closure. The closing was reported in regional media on March 17 and 18. The mental health care system's response to the closing included the following:

- County leaders and local providers met among themselves and with DHS Commissioner Jesson and other policy leaders to plan and coordinate a response. Many stakeholders met in multiple settings to discuss the closing and identify actions needed.
- The Riverwood Centers Executive Director, with the approval of the Region 7E AMHI Chair, made arrangements with a provider in the Twin Cities to roll the region's crisis phones to a new number with costs initially covered by the AMHI.
- County officials and DHS attorneys met to secure clients' medical records, which included some 900 boxes and more than 40 hard drives. The records were transferred to Chisago County for safekeeping.
- County staff continued to work on communicating with clients and connecting clients with new providers.
- Local providers and DHS set up a meeting to help former employees connect with potential employers.
- Counties began the process of contracting with new providers to provide services, especially crisis services.

- Advocates proposed legislation which subsequently passed to require that mental health providers give adequate notice before closing and that they develop contingency plans to assure that closings are orderly and that clients' medical records are safeguarded.

While most interviewees felt that the response to the closing was swift and well-organized, they did not downplay the seriousness of the effects of the closing. For example, for a short time, callers to the region's crisis line heard a recorded message that the number was out of service, although AMHI members noted that the 800 crisis number was ported and set up on the day of the Riverwood closure, minimizing any disruption of this service. A consumer advocate described the client experience in this transition, *"This had the same impact as if someone had called 911 for fire or police assistance and had gotten that message. A crisis is a crisis, and the impact for those people was huge."* Riverwood clients immediately began reaching out to their informal networks of consumers and peer leaders in the region, who contacted county leaders and advocacy organizations to try to figure out what had happened. Once it was clear that Riverwood had closed, both formal and informal networks of consumer support got active, communicating with and reassuring clients and arranging public communication about the closing.

Local consumer advocates organized a healing event scheduled for May 30. *"We shouldn't just say, 'well, businesses close all the time, and we can move on.' We shouldn't forget that people using the services don't feel that way. They feel loss and betrayal."* Advocates also began meeting to organize a local consumer chapter. The region once had a Consumer Survivor Network chapter in St. Cloud, but it closed a few years ago. Wellness in the Woods provides consumer support in north central Minnesota, but is quite far away from many people in Region 7E. The advocates hope that the Riverwood closing will provide a renewed impetus for a local consumer organization.

The closing was also extremely difficult for Riverwood's staff. Not only did they abruptly lose their jobs and health benefits, but they had to endure uncertainty about whether they would receive their final paychecks and vacation reimbursements as well as whether they would be able to find new jobs. Moreover, they mourned their work and their relationships with clients. Several interviewees emphasized that the impact on employees was just as traumatic as the impact on clients.

Interviewees made a few suggestions for actions that DHS could take to ease the community's transition:

- Temporarily allow private health insurers serving Region 7E to waive the requirement that clients receive only one psychiatric evaluation per year. This would allow clients to transition more smoothly to new providers.
- Temporarily waive the requirement that limits medical transport to 60 miles for clients in Region 7E until more service providers are operating in the region.
- Find a way to reimburse Chisago County for holding Riverwood's medical records, or perhaps DHS should take the records and responsibility for making them available to clients.

Several interviewees felt that the closing, while certainly creating many problems, would have some positive impacts as well. They mentioned increased communication among the region's counties and

providers and a sense of optimism about structuring services in new ways that would work better for clients. *“This has forced other agencies to come out and say that they would help, so it has created more of a cooperative feeling in the area. Providers are pulling together around this.”*

## **V. Factors Contributing to the Closing**

The immediate reason for the Riverwood closure was that the agency ran out of cash. It had been in a precarious cash flow position for a long time, caused by more basic financial challenges including low reimbursement rates for some services, outstanding debt, and inadequate financial management and reporting systems. Interviewees explained that these challenges were reinforced by non-financial contextual factors, including the relationship between Riverwood and its counties, oversight by the Board of Directors, some management decisions of the Executive Director, the DHS audit, and actions of the DHS mental health program consultant. This section explores these factors, beginning with the financial factors and then moving to non-financial factors. This order does not necessarily reflect the relative priority or importance of the factors; it is just an attempt to describe the context in a clear, understandable way.

### **A. Riverwood’s Cash Flow Position**

According to Riverwood’s charter, they were only allowed to keep a cash flow cushion equal to 2 months of operating income. Most organizations would consider this inadequate to accommodate unforeseen expenses, especially organizations whose revenue comes mainly from reimbursements (as opposed to direct sales). This is somewhat moot because Riverwood had not reached that level of cash reserves in the decade leading up to the closing.

Several interviewees, including directors of other CMHCs, explained that CMHCs in Minnesota operate with very thin margins. They explained that it requires constant creativity and deft management to put together a package of services that both meets the needs of their communities and generates the revenue necessary to keep the organization financially viable. Without a reliable financial reporting system that provides systematic accounting of the costs and revenues associated with each program, such creativity and deft management is very difficult.

Given Riverwood’s precarious financial situation in the years leading up to the closing, it is incomplete to say that the main reasons for Riverwood’s closing were the cash flow challenges that the organization experienced in the fall and winter of 2013: Region 7E’s decisions to revert to a reimbursement payment model for 2014 crisis services, Mille Lacs County’s decision to not contract with Riverwood for 2014, and the accounting for the 20% administrative pre-payments in February of 2014. Most CMHCs operate successfully on the reimbursement payment model, and most do not rely on administrative prepayments. Other CMHCs have experienced the loss of significant contracts with little advanced notice and survived. What was different for Riverwood was the perfect storm of these challenges and other contextual factors.

Policy questions:

- Should there be some expectation or guidelines around a community mental health center's cash flow position? If so, what would be considered a reasonable guideline for adequate cash reserves?
- What is an appropriate role for DHS if a CMHC's cash flow position falls below such guidelines?

## B. Riverwood's Debt

The five counties involved in Riverwood made loans to the agency when it first opened to help defray setup costs; additional advances were made to the agency in 1998. By 2003, it was clear to some counties that Riverwood would be unlikely to be able to repay these loans, and eventually the counties decided to write off the loans. Thus in 2009, \$94,550 of long-term debt was retired, and in 2010, an additional \$193,166 of debt was retired. However, Riverwood's debts soon began to mount again (as described in Section III). Some interviewees said that the history of Riverwood's debts contributed to some of the mistrust that counties felt toward Riverwood, which then further affected Riverwood's finances.

## C. Reimbursement Rates and Processes

### 1. Low Rates

Many interviewees felt that the source of some of Riverwood's problems was the low reimbursement rates for some of the services that they provided. A programmatic profit-and-loss analysis for CY 2013 included in Riverwood's January 29, 2014 Board meeting minutes indicated that revenue for at least three of Riverwood's programs (psychiatry, Community Support Program, and Day Treatment) did not even cover the professional staff costs of those programs, much less the other expenses associated with the work (benefits, travel, rents, utilities, etc.). Several interviewees felt that the inadequate rates were a significant threat to the safety net system. *"In many [mental health programs], DHS had better look at rates or we're going to have more closures. This closure was very public, but others might close, though more slowly. It's going to be like dentistry. The same economics apply."*

Many interviewees reported that the reimbursement rates for some mental health services do not cover the costs of providing those services. Even though Rule 29 community mental health centers receive a 23.7% reimbursement premium for providing general mental health services, neuropsychological services, medication monitoring, psychotherapy, children's therapeutic services and supports, and children's day treatment, this is often not enough. Psychiatry is a particularly telling example: the costs of employing and supporting psychiatric staff are more than most CMHCs can bill for psychiatric services

### 2. Rates Not Covering All Costs

Another challenge is that reimbursements do not cover the provider's associated costs of setting up services, credentialing new staff, and lag time once billing starts. Providers are often expected to fund these related costs and start-up costs with cash reserves (although sometimes counties or the state

provide grants to help defray startup costs).<sup>5</sup> One interviewee explained that it can often take two or three months for a new clinical staff member to be properly licensed and credentialed to provide a new service; during that period, the agency is incurring personnel and related costs but is not yet able to bill for that employee's work.

### 3. Problematic Rate Processes

Interviewees mentioned a third challenge regarding reimbursement rates: the unpredictable nature of rate-setting and payer reimbursement. Both DHS and private payers received round criticisms in this regard. Interviewees gave examples of rates that were reduced retroactively, leaving providers to make up the difference between the reimbursements they budgeted for and the actual revenue they received for services that had already been provided. There were also examples of payers delaying or ignoring rate increases or demanding extra work by CMHCs to receive the entire reimbursements to which they were entitled. *"The staff time and expertise needed by providers to solve these problems is not paid for and comes out of already inadequate rates."*

These rates, policies, and practices mean that provision of some services actually drains the agency, providing no support for indirect expenses or cash reserves that could help a CMHC like Riverwood to improve its cash flow position, invest in improvements, or repay debt. Because these services accounted for a significant percentage of Riverwood's overall revenue, interviewees felt that these limitations contributed to Riverwood's ongoing financial problems.

### 4. Policy Issues

Interviewees mentioned several policy issues around the community mental health center business model and healthcare rate structure:

- Using the time study method for determining Rule 79 targeted case management has led to wildly differing rates for similar services across counties.<sup>6</sup> How can DHS help assure reasonable and/or consistent rates?
- How should the state differentiate health care services from community support services? For example, is mobile crisis service really health care, or is it community support? Everyone agrees that it's important; the question is, who is responsible for it (and for paying for it)?
- Can Minnesota institute some form of universal credentialing so that service providers do not experience such a delay between the hiring of new staff and the ability for those staff to actually bill for services?
- What is the legislative history of providing some entities (including CMHCs) the 23.7% reimbursement premium? If a for-profit agency is providing the same services as a nonprofit, why are they not entitled to the same reimbursement?

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<sup>5</sup> For example, when Riverwood began operation, the participating counties loaned the agency money to help defray startup costs.

<sup>6</sup> Riverwood itself did not provide targeted case management services, but it is included because interviewees pointed out that other CMHCs do provide this service.

- Does it make sense to only cover direct costs of services provided under AMHI grants? Some interviewees claimed that other regions do allow their CMHCs to bill for some indirect expenses or to use their MA reimbursements to serve other uninsured clients. Indeed, after Riverwood closed and counties began trying to contract with other providers for services, Isanti County asked DHS whether new vendors would be required to follow the same reimbursement requirements that Riverwood had been held to; as of May 10, 2014, DHS had not provided an answer to that question, which compromised the ability of counties to move forward with contracts. If it is true that some regions are allowing local CMHCs to keep MA reimbursements and others are not, why is DHS not enforcing a uniform policy?
- Why were the rules about AMHIs' handling of MA reimbursements not clear in the first place? As one interviewee put it, *"A couple of years ago, there were hundreds of thousands of dollars of [MA reimbursements] that host counties were being asked to pay back. That should be a clue that the rules and regulations hadn't been well-communicated."*

#### **D. Accounting Information and Policies**

When the Executive Director of Riverwood started in 2011, he gradually learned that Riverwood's financial records were problematic. He hired an independent accounting firm to audit the agency, and the firm concluded that *"[Riverwood] does not have a system of internal controls that would enable management to conclude the financial statements and related disclosures are complete and presented in accordance with generally accepted accounting principles."* The Executive Director contracted with the firm to reconstruct the agency's books for 2008-2012 and to file tax returns for 2009, 2010, and 2011 (which had not been filed by Riverwood's former accounting manager).

The DHS audit of Riverwood released in 2014 reached similar conclusions. *"Our review of Riverwood's policies and procedures found that they had no written policies and procedures governing their financial staff. Had Riverwood developed, implemented and followed formal policies and procedures, the situation that occurred in 2011 and 2012 where bills were not being paid on time and where regular, accurate financial updates were not being provided to the board of directors could have been avoided. We believe this led directly to the problems encountered as they expanded clinical services into Pine County, under-estimated the true costs, and were overly optimistic on how quickly they could arrange billing for these services and receive revenues."*

The Executive Director, working with the accounting firm, attempted to address Riverwood's financial challenges, but while the accounting and financial reporting systems were being rebuilt, he and the Board of Directors were making decisions without adequate, reliable financial information to guide them. A few interviewees felt that this lack of accurate financial information was a key factor in the agency's ultimate closure.

#### **E. Relationship between Riverwood and Counties**

##### **1. Conflicts between CMHCs and Counties**

According to interviewees both inside and outside Region 7E, the relationships between CMHCs and the administrations of the counties they serve can be contentious. County commissioners who sit on some

CMHCs' boards of directors are not always familiar with the complexities of mental health service provision and can come to see the CMHC contracts mainly as an expensive budget item that they are very intent on controlling. County directors and supervisors (overseeing social workers and clinicians who regularly collaborate with CMHC-provided services) can be driven to control CMHCs. CMHCs, struggling to put together a viable business model and complement of services, can feel constrained or micro-managed. About half of the CMHCs in Minnesota were created by counties, and some chafe under county direction, especially as county contracts shrink as a percentage of CMHCs' budgets. With county officials on the boards of CMHCs, some CMHCs feel that their ability to compete in the mental health services marketplace is constrained, leaving them financially vulnerable.

There are other structural sources of conflict between CMHCs and counties. One is the potential for competition or a conflict of interest between the two over provision of services. One example that interviewees mentioned concerned the provision of Targeted Case Management (TCM) services.<sup>7</sup> Because of the way that TCM services are reimbursed, counties can end up spending significantly more to provide TCM services themselves than the rates that other counties set in contracts with providers. Some CMHCs feel that it is a conflict of interest for counties to get to decide to provide TCM services themselves without an open bidding process. Moreover, if counties can prevent CMHCs from providing services that could compete with TCM, like Assertive Community Treatment (ACT), this power could unduly constrain the CMHCs and perhaps hurt the quality of the service continuum in that community.

While several interviewees talked about county commissioners' possible conflict of interest as a problem that hampered Riverwood's ability to develop a sustainable complement of services, two interviewees saw the conflict of interest having the opposite effect. They felt that the arrangement favored Riverwood at the expense of other providers. This viewpoint was also presented in the DHS audit, which commented, *"Having county commissioners on Riverwood's Board of Directors could be seen as a way for the counties to give money to their favored organization over any other area agencies. This could become a problem if a perceived conflict of interest is seen with the county commissioners controlling both the funding from Region 7E and services provided by Riverwood, thus favoring Riverwood over other agencies."*

Conflict among counties in an AMHI can be exacerbated by the fact that counties face somewhat differing demographics, economic circumstances and political constituencies, especially because some are exurban and some are very rural. This can lead to mistrust among counties that bleeds over into the counties' relationships with the CMHC. As one long-time CMHC director put it, *"[The legislature] forced those counties together and forced them to pool their resources, so from the beginning they were worried about who got what resources."*

## **2. Conflicts between Region 7E Counties and Riverwood**

While this contentiousness might be part of the fabric of the relationships among counties and CMHCs, it was particularly pronounced in Region 7E. Interviewees described acrimony and mistrust that had

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<sup>7</sup> Riverwood did not provide Targeted Case Management itself, but this example is included because it was raised by more than one interviewee.

spanned decades but that felt particularly pronounced in the years leading up to the closure. Interviewees described that the counties in Region 7E considered Riverwood to be more of a county service than an independent nonprofit provider with which they contracted. The essence of this disagreement was about the nature of the money that Riverwood received from the counties and from the Region 7E Adult Mental Health Initiative. From one perspective, these were payments to fulfill contracts for services; from another perspective, they were grants that gave the counties responsibility and wide latitude to control the operations of Riverwood. As one interviewee explained, *“It ended up looking like this hybrid of a county-based agency and an independent business.”*

These differing perspectives on the appropriate relationship between Riverwood and counties were reflected in various aspects of their relationship. Several interviewees reported that the counties were frustrated by the financial and service-related information that they got from Riverwood. They received aggregated bills that did not show specific services provided to specific clients at specific times, leaving them to wonder about what they were paying for. The Executive Director of Riverwood explained that he could not provide such client-specific information because it would break rules about client confidentiality, so one county asked for the data with client identifying information removed. The Executive Director said that that would be too time-consuming to provide. Said one county staff person, *“We were all so frustrated about not knowing if we were over-spending or underspending. From [another CMHC that the interviewee had worked with in another region], we got a list every month of who they were serving and what services they were receiving. But we never got anything from [Riverwood].”*

The friction played out in client referrals, too. One interviewee reported that there were times when county social workers would refuse to refer clients to Riverwood, saying that their supervisors were “mad at Riverwood.” Another interviewee summed up the relationship this way: *“The counties loved to hate the mental health center.”* Other interviewees said that some county employees were concerned about the quality of the services that Riverwood provided, and thus tried to steer clients to other providers: *“It’s hard to pay an agency that much money and not be happy with it . . . or to not be getting the services we’re paying for.”*

### 3. Policy Issues

It is not the point of this report to figure out who was more at fault in this conflict. Clearly, the relationship between counties and Riverwood was strained. This tension raises policy questions:

- What is the appropriate nature of the relationship between counties and CMHCs and what responsibilities does each have to the other? What kind of oversight or direction should counties have over CMHCs, if any?
- What should the relationship be between the AMHI regions and the providers and advocates in the community? Two interviewees suggested that the Region 7E AMHI made it difficult for non-county people to attend their Governing Board meetings and sometimes held closed “supervisors’ meetings” as a way of keeping others out. AMHI board members have responded that meetings may have specific foci for different members, but that all are scheduled and conducted in accord with Minnesota open meeting rules. The remaining issue is how best to

schedule and conduct meetings to promote transparency and clear communication between the AMHI and the clients served in their region.

- If counties (or AMHIs) get into unproductive conflicts with providers, what's the best way to mediate such disputes? Could professional associations play a role?

## **F. Oversight from Riverwood's Board of Directors**

Although DHS reached out to members of Riverwood's Board of Directors to prepare this report, we were able to conduct interviews with only three former Board members. Much of this section therefore also includes other interviewees' thoughts about the Board's oversight.

Interviewees identified several aspects of the Riverwood closing that raise issues about governance. Some interviewees questioned the ability of Riverwood's Board of Directors to provide proper guidance to the agency. The Board was made up of county commissioners and lay members, and many interviewees felt that the commissioners had a conflict of interest, as described previously. Moreover, some interviewees reported that the Board members sometimes seemed confused about their role in Riverwood's oversight, believing with their "county hat on" that they did not have direct control over Riverwood's operations, even though their "Board hat" did give them that power.

Interviewees also felt that their inexperience with the details of the mental health field led them to defer to the Executive Director too often. The Board meeting minutes contain almost no discussion of Riverwood's long-term vision, the overall vision for mental health in the region, or planning or prioritizing around particular needs for services. At least two interviewees felt that the Board was more concerned with each county's contract with Riverwood than about Riverwood's role in the entire system of care in the region. Several suggested that Riverwood's Board should have been expanded to include members with specialty knowledge in professional fields like accounting, finance, and mental health services provision.

Interviewees reported that some formal requests to the Board for discussions of problems at Riverwood seemed to go unheeded. For example, in 2012 a group of Riverwood staff wrote a letter to the Board about some concerns they had about Riverwood's operations and the Executive Director's actions, but the letter was not acknowledged and no response was apparent to the staff. In another example in 2013, Mille Lacs County's Commissioner (a Riverwood Board member) requested a special meeting of the Board to discuss Riverwood's financial circumstances, but the Board decided not to hold the meeting.

One interviewee was perplexed by the Board's handling of the closure: *"You'd think they would just fire [the Executive Director] and find someone else, or contract with [another provider] for management . . . I never thought they'd say, 'we don't care about our mandate and we'll just close and abandon clients.' I did not expect such an abrupt and total closure. I don't understand it to this day."* While it may be uncharitable to think that the Board did not care about their mandate or about abandoning clients, this interviewee was expressing a sense of disbelief that was found in several interviews: why did the Board let this happen? Some interviewees focused on the role of county social service directors and mental

health supervisors—why did they let this happen? Why were they not communicating with their county commissioners (who made up the Riverwood Board) to at least assure an orderly and planned closure?

Policy questions raised by interviewees included:

- Should there be changes in the governance/oversight of community mental health centers?
- Should CMHC Boards be restructured to include a wider variety of stakeholders?
- Could there be more guidance and technical support available to Board members?
- What is the liability of Board members when a CMHC goes bankrupt?

## **G. The Role of the DHS Mental Health Program Consultant**

Several interviewees talked about the role of DHS’s mental health program consultant for Region 7E during the year leading up to the Riverwood closure. Almost all were complimentary of the consultant’s efforts to assist the region, but a few expressed concerns about her role in some of the decisions that exacerbated Riverwood’s cash flow problems. Some felt that she “took sides” in the conflict between the counties and Riverwood, holding Riverwood to a higher level of scrutiny than what was being applied to other CMHCs in the state. Others questioned whether there was adequate communication within DHS about Riverwood’s problems and whether DHS had mobilized adequate resources to address the situation. Most agreed that the role of the mental health program consultants needs to be clarified, especially how the consultants fit within the overall resource allocation and decision-making structure of DHS.

*“DHS should [clarify] the job description of the state liaisons—what the basic purpose of the position is, what resources they bring to the table, and [what kind of DHS supervision they receive]. . . If you don’t give them direction, then the counties end up trying to manage them. They can come out and regurgitate legislation, but I’m looking for more technical guidance, especially planning, population assessment and that kind of stuff. They should also recognize that they are in collaborative settings, and if they are going to say something, it had better be in a mediating kind of way—no other way.”*

Policy questions raised by interviewees include:

- What is the role of the mental health program consultants in the Adult Mental Health Division of DHS? Can this role be spelled out so that all of the people involved in regional AMHIs understand and agree with it?
- What kind of training and support are the mental health consultants program provided? What should stakeholders be able to expect from them?
- What is the nature of the communication and decision-making channels between mental health program consultants and the rest of DHS?
- Can coordination among DHS’s licensing, auditing, and mental health divisions be improved?
- Where is the accountability for mental health program consultants? Should stakeholders have some way to communicate with DHS about their experiences with the consultants?

## H. The DHS Audit of Riverwood

At the request of DHS's Adult Mental Health Division, DHS's Internal Audits Office undertook an audit of Riverwood in March of 2013. Though most interviewees knew about the audit, the purpose of the audit was not made public, which left people in the region speculating about its focus. Some interviewees felt that this undermined the credibility of Riverwood, especially because the results of the audit were not circulated in a timely way after the audit interviews were conducted.

When the audit was released on March 31, 2014, after Riverwood closed, its scope and findings were spelled out as follows:

<b>Summary of DHS Audit of Riverwood</b>	
<b>Allegation Leading to Audit</b>	<b>Audit Finding</b>
Riverwood owed Region 7E about \$60K for the excess MA reimbursements it had wrongly retained and for the December, 2012 settle-up process.	Riverwood did owe Region 7E about \$62K (although the amount had been reduced to \$42K by mid-2013). Region 7E paid the funds back to DHS, but Riverwood still owed Region 7E the money at the time of the closure.
Riverwood was not paying their bills in a timely manner.	Although the audit found evidence that Riverwood had been behind in their bills in 2012, they reported that Riverwood had caught up and were current as of March 2013.
Riverwood had comingled their Adult Mental Health Initiative funding with other funding received by the agency and thus could not track that funding.	For calendar year 2011, Riverwood was unable to provide accurate financial records and statements. This made it impossible for the auditors to substantiate the allegation of comingling of funds, although it substantiated the allegations that Riverwood could not track the AMHI funding.
Riverwood had experienced a substantial number of employee resignations that raised questions about their ability to provide services to the area.	The auditors were unable to substantiate that a high number of resignations significantly impacted Riverwood's ability to provide adequate services.
	The auditors recommended that Region 7E and Riverwood continue to do monthly settle-up of their crisis prepayments and revenues (which was discontinued in January of 2014 when the Region insisted on reverting to a reimbursement payment model).
	The auditors concluded that county commissioners on Riverwood's Board had a conflict of interest that could unduly benefit Riverwood in contracts for services, and recommended that Region 7E request proposals for mental health services in the area.
	The auditors recommended that Region 7E and DHS develop contract requirements for Riverwood and other providers to report on a monthly basis the number of clients, the source of the clients, and the disposition of cases for their crisis services contracts (Riverwood was providing this information, but it was not in their contract to do so).
	The auditors recommended that Riverwood develop a policy and procedures manual for their billing and accounting practices and other administrative practices.

Several interviewees felt that the delay of the audit contributed to Riverwood's abrupt closure. They believed that if the audit results had been delivered in early 2013, it could have either helped dispel the

rumors about Riverwood's financial challenges or made those challenges public so that a better transition could have been planned and undertaken.

Interviewees also questioned DHS's handling of the information they gathered during the audit. They wondered how the auditors could have looked at Riverwood's financials at that time and not identified the agency's cash flow position as a problem. At the end of the audit period (December 31, 2012), the agency owed \$264K to Isanti County, Pine County, and Region 7E, their line of credit balance was at \$94K, and expenses for 2012 had exceeded revenues by \$64K.

Staff in the DHS Internal Audit Office explained that the delay in release of the audit report was due to staff shortages the Audit Office was experiencing at the time. The rough draft of the report was completed in August of 2013, but because they knew that the audit results were not holding up a contract or funding to Riverwood, they did not make the final report a high priority. They acknowledged that they had concerns about Riverwood's cash flow, but relied on the judgment of Riverwood's accounting firm that Riverwood had sufficient cash flow.

Policy questions raised by the interviewees included:

- What's the appropriate scope and role of DHS audits?
- How much coordination should there be between auditors and the rest of DHS's technical assistance and oversight functions?
- Should there be requirements that audits be completed within a certain time period?

## I. Oversight of Rule 29 programs

Several interviewees felt that the Rule 29 certification process does not present adequate oversight of Rule 29 programs. *"If community mental health centers are so important, then maybe more licensing is needed. You have Executive Directors who are running the show and they have a lot of latitude. If you have certification as a Rule 29, then the state should know enough about your finances to know that a problem like [Riverwood's financial struggle] is happening."*

Policy question:

- What other oversight should DHS be providing to Rule 29 programs? Are site visits required, and how often? What is the nature of the site visits, and what should be done with results of the visits?
- When a program is out of compliance, for example, when they are operating without a prescriber, what is the process for addressing this problem? What are the specific requirements for prescribers' roles at Rule 29 programs?
- Should certification of Rule 29 programs be changed? Should licensing be considered?

## IV. Implications of the Closing

In addition to the immediate policy issues identified in the previous section, interviewees raised several more general implications of the Riverwood closing. These are discussed below.

## A. The Future of Community Mental Health Centers

According to some interviewees, the future of CMHCs is uncertain. Establishing special status for CMHCs made sense when mental health providers were scarce and most of the funding for public-pay clients came from grants. Today, there are more providers and a much smaller percentage of public mental health services are paid for by grants. The most significant payers are public and private insurers, and as Minnesota continues to insure more people, the need for state grants to counties will erode even further. Some interviewees felt that if Minnesota is going to retain the CMHC model, changes need to be made to boost CMHCs' financial stability. *"If we want to have safety net providers, we have to commit adequate safety net funds to them, through the state or the county. If we don't provide that, then [the CMHC] has to have a business model that works."* Interviewees also wanted to see clarification of CMHCs' role and an increase in their accountability. *"The [Rule 29] statute about the provision of community mental health services should have some performance indicators. . . Right now the statute doesn't really define accountability."*

Alternatively, some interviewees said that Minnesota should move away from the traditional CMHC model. They felt that in Minnesota's move toward accountable care, CMHCs should be "freed" to compete as independent providers (with independent Boards of Directors) and that all providers should face the same competitive environment. Some suggested that the 23.7% rate premium be available to all providers, nonprofit or for-profit, or that it be tied to specific responsibilities or deliverables rather than to the type of organization providing the services.

Interviewees mentioned another perk of CMHCs: student loan forgiveness. Student loan forgiveness helps CMHCs attract staff who might otherwise be drawn to for-profit providers. While this is a benefit for CMHCs, one interviewer pointed out that this has turned CMHCs into a training ground for the field; staff remain at the CMHC until their loans are paid off, then they leave. This puts strain on the CMHC to handle the burden of training and frequent turnover. The interviewee suggested that if the state values the role of CMHCs in workforce preparation, it should give CMHCs more financial support to fulfill this role.

Policy issues raised by interviewees included:

- Should community mental health centers continue to have special status? Should they be certified or licensed in any way different from other providers? Should they continue to receive the 23.7% reimbursement premium that for-profit providers are not eligible for? If so, what additional accountability should they bear?
- Should student loan forgiveness programs be made more generally available to mental health providers in rural areas? Should CMHCs receive financial support to fulfill their workforce preparation role?
- Should CMHCs' special status trigger a special role for DHS when a CMHC is in extreme financial straits? Should DHS step in, or let the organization fail?
- If CMHCs are treated like other providers, how will the state assure that un- and under-insured clients retain access to services? Are there more efficient ways to subsidize their care than the current model?

- What does “under-insured” mean now? If a person elects not to invest in their own health care and to just buy catastrophic coverage, should a county or a CMHC be financially responsible for subsidizing their care?

## **B. Future of the State-Managed, County-Administered Mental Health System**

Several interviewees felt that the Riverwood closing was evidence that Minnesota’s state-supervised, county-administered mental health service system may need revision, voicing concern for DHS’s ability to manage the mental health system in the health care reform environment. *“I feel like over the decades someone might have asked [counties], ‘What is your plan for the service delivery system, and let’s look at your current needs assessment to see if you are on plan. Can we help you with that process?’ That hasn’t happened over decades, and the laws don’t need to change to make it happen. There just needs to be more active oversight.”* Another interviewee expressed concern about a narrow focus on service costs per client served. *“With the recession, people come at service planning as a math problem—how many heads did you serve for this much money? You have to start from a population basis—who do you have and what are their needs? Should we go to public health and let them do population mental health?”*

Most interviewees voiced support for the Adult Mental Health Initiative regional system; they appreciated the opportunity to collaborate locally to plan and support the mental health service system. *“The Initiative structure works well because it has local control. It gives control to people who know what’s needed and can make [changes] happen.”* However, some interviewees expressed concern for the Initiatives’ accountability. They felt that DHS has not done a good job of overseeing regions’ needs assessments and planning or of holding regions accountable for the results of the investments they make. Some interviewees said that Initiatives vary widely in their performance and effectiveness. If they are truly pilots, as they were originally envisioned, what has been learned from them? Are there minimum standards that all Initiative regions should be held to? Can effective practices be instituted within all regions? Other interviewees were worried that the Initiative regions’ were not making adequate investments in their own operations: *“The AMHI is trying to get the money out to consumers, but by doing that, they have missed the mark on looking at their own functioning and infrastructure. If you’re managing a million dollars, you should have some robust operational infrastructure.”*

Some interviewees wondered about the future governance and funding of Adult Mental Health Initiatives. After Riverwood closed, at least one county considered withdrawing from the Region 7E AMHI, requesting information from DHS on how it could get its money out of the region. This raises questions about the nature and future of AMHIs.

Interviewees posed several policy questions:

- What is the appropriate role for DHS in situations where a mental health provider is in extreme financial straits? Should DHS step in, or let the business fail?
- How will Minnesota assure that integrated or coordinated care can be provided for clients with complex needs for mental health and substance abuse disorder services? Will integration happen through the emerging affordable care models, including behavioral health homes?

- Can Minnesota’s rate reform efforts be thorough and timely enough to assure that providers don’t “cherry pick” the most lucrative services and clients and allow less lucrative clients to fall through the cracks in the safety net?
- Should counties remain the authorizing agents for contracts, or should the funding be directed back to the state plan?
- As case management is privatized, will counties continue to be held to their ten-year-old maintenance of effort (MOE) amounts?
- What roles should the AMHIs play in the future? If counties move toward contracting individually with providers, or if contracting diminishes entirely, what role will be left for the AMHIs?
- Should AMHIs be held more accountable for the outcomes of their activities and the population mental health of their region? How can DHS assure that lessons learned in one region are transferred to other regions?
- Can an AMHI disband? If so, what happens to the funding that formerly went to that AMHI? Whose money is that? And if a county wants to contract separately for a particular service or services but remain in the AMHI, how should money be allocated?
- Should DHS continue to pursue mental health services that are bundled for people enrolled in specific programs, or should it unbundle services and allow clients to access/purchase the services they need when they need them?
- There is growing collaboration between local public health and social services administrations. How will DHS increase collaboration between mental health policy and public health at the state level?
- Is DHS going to exert some strong leadership in the mental health arena on these policy questions, or leave them to be made by counties or the marketplace? Who is going to facilitate comprehensive, statewide planning for the mental health service system?

### C. The Appropriate DHS Role in Overseeing Community Mental Health

The interviewees made several comments about the DHS response to the Riverwood closing and DHS’s role going forward. They welcomed DHS’s show of commitment to the region and their assistance with securing clients’ records. They also appreciated the DHS-scheduled meetings to talk about the impact of the closing and to help former Riverwood employees connect with potential employers. They made the following recommendations to DHS about an appropriate response going forward:

- Use the Riverwood closure as impetus for policy conversations and planning. As described throughout this document, the closure raises many practical and policy issues that warrant further attention.
- Don’t jump to conclusions. A few interviewees cautioned against using the Riverwood example to draw too many conclusions about the system as a whole. They felt that this perfect storm is not indicative of circumstances of most of the state’s CMHCs, and that policymakers should not over-react. *“So we don’t want to see any knee-jerk reaction by the state. We need to get the different perspectives. If [we are talking about] a Community Mental Health Center, there are*

*already a lot of regulations on these really small providers. For them to meet the requirements to get MA, they already have a lot of regulations. Maybe we just need more oversight.”*

- Don’t assume that the closure was a bad thing. While all interviewees agreed that *how* the closure occurred was a problem and shouldn’t be repeated, many felt that closure probably was the right solution in this particular instance. They recommended that DHS focus on supporting the care system in that region and helping clients and employees to heal from the hurts of the closing, not on creating a new CMHC to replace Riverwood.
- DHS should focus on setting expectations for the state as a whole and on facilitating regional planning. Interviewees appreciated DHS’s assistance after the closing, but a few urged DHS not to get too involved in the local response to the closing and instead to let the local region handle it as much as possible.
- DHS should consider direct vendor contracting for crisis services rather than funneling crisis funds through the AMHI structure. This mechanism is already in use for children’s mobile crisis services, and could also aid the development of a uniform crisis network for the state.

#### **D. Need for More Public Education about Mental Health**

Several consumer interviewees emphasized that Riverwood played an important role in the regional care system, but that DHS needs to better support public education about mental health—in schools, community centers, spiritual organizations, etc. They also suggested that formal education begin training people interested in careers in mental health while they are still in high school. If high school students could be trained as peer counselors or mentors, this would both improve understanding of mental health challenges while also priming a workforce pipeline that could address the shortages of mental health professionals and certified peer specialists. Interviewees also emphasized the importance of training first-responders to understand mental health crises and respond appropriately to people in crisis. All of these changes could help prevent clients from needing more intense levels of mental health services.

## **VII. Conclusion and Next Steps**

The analysis provided in this report can be summarized in the following major points:

- Due to problematic reimbursement rates and processes for some mental health services, community mental health centers operate with very small financial margins, leaving them vulnerable to unforeseen financial problems.
- Prior to its closing, Riverwood had struggled financially for years with narrow margins, increasing debt and inadequate financial recordkeeping and reporting. The agency experienced increasing cash flow problems in the two years before the closing, going deeper into debt as they tried to make changes that were intended to ultimately put the agency back on firm financial footing.
- The closing was a “perfect storm” of factors; no single factor should be identified as *the* cause of the closure. While a lack of cash is what ultimately precipitated the closing, the agency’s longer

term financial difficulties were what led to the cash flow crisis. Those difficulties were supported by a range of non-financial factors.

- The abrupt closure of Riverwood was shocking and traumatic for clients of Riverwood and for the employees who were displaced. Clients' chief concerns were about the temporary lack of crisis services, the security and confidentiality of their medical records, and the loss of long-term therapeutic relationships with their providers at Riverwood. Employees shared those concerns and also faced uncertainty about their final paychecks and back vacation payouts as well as whether they would be able to find new jobs.
- The system response to the closure was swift and effective, and continues to this day. Essential services were quickly transferred to other providers, medical records were secured, and meetings were held to coordinate and communicate about the response and to begin healing from the trauma. Most clients were quickly connected to other providers and many employees were soon hired by other providers in the region. However, the fallout of the closing is still being felt.
- There were mixed opinions among interviewees about whether the Riverwood closure was a bad event that should have been prevented. There was unanimous agreement that *how* it happened was wrong and should be avoided in the future.
- The closing raised dozens of policy-related questions that should receive future attention by all of the stakeholders involved, including the Department of Human Services, providers, clients and advocacy organizations, payers, counties and tribes.

Now that the immediate crisis presented by the Riverwood closure is being addressed on multiple fronts, it is time to consider what could be learned from the experience in order to strengthen the mental health service system both in the region and in the state as a whole. DHS deeply appreciates the input provided by interviewees and their identification of policy questions to be considered in the coming months. DHS looks forward to meeting with stakeholders to discuss the contents of this report and identify statewide issues that should receive priority attention.

## **Appendix 1: Acronyms Used in this Report**

ACT: Assertive Community Treatment

AMHI: Adult Mental Health Initiative

ARMHS: Adult Rehabilitative Mental Health Services

CMHC: Community Mental Health Center

CSP: Community Support Program

CTSS: Children's Therapeutic Services and Supports

TCM: Targeted Case Management