A Report on the Community Mental Health Center Roundtable

April 2008

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Mental Health Center Round Table

As part of our work with the Early Intervention Planning Council (EIPC), the Center for Health Policy convened a meeting of representatives from four major mental health centers that provide child mental health services in Marion County, including Adult and Child Center, Behavior Corp, Midtown, and Gallahue. The meeting was a round table discussion during which the representatives shared their concerns about child mental health services in Marion County. The discussion revealed some strengths and weaknesses of these services. Several key concerns arose during the discussion.

The key concerns can be summarized as:

- a reduction in Medicaid reimbursement, leading to fewer children being served, fewer services per child, and a related lack of funding for prevention and screening;
- a change in Medicaid's definition of *case management* which will require either new funding sources for case management or fewer case management services;
- difficulty finding qualified staff, particularly clinical nurse specialists (CNSs) and child psychiatrists;
- insufficient resources for early intervention programs in schools, particularly in the Indianapolis Public Schools (IPS);
- more resources needed to expand the early diagnosis services offered in Marion County; and
- insufficient sources for mental health care for individuals from families with household incomes above 200% of the federal poverty level who either have no health insurance or who have insurance with no mental health coverage.

Medicaid Funding

The mental health centers in Marion County operate on a fee-for-service basis. As a result, they have limited capacity to provide services for which they are not reimbursed. Combine this fact with the decrease in Medicaid funding, and it is no surprise that the representatives of the mental health centers report that they are now able to serve fewer children and often must provide fewer services to the children they do treat. Some representatives said their organizations have had to close entire service lines. The problem also extends to services for which Medicaid is approving reimbursement.

The managed care organizations (MCOs) have become strict about the number of treatments they will provide to children. Some children are not approved for additional treatment because they have shown improvement, even when the children are still at risk for future problems. Other children are not approved because they have failed to show significant progress. As one representative said, "What do you do with the ones they declare 'not treatable' because in four sessions they haven't moved forward?"

Representatives also reported problems with the ease and timeliness of reimbursement from the MCOs. CompCare was cited as a particularly difficult MCO with which to work. Magellan, on the other hand, was praised as being much easier to work with.

There are three upcoming Medicaid rule changes which will negatively impact the funding of the community mental health centers. These changes are:

1. the redefinition of targeted case management,
2. revisions to the Medicaid rehabilitation rule and,
3. redefinition of intergovernmental transfer.

The redefinition of case management requires that there be only one case manager per child. This change is an attempt by the federal government to reduce costs, but will ultimately diminish the services provided to children. One representative said that the change in the definition of case management will eliminate half of what her organization does and is likely to dismember the system of

care. Services billed to case management include linking children and families to services, monitoring children's behavior, and working with the family. Without alternative funding sources, these services will not be provided.

The revisions to the Medicaid rehabilitation rule require narrowing the definition of *medical necessity,* and specific rehabilitation goals, and a demonstration of progress in a short period of time. This focus on the medical model of treatment rules out valuable treatment options that address social and environmental issues, and the time requirements can rule out treatments which are effective but slow.

Finally, the change in the definition of intergovernmental transfers affects the federal matching of Medicaid dollars. A transfer must be an intergovernmental transfer for there to be matching. Transfers to the community mental health centers qualified for federal matching dollars under the previous rules, but do not under the new rules. Indiana Senate Bill 350 sidesteps this rule by having the county governments send money to DMHA so that it will qualify for a federal match. This money is then distributed to the community mental health centers by the DMHA.

The first two rule changes will not be so easy to sidestep, and stopping these rules from going into effect would require an act of Congress. As a result, the state and counties face a choice of discounting some services provided by the community mental health centers or finding an alternative source of funding for these services.

Hard to Find Staff

Another key issue mentioned was the difficulty of finding qualified staff. There are two key aspects to this problem: 1) a lack of qualified individuals available in the job market, and 2) insufficient funds to hire the necessary staff.

The lack of qualified individuals is, to a large extent, a training problem. One particular problem is that there is a shortage of individuals who are qualified to assess children younger than three. This problem is discussed further in the section on early diagnosis. There is also a shortage of clinical nurse specialists (CNSs) and child psychiatrists.

One representative stated that even if her staff can get a child in the door to see a clinician, it could still be up to four months before the child is able to see a CNS or child psychiatrist. The same representative said that if two CNSs walked in her door, she would hire them both in a heartbeat. Indiana has more child psychiatrist than some states; however, it can take 1 to 1.5 years to find a replacement for a child psychiatrist who leaves. To address these problems requires training for more CNSs and child psychiatrists in Indiana or attracting qualified individuals from out of state.

Schools

The mental health centers operate in the schools with the mission of providing early intervention and preventive care. However, the referrals they receive from the schools are for children who are past the point of early intervention and prevention; they are the kids who are "falling off the cliff." Part of the problem is a lack of capacity. There is such a large volume of children who need help that the agencies end up treating the children who are already showing the most impairment. However, there is one benefit—some children end up staying in school who would otherwise be expelled.

One representative noted that her organization has been moving out of Indianapolis Public Schools because they cannot break even when they provide services to IPS. She also noted that they are moving into schools that pay, because they can at least break even in these schools. This is occurring despite the need for more capacity at IPS schools. Furthermore, schools are trying to be proactive by identifying pre-kindergarten children who they anticipate will have problems; however, the mental health centers

are not receiving funding for these purposes. These facts all validate the need for additional funding to provide early intervention and prevention services at Marion County schools, particularly IPS.

Funding for Children Who Fall Through the Gaps

There is a need for funding to cover middle class children with mental health issues. Some commercial insurance does not cover behavioral health. As one representative stated, sometimes the only choice for treatment for these children is to put them in a state hospital because there are no other options.

Early Diagnosis

Because early intervention can be much more effective than treating full-blown problems, there needs to be a focus on early diagnosis of problems. Currently many children are not diagnosed until they either enter school, are declared a child in need of services (CHINS), or enter foster care. Early intervention is possible and could be done in prekindergarten settings such as day care and child care centers.

In order to facilitate effective early diagnosis, there is a need for more individuals who are trained in assessing child mental health problems. One representative said she has only four individuals on staff capable of performing a solid assessment on children three years old and younger. It would also be beneficial for pediatricians to receive training in assessing young children, as they are often the only medical professional a young child sees on a regular basis. Trained pediatricians would then be able to refer children with mental health issues to an appropriate mental health professional. One representative said that mental health and primary care professionals do not work well together and need to communicate better. Better communication between mental health and primary care professionals combined with some initial screening by children's primary care physicians could go a long way to identify children with problems at a younger age when issues can be dealt with more efficiently.

Mental Health Center Budgets

The four key mental health organizations in Marion County were also kind enough to share information regarding revenues, expenditures, and the number of children served in Marion County. All of the agencies were gracious enough to reply; however, Adult and Child Mental Health Center was unable to provide the requested data. This is because Adult Child and Behavior does not keep the records for the children they serve in Marion County separate from their records for children in other counties.

Behavior Corp

In 2006 BehaviorCorp spent $1.98 million on serving children in Marion County (see Table 5). The largest portion of their funding (47.19%) was obtained from Medicaid and other revenue; 44.22% of their revenue was state revenue, and the remaining 8.58% of their revenue was from Marion County. Over time, we see that BehaviorCorp has been receiving a smaller share of their revenues from Medicaid while the shares from Marion County and the state have both been increasing.

During 2006, BehaviorCorp served 815 children, an increase of 13% since 2004 when 757 children were served. The average cost per child in 2006 was $2,426, lower than the $2,556 per child in 2004. It would take further investigation to determine whether the decrease in spending per child can be

attributed to efficiency gains, to providing fewer services for each child, or some combination of the two.

Table 1: BehaviorCorp Budget			
	FY 2004	FY 2005	FY 2006
Children Served	757	789	815
Total Estimated Expenses	$ 1,935,000	$ 1,980,000	$ 1,977,000
Estimated Revenue			
Medicaid & Other Revenue	$ 1,111,900	$ 1,086,000	$ 933,000
Marion County Revenue	$ 119,460	$ 130,910	$ 169,680
State Revenue	$ 703,640	$ 763,090	$ 874,320
Total Revenues	$ 1,935,000	$ 1,980,000	$ 1,977,000
Cost Per Child	$ 2,556	$ 2,510	$ 2,426

Gallahue

In 2006 Gallahue spent $13.6 million toward services for children in Marion County (see Table 6). The largest portion of their funding (70.43%) was obtained from Medicaid and other revenue; 7.0% of their revenue was from the Division of Mental Health, 6.5% of their revenue was from Marion County, and the remaining 15.8% was from other sources. The mix of Gallahue's funding has remained stable.

During 2006, Gallahue served 4,471 children, an increase of 22% since 2004 when 3,653 children were served. The average cost per child in 2006 was $3.041, lower than the $3,533 per child in 2004. It would take further investigation to determine whether the decrease in spending per child can be attributed to efficiency gains, to providing fewer services for each child, or some combination of the two.

Table 2: Gallahue Community Mental Health Center Budget			
	FY2004	**FY2005**	**FY2006**
Children Served	3,653	4,150	4,471
Salaries & Benefits	$4,342,036	$4,828,728	$4,674,511
Other Direct	$8,564,478	$8,687,033	$8,922,776
Total Expenditures	$12,906,514	$13,515,761	$13,597,287
Medicaid	$9,214,513	$9,386,476	$9,576,341
Division of Mental Health Grant	$803,424	$942,485	$942,810
Marion County Contracts	$858,096	$841,746	$888,629
Other	$2,131,941	$2,211,393	$2,152,987
Total Funding Sources	$13,007,974	$13,382,100	$13,560,767
Cost Per Child Served	$3,533	$3,257	$3,041

Midtown Community Mental Health Centers

During 2006, Midtown spent a total of $4.29 million dollars serving children in Marion County (see Table 7). The majority of their funding (68.60%) was received from Medicaid. Additionally, they received 18.45% of their funding from a state Division of Mental Health Grant, 8.71% from Marion County, and the remaining 4.24% from other sources. Midtown's expenditures in 2006 have decreased 8% from the $4.67 million which Midtown spent in 2004. Midtown has seen an increase in the share of funding from Medicaid and from other sources, while revenues from Marion County and the Division of Mental Health Grant have declined.

Midtown Community Health Center served 2,918 children in Marion County during 2006, a decrease of 5% since 2004 when Midtown served 3,056 children in Marion County. The average cost per child in 2006 was $1,774, a decrease of 3% since 2004, when the average cost per child was $1,834.38. It would take further investigation to determine whether the decrease in spending per child can be attributed to efficiency gains, to providing fewer services for each child, or some combination of the two.

Table 3: Midtown Community Mental Health Center			
	FY2004	FY2005	FY2006
Children Served	3,056	3,268	2,918
Salaries & Benefits	$5,089,390	$4,008,915	$4,581,833
Other Direct	$516,483	$497,169	$595,450
Total Expenditures	$5,605,873	$4,506,084	$5,177,283
Medicaid	$3,005,037	$2,905,273	$2,943,647
Division of Mental Health Grant	$1,155,883	$976,811	$791,566
Marion County Contracts	$511,637	$230,527	$373,919
Other	$0	$208,556	$182,010
Total Funding Sources	$4,672,557	$4,321,167	$4,291,141
Cost Per Child Served	$1,834	$1,379	$1,774

Budget Trends

Looking at the data for the three mental health centers, three trends stand out. First, we see a decrease in the cost of services per child at each of the three mental health centers. Whether this is due to efficiency gains, because of fewer services for each child, or some combination of both is unknown. Secondly, there is an increase in the number of children being served by both BehaviorCorp and Gallahue. The number of children served by Midtown decreased 5% from 2004 to 2006. The number of children served by all three institutions has increased since 2004. A hypothesis consistent with these two trends is that the number of children being served is increasing more quickly than the capacity at these institutions thus leading to lower spending per child. The fact that Midtown is serving fewer children yet still has lower spending per child does, however, is inconsistent with this hypothesis. Finally, we see that the amount of funding from Medicaid has decreased at Midtown and Behavior Corp. The amount of Medicaid funding at Gallahue has increased slightly; however, the amount of Medicaid spending per child has decreased.

Medicaid Rule Changes

The Medicaid rule changes regarding the optional state plan case management services mentioned by the representatives of the mental health centers are available in the Federal Register.[1] The rules changes were not in effect at the time of the round table, but are scheduled to take effect as of March 3, 2008.

There are several issues with the Medicaid rule changes. First, the rules restrict state flexibility in a way that could make Medicaid payments less efficient. Some individuals feel this change violates a central tenant of Medicaid, namely that states must follow federal guidelines but should be allowed broad flexibility over payment rates and policies.[2] Second, the rules prohibit states from making fee for service payments in increments exceeding 15 minutes. This is a significant change from the case rates and per diem rates often used by states. While intended to keep cost down by making providers more accountable, the additional overhead required for billing could reduce efficiency. Finally, the rules

[1] Federal Register Vol. 72, No. 232. Tuesday, December 4, 2007. http://edocket.access.gpo.gov/2007/07-5903.htm

[2] Solomon, J. "New Medicaid Rules Would Limit Care for Children in Foster Care and People with Disabilities in Ways Congress Did not Intend." Center on Budget and Policy Priorities. http://www.cbpp.org/12-21-07health.htm

require that a state provide no more than one case manager per beneficiary. In most cases, having one case manager is beneficial as it eliminates duplication of effort; however, some beneficiaries with multiple conditions may need the expertise of more than one case manager.

Senator Grassley, of Iowa, has written a letter to HHS Secretary Michael Levitt, in which he states that "[Case management] services, which the Congress intended would be appropriately considered a Medicaid expense, are particularly important to children in foster care."

Conclusion

The round table identified several problem areas that need to be addressed further.

Medicaid funding, unfortunately, is outside the control of the local government. In order to fund early intervention and prevention, alternative funds need to be found. This has been made more difficult thanks to the current political climate with regard to property taxes.

Staffing problems are not unique to mental health. Incentives for training and to encourage workers to locate to areas of need have been used in other areas, and these incentives have met with mixed success. Again, attracting additional CNSs and child psychiatrists is likely to require additional funds, which means more local tax dollars.

The bright side of the story is that the City County Council is proactively investigating the potential of early child intervention and planning. Members of other agencies, including IPS, DCS, the Mental Health Centers, and the juvenile justice system are also advocating early intervention. In the long run, an investment in intervention should be more than paid for by the reduction in child care and juvenile justice services. The challenge is to make a solid case for early intervention and obtain the funds necessary to expand early intervention in Marion County.