

Rhode Island

Public Mental Health Financing Study

Submitted to: The Rhode Island Foundation

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Rhode Island Foundation

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Executive Summary

BACKGROUND AND PURPOSE OF STUDY

Public mental health services in Rhode Island and across the country are financed by multiple sources and through many agencies. The complexities involved with federal block grants, Medicaid, state appropriations and the multiple agencies involved are often confusing to advocates and policy makers. To assist with grant making priorities, and to aid state administrators and advocates, the Rhode Island Foundation retained Dougherty Management Associates, Inc. to analyze the financing for public mental health services and to “map” the financing by identifying key features of the system and its funding sources.

While Rhode Island has been recognized as a national leader in providing health care to its citizens, a number of previous studies and reports have recognized the need for changes in public mental health systems for children and adults in the state. Many have identified changes in financing as key to the solution. This project aims to help give Rhode Island stakeholders information with which to answer the following questions:

Who funds public mental health services?

What services are funded?

Who receives these services?

How much is the funding?

How does this compare to other states?

In Rhode Island, as in most states, identifying the sources of funding and the scope of coverage for mental health services is challenging, because of the complex interaction of Medicaid and state funding. Multiple agencies are involved in delivering services, yet there are no financial reports that summarize mental health services across these agencies. In Rhode Island, the complexity of rules and practices around the use of Fee-For-Service Medicaid, Managed Care, the Medicaid Rehabilitation Option and the overlapping roles of the State Mental Health Authorities for children and adults and the Medicaid agency make analyses and comparisons particularly difficult and sometimes confusing. Furthermore, it became apparent that the years selected for the study, state fiscal years 2001 and 2002, were years of significant changes in the financing of the system, particularly for DCYF and DHS.

In late 2002 and 2003, interviews were conducted with Rhode Island state officials from the various state agencies responsible for the provision of mental health services. Each interview covered the range of mental health services funded by each agency, the nature of those services, how the services were delivered and to what populations. Expenditure and utilization data were requested for State Financial Years 2001 and 2002 from the different state agencies in such a way as to identify any duplicate reporting across the system. Comments on the draft report were received in person and in writing from all of the state agencies and incorporated into this report.



RHODE ISLAND'S PUBLIC MENTAL HEALTH FUNDING STREAMS

Public mental health services in Rhode Island are funded by the following Departments: Mental Health, Retardation and Hospitals; Children, Youth and Families; Human Services (Medicaid); Corrections; and Health. Each of these agencies is responsible for different services and different population groups.

- ***The Department of Mental Health, Retardation and Hospitals (DMHRH)*** and the ***Department of Children, Youth and Families (DCYF)*** are the primary authorities funding mental health services to adults with serious mental illness and children with serious emotional disturbance. A large percentage of DMHRH and DCYF mental health services are Medicaid funded.
 - Certain Medicaid covered services to eligible children and adults are reported by the Department of Human Services (DHS) under DMHRH and DCYF Funding Codes. The corresponding state department assumes the state match for these services and reports the full amount of the spending in its budget and financial statements.
 - For those services where DHS has full responsibility for the state match, they are funded by Medicaid fee-for-service or by RItCare.
- ***The Department of Human Services (DHS)*** is the single state agency for Medicaid and provides funding for Medicaid services through traditional fee-for-service; coordination of federal funding for services that are purchased by DCYF and DMHRH; and RItCare, DHS' managed care initiative. The Medicaid Fee-for-Service program provides services to individuals who are excluded from managed care and covers services that are exempt from managed care for certain populations.
- ***The Department of Corrections (DOC)*** is responsible for the provision of mental health treatment, including psychiatric medication, to the incarcerated adult population in need of services through, full time, part time and contracted mental health personnel.
- ***Department of Health School Based Health Clinics*** also provide mental health services for youth thorough school based health clinics.

MAJOR FINDINGS BY AGENCY

DCYF:

- Total mental health expenditures increased (6%) from \$96,074,507 to \$101,624,165 between SFY01 and SFY02.
- In SFY02, the majority of mental health spending was allocated to Residential and Group Care Treatment; 16% was attributed to outpatient care and 7% to inpatient care.
- There were significant changes in the Medicaid funding for DCYF services over the two years of the study. Many DCYF foster care youth were enrolled into DHS' managed care program, RItCare. This resulted in significant changes in

some other services. For instance, Children's Intensive Services (CIS) expenditures dropped significantly (60%) within DCYF Medicaid, but increased in Medicaid Fee for Service.

DMHRH:

- Mental health related spending amounted to approximately 20% of total DMHRH expenditures in both fiscal years.
- Community based mental health services represented approximately 73% of mental health funding, while inpatient mental health spending accounted for 27% of DMHRH's mental health budget.
- Approximately 85% of the services funded by DMHRH are Medicaid eligible. DMHRH Medicaid spending for community services increased by 17% from \$43,956,496 to \$51,562,110. Virtually all (95%) of the Medicaid eligible consumers are SSI eligible disabled.

Department of Human Services:

Medicaid Fee For Service (FFS):

- Total FFS mental health expenditures grew significantly (by 30%) from SFY01 to SFY02 (\$38,414,664 and \$49,764,017). Much of this was related to changes in financing of services by DCYF.
- Inpatient services are the largest single component of FFS spending, ranging from approximately \$16M to \$18M in SFY01 and SFY02.
- Disabled services accounted for the highest proportion of expenditures in both years (43% and 36%), while expenditures for Foster and Managed care grew significantly.

Medicaid Managed Care, RItE Care:

- Total mental health expenditures by RItE Care plans increased substantially (64%), from \$10,263,598 to \$16,822,493 in the two years of the study. An increased enrollment of youth in DCYF custody appears to be the major contributing factor.
- Outpatient services dominated Managed care spending, accounting for 68% of total costs in SFY01 and 61% in SFY02. Inpatient services accounted for about one-third of total spending.

Department of Corrections:

- Personnel costs of providing mental health services are approximately \$1million per year. DOC was not able to report any utilization or access data. Approximately 17% of the prison population is receiving some form of psychotropic medication.

Department of Health School Based Health Clinics:

- While services at school based health centers have been expanded over the past several years, no mental health services were separately reported from these centers.

- It is likely that services for many youth found to be in need of mental health services were billed directly by Health Centers to Medicaid; alternatively, these youth were referred to Community Mental Health Centers.

REIMBURSEMENT RATES AND COMPARISON DATA

- Reimbursement rates varied significantly for mental health services funded by the different agencies. They were generally comparable with rates paid by other New England states.
- Based on available data, the number of children served (children receiving a mental health service) in Rhode Island is well above the national mean; in SFY01 and SFY02, the state reported 26 per 1000 (population), compared to the national average of 18 and 19 per 1000 in the respective fiscal years.
- Rhode Island's RItE Care program appears to provide a significantly lower level of mental health services than other Medicaid Behavioral Health programs. This is likely the result of a limited Medicaid benefit to some eligible groups and variability in case-mix compared to other states

RECOMMENDATIONS AND CONCLUSION

Most of the recommendations contained in the report involved new approaches to, and methods for reporting of, the mental health service expenditures to assist in policy planning. Public financial and utilization reporting systems should permit population-based, as well as program-based, reporting of service utilization and costs with a minimum of overlap between funding streams. As a result, recommendations included developing reporting methods that have a single service taxonomy and which integrate agency and Medicaid data systems. Fiscal transparency should be the overarching policy in reporting for the public mental health system. The State Block Grant planning process and recent efforts to reorganize health and human services within the state are steps in this direction.

Rhode Island has been a national leader in Medicaid financing of public mental health services. It has been committed to the effective design and funding of an integrated delivery system for mental health for both adults and children. The growth and significant changes in expenditures between 2001 and 2002 are indications of a system adapting to meet the needs of its citizens in the most cost effective way possible. The findings and recommendations in this report suggest that there are opportunities for further improvements in the financing and cost effectiveness of mental health services in the state.

A better understanding of the complex mental health funding streams will serve to inform policy, program planning and advocacy efforts. Clear and comprehensive data on current utilization and financial system can help define the opportunities for change during this period of scarce resources for public mental health services.

Department of Children, Youth and Families

The Department of Children, Youth and Families (DCYF) provides behavioral health, child welfare and juvenile justice services to children and their families. Mental health services are a subset of DCYF expenditures, are administered by the Children's Behavioral Health Services program, and most of these services are covered by Medicaid. Mental health services are provided to youth in the custody of the department as well as those youth in need of services with serious emotional disturbance. DCYF has responsibility for the provision of a comprehensive set of mental health services and pays the state match for certain Medicaid covered services to youth in the custody of the department.

DCYF is a national model of an integrated children's service agency and the state has developed a number of different innovations in the provision of care for youth in custody and those with serious emotional disturbance. DCYF funds services in several ways:

- Contracts with Community Mental Health Centers (CMHCs) and other community agencies. These are funded using grants or cost-based services and the providers are responsible for billing DHS for Medicaid covered services.
- Fee-for-Service reimbursement to residential treatment providers. Residential programs bill DCYF for days of service and DCYF processes the payment and the federal Medicaid portion of services using their Statewide Automated Child Welfare Information System (SACWIS).
- DCYF funds the FFS Medicaid services for inpatient and community treatment for children who are not involved with DCYF, but for whom no other resources are available.
- DCYF funds the state match of Medicaid funded inpatient and community services for children in state custody with the exception of certain Children with Special Needs.
- DCYF funds the state match for the RIte Care premium for all youth in substitute care.
- DCYF funds provision of services to incarcerated youth.

Since there were different reimbursement and data systems used for these services, the information we were able to collect varied. Our sources of data included the following:

- DCYF reported data for combined mental health spending as a part of another very similar data request for the Children's Mental Health Benchmarking Project¹.
- The SFY 2004 Budget includes spending levels by account for SFY 2001 (Audited) and SFY 2002 (Unaudited). These numbers were used to check the data and reconcile with the spending levels reported.²

¹ Children's Mental Health Benchmarking Project, Dougherty Management Associates, Inc., 2002 and 2003. See www.doughertymanagement.com/reports.htm.

² Note that we sought to reconcile any inconsistency in the ways that DCYF staff reported mental health services for this report from the state budget reporting methods.



- As noted earlier, DHS reported Fee-for-Service Medicaid spending and utilization data for the DCYF Funding Source Code. These are funds where DCYF has the responsibility for the state match and the oversight of services. Fiscal years 2001 and 2002 showed many changes in the ways that these Medicaid services were funded.

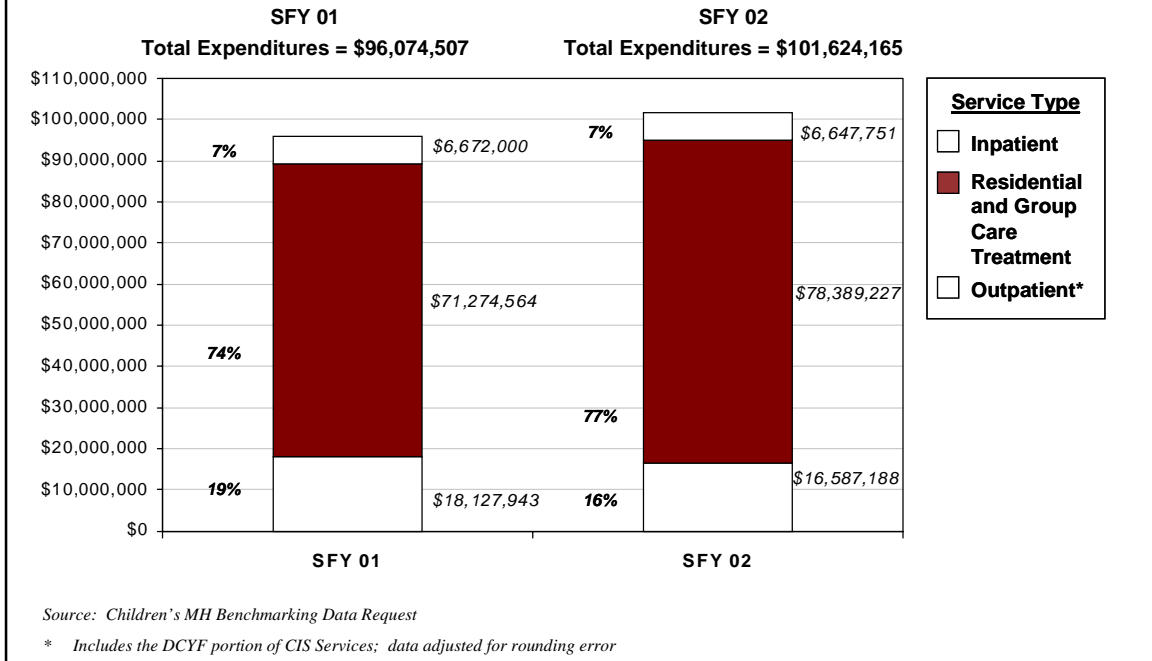
Note that in many ways, the DCYF data is the most complex data received because of the multiple funding streams and the different data systems. First, Children’s Mental Health services are a subset of the total services reported for DCYF Children’s Behavioral Health. Secondly, DCYF reported Residential Treatment and Group Care Services as a part of their “mental health” expenditures. These costs are reported as a part of the Child Welfare program within the DCYF state budget. Medicaid expenditures for DCYF youth include services where DCYF pays the state match (DCYF Medicaid), CIS services where DHS pays the state match, and RItE Care services. Finally, fiscal years 2001 and 2002 were years of extraordinary change for the financing of services for DCYF youth. While there were few if any changes noticed by youth and their families and caregivers, many youth in foster care were enrolled in RItECare, the state’s Medicaid managed care program. Changes occurred in the way inpatient services were financed. In addition, as a result of this managed care enrollment, the state match for Children’s Intensive Services became a shared expense with DHS, rather than being charged solely through the DCYF Medicaid accounts.

Specifically, DCYF reported the following mental health costs for 2001 and 2002.

Table 1		
DCYF Children's Mental Health Expenditures		
DCYF Overall	Total Expenditures	
	SFY 2001	SFY 2002
Inpatient - Acute	\$6,672,000	\$6,647,751
Outpatient		
Office/Clinic *	\$10,053,552	\$7,588,584
School/Home/Community	\$1,869,393	\$2,283,331
Day Tx/Partial Hospital	\$1,023,972	\$1,055,131
Case Management	\$2,318,282	\$2,334,045
Other Services **	\$2,862,743	\$3,326,097
<i>Subtotal - (Inpt. & Outpt.)</i>	<i>\$24,799,943</i>	<i>\$23,234,938</i>
Residential and Group Care Treatment - Total	\$71,274,564	\$78,389,227
Total	\$96,074,507	\$101,624,165
<small>Source: Children’s MH Benchmarking Data Request * - Includes the DCYF portion of CIS services ** - Adjusted for rounding error</small>		

Chart 1

DCYF: Children's Mental Health Expenditures



Staff from the Children's Behavioral Health Unit included residential and group care treatment costs because these programs have been significantly enhanced over the last decade to include mental health and treatment services rather than just the costs of board and care. This is consistent with other states and best practices and we generally concur with the categorization of these services as mental health services. The inclusion of these services, however, significantly increased the reported spending and may make per capita comparisons difficult with other states.³

We attempted to reconcile these figures with the State Budget which shows the DCYF state-only as well as the Medicaid (state and federal) spending for DCYF managed services. In general, we concluded that the data reported to us as Children's Mental Health related spending is appropriately categorized and while there were some inconsistencies in the numbers reported from the various sources, this was the result of different reporting systems and timeframes for the data. Further detail on the reconciliation is included in Appendix B.

³ For instance, the Massachusetts Department of Mental Health funded mental health services to youth with serious emotional disturbance and the Massachusetts Behavioral Health Partnership funded the vast majority of Medicaid mental health services, however this does not include the more than 2,200 youth in residential care, funded by the Department of Social Services (DSS).

CHILDREN SERVED

DCYF has responsibility to provide publicly supported mental and behavioral health services not just for children and youth who are in the custody or care of the Department, but also for other children and youth covered by the Fee-for-Service (FFS) Medicaid program, including SSI, Katie Beckett and Adoption Subsidy cases, who have need of mental and behavioral health services and are either under-insured or did not have health care coverage. The total number of children whose mental and behavioral health care coverage was funded by DCYF in SFY 2001 and SFY 2002 is outlined below in Table 2. The noticeable decline in the number of adolescents funded by DCYF represents an increase in the number of these youth becoming enrolled in DHS managed care. It is not representative of a decline in the number of adolescents between 13 and 17 who are in the custody of DCYF, as this number has increased in SFY 2002.

Table 2 Number of Children Served <i>(Includes all children / youth in FFS Medicaid)</i>		
DCYF – Overall Children Served	SFY 2001	SFY 2002
Total Number of Children Served	6,540	6,388*
Number age 0-6 served	1,485	1,574
Number age 7-12 served	1,882	1,934
Number age 13-17 served	2,750	2,481*
Number age 18-21 served	423	399
<i>* The number of youth in DCYF custody between 13 and 17 years of aged increased from 1385 to 1414 in SFY02 Source: MMIS</i>		

DCYF's Statewide Automated Child Welfare Information System (SACWIS) allows access to needed data on the numbers of youth served and the costs of these youth. At the same time, there is no current integration of this data system with the Medicaid data system.

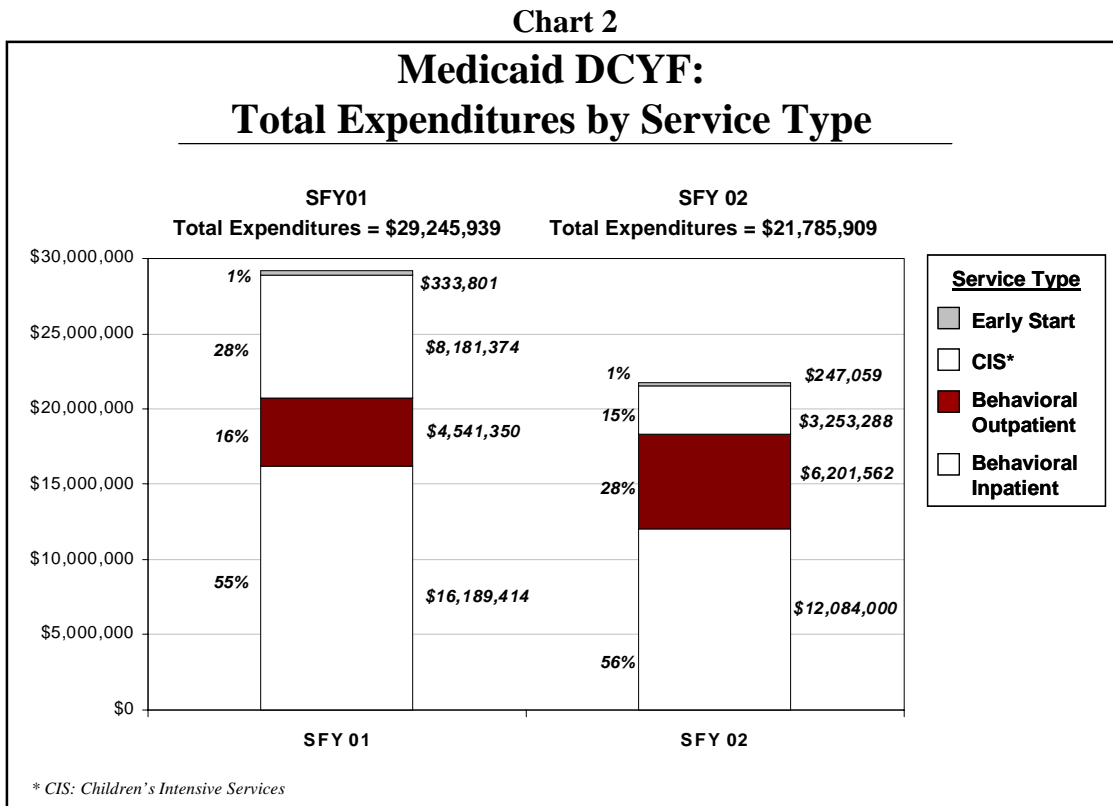
DCYF MEDICAID AND OTHER FEDERAL FUNDS

DCYF funds mental health services which are generally eligible for federal funding under Medicaid and other sources, such as Title IV-E. In the section that follows, we have summarized the services funded by Medicaid and other sources. We have also included some more detailed analyses of these costs in Appendix C since they may provide useful information on the populations served by Medicaid funded services within DCYF.

Medicaid eligible services were separately reported by Medicaid under the DCYF Funding Source Code. DCYF was responsible for the state match for these services. Specifically, the majority of DCYF related inpatient costs were a Medicaid funded service. However, most of these expenditures cover services for the developmentally

disabled and were not reported as mental health costs by DCYF.⁴ Medicaid Behavioral Outpatient services include services to individuals under 21 years who are primarily served in Community Mental Health Centers under contract to DCYF. The DCYF portion of Children’s Intensive Services (CIS) is included here. Note that during these two years, responsibility for funding both inpatient and CIS services began to be transferred over to DHS as foster care children and those in adoption subsidy were increasingly enrolled in RItE Care. The CIS services are reported in the Medicaid Fee-for-Service category below. During this time there were also changes in reporting that occurred at DHS for certain reporting categories for children enrolled in managed care. The combination of these issues makes a one to one comparison of DCYF and Medicaid funds impossible.

The total expenditures received from DHS for the DCYF Funding Code are as follows:



Total DCYF Medicaid service expenditures decreased significantly in SFY 2002, dropping from \$29,245,939 to \$21,785,909. Despite the declining levels of spending, inpatient services accounted for over half of total expenditures in both years. Early Start spending also remained stable but very low, accounting for only 1% of overall expenditures. However, outpatient and CIS (Children’s Intensive Services) expense distributions experienced significant change; outpatient spending increased by 40%,

⁴ Specifically, DCYF total inpatient costs reported in the Children’s Behavioral Health Division within DCYF for SFY 2001 and 2002 were \$15,757,913 and \$13,374,614. This includes spending for services classified as inpatient for youth with developmental disabilities at dedicated units at Butler and Bradley Hospitals. These costs were reclassified as long-term residential treatment rather than inpatient.

while CIS spending declined by 60%. Most of this variability between SFY 2001 and SFY 2002 is attributed to the fact that many of the DCYF youth were enrolled into RItE Care in SFY 2002. As a result of their RItE Care enrollment, these youth received Children’s Intensive Services with the state match funded through DHS, rather than through DCYF. DCYF appears to have used some of these CIS savings for other outpatient services.

Table 3		
DCYF Medicaid Mental Health Expenditures		
Service Type	SFY 2001	SFY 2002
Medicaid Behavioral Inpatient	\$16,189,414	\$12,084,000
Medicaid Behavioral Outpatient	\$4,541,350	\$6,201,562
CIS	\$8,181,374	\$3,253,288
Other (Early Start)	\$333,801	\$247,059
DCYF Medicaid Total Expenditures	\$29,245,939	\$21,785,909
Excluded Behavioral Inpatient Costs (non-MH)	(\$9,517,414)	(\$5,436,249)
Adjusted DCYF Medicaid Total <i>(Eliminates non-MH costs)</i>	\$19,728,525	\$16,349,660
<i>Source: DHS –Medicaid claims for DCYF funding source</i>		

Since DCYF did not include all their inpatient spending in the “inpatient-acute” category of DCYF Mental Health costs⁵, the total has been adjusted to exclude non-mental health inpatient costs as shown in the above table. While not all children’s mental health acute inpatient costs were likely to be Medicaid eligible, the vast majority of these youth would be eligible for Medicaid as a result of their custody by DCYF and their hospitalization. As a result, all inpatient expenditures have been treated as if they were Medicaid eligible.

Medicaid and other federal funds were also received for Residential Treatment and Group Care expenditures. DCYF officials reported that for Medicaid, Title IV-E, and SSI Trust Accounts they received reimbursement for \$58,086,354 in SFY 2001 and \$65,215,896 in SFY 2002.

SUMMARY

Total DCYF mental health costs for services break down into an estimate of federal and non-federal funds as follows:

⁵ As noted earlier, DCYF excluded certain long-term treatment, or residential, services for a primarily DD population in special units at Butler and Bradley Hospitals.

Table 4 DCYF Summary of Funding		
Type of Funding	SFY 2001	SFY 2002
Non-Medicaid Outpatient*	\$5,071,418	\$6,885,278
DCYF Medicaid-Inpatient & Outpatient	\$19,728,525	\$16,349,660
Residential Non-Federal (State-Only) Funds	\$13,188,210	\$13,173,331
Residential State and Federal funds	\$58,086,354	\$65,215,896
Total	\$96,074,507	\$101,624,165
<i>* Non-Medicaid and Non-Federal funding calculated by deducting the Medicaid and federal funds from total reported spending for inpatient, outpatient and residential services. This allows us to reconcile with state expenditure reports.</i>		

Non-federal funds are estimated as 19% and 20% of total funding in SFY 2001 and SFY 2002 respectively. Total costs per youth served were \$14,690 in SFY 2001 and \$15,901 in SFY 2002. This is primarily the result of increases in residential spending and growth of outpatient services. The total DCYF costs per youth would be even higher in SFY 2002 if we included the costs of CIS services that were funded by DHS for DCYF youth that were enrolled in RItE Care.

Department of Mental Health, Retardation, and Hospitals (DMHRH)

DMHRH is recognized as a national model for the delivery of comprehensive community based services to individuals with serious mental illness and co-occurring conditions. In August 2001 DMHRH issued six different grants to serve individuals with co-occurring substance abuse conditions and the state has long been at the forefront of the recovery movement. This has included a significant effort to secure employment and housing for individuals in the community, and recognition of the importance of “recovery” in services to individuals with mental illness and substance abuse disorders.

FUNDING OVERVIEW

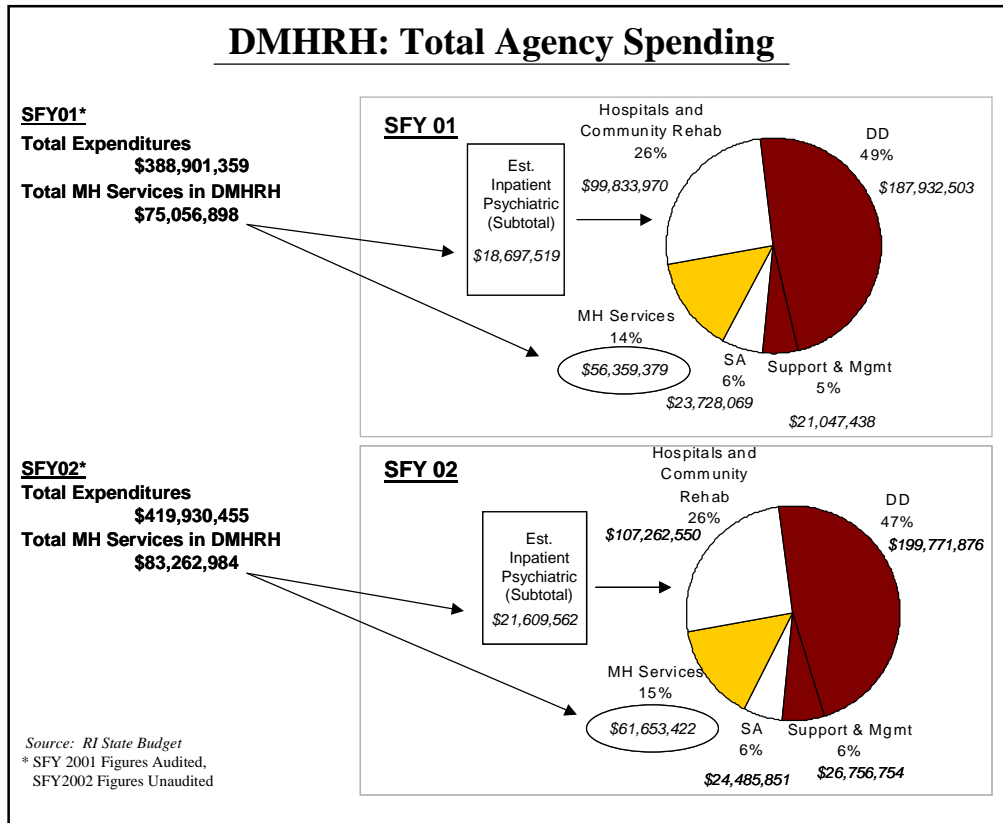
DMHRH funds services to adults with mental illness in the state of Rhode Island. Services are delivered by the eight Community Mental Health Centers (CMHCs), three other community providers (who provide residential and other support services) and Eleanor Slater and Butler Hospitals. DMHRH operates the Community Support Program (CSP) for individuals with serious and persistent mental illness (SPMI) and the General Outpatient Program with traditional outpatient services for non-SPMI. Butler Hospital provides acute care services, usually up to 90 days. Slater Hospital, operated by DMHRH, provides long-term-care services. Funding for DMHRH services include the following costs:

- CMHCs are funded with formula based on historical costs and services
- For Medicaid eligible CSP clients: CMHCs bill DHS 100% then DHS charges the state match directly to DMHRH accounts (direct debit accounts).
- For non-Medicaid clients: DMHRH grant-based contracts include some funds for uninsured and non-Medicaid individuals. This non-Medicaid funding has decreased over time. DMHRH tries to carve out some funds directly for non-Medicaid individuals.
- DMHRH purchased a set number of bed days per year from Butler Hospital⁶. This is paid 100% by DMHRH since it is a psych-only hospital and thus is excluded for federal reimbursement as an “Institution for Mental Disease” (IMD).
- Slater Hospital is part of DMHRH budget and does qualify for Medicaid reimbursement since the majority of its beds serve individuals without psychiatric conditions as the primary diagnosis.

⁶ Note that this does not reflect DMHRH’s current approach to contracting for acute inpatient services with Butler Hospital.

Sources for DMHRH spending data included DMHRH staff, the state budget and DHS Medicaid data.

Chart 3



Total DMHRH spending for SFY 2001 and SFY 2002 was \$388,901,359 and \$419,930,455, respectively. This reflects an 8% increase over the two fiscal years. Community Based Mental Health services represented 14% and 15% of the total spending; an additional 5% of the budget is the mental health portion of inpatient mental health spending at Slater and Butler Hospitals⁷. Thus total mental health related spending in DMHRH was estimated as \$75,056,898 in SFY 2001 and \$83,262,984 in SFY 2002. This is close to an 11% increase in spending.

DMHRH spending breaks down into a number of different categories in the Rhode Island State Budget. These include:

- Inpatient services at Slater Hospital
- Community Inpatient services (Disproportionate share of funding)
- Administration
- Certain block grant related spending
- Three different accounts for Community Mental Health services which include the state and federal share of Medicaid Rehabilitative services. Each of these are shown in the following table and chart:

⁷ Note that Inpatient spending was estimated from the overall budget by using the federal cost based rates for service at the hospital and multiplying this by the number of days of service for individuals with a primary diagnosis of mental illness.

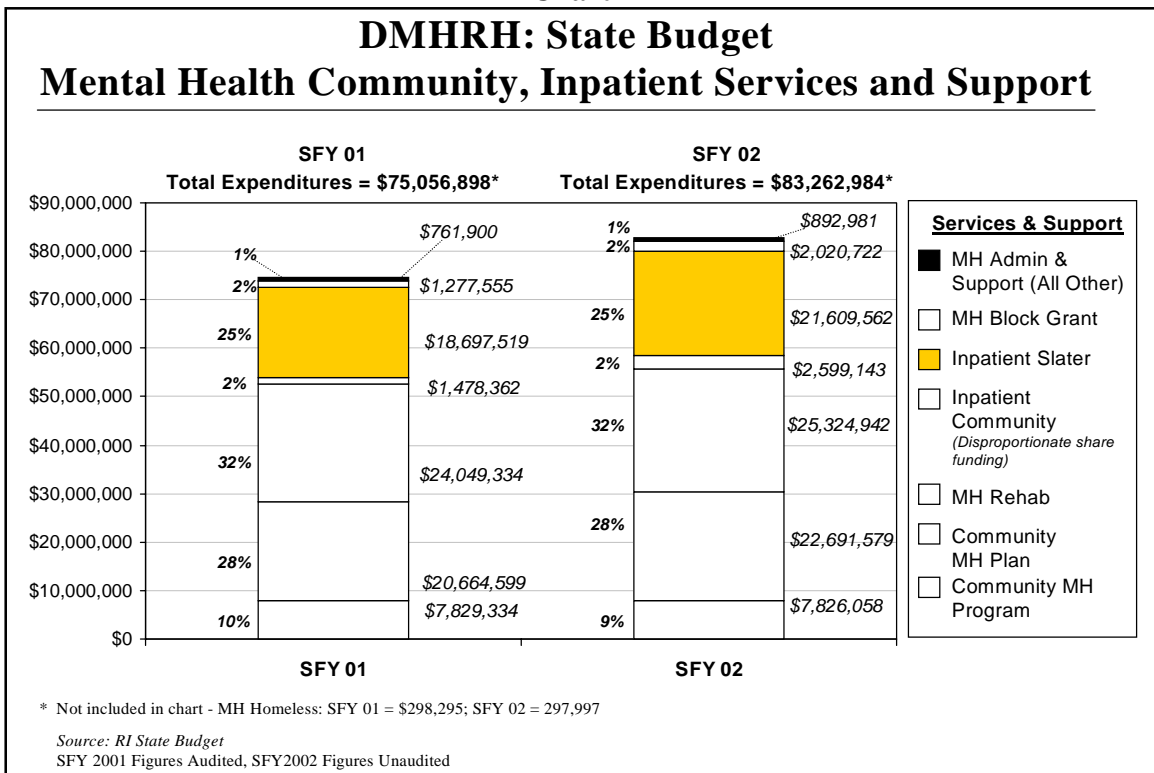
**Table 5
Total Mental Health Expenditures by State Fiscal Year**

Services	SFY 2001	SFY 2002	% Change
Community MH Program*	\$7,829,334	\$7,826,058	-0.04%
Community MH Plan – MA General Res.	\$20,664,599	\$22,691,579	10.00%
MH Rehab – MA. Federal Share	\$24,049,334	\$25,324,942	5.00%
Inpatient – Community Disproportionate Share	\$1,478,362	\$2,599,143	76.00%
MH Homeless	\$298,295	\$297,997	-0.10%
MH Block Grant	\$1,277,555	\$2,020,722**	58.00%
All Other	\$761,900	\$892,981	17.00%
<i>Sub-Total Community MH Services (less Slater)</i>	<i>\$56,359,379</i>	<i>\$61,653,422</i>	<i>9.00%</i>
Inpatient Slater	\$18,697,519	\$21,609,562	16.00%
Total	\$75,056,898	\$83,262,984	11.00%

* Includes internal costs (personnel & supplies, commitment payments and other miscellaneous item). Included is some portion of Butler payment with the remainder in disproportionate share.
 ** Reflects one-time expenditures of accumulated balance
 Source: Rhode Island 2004 State Budget - 2001 Audited; 2002 Unaudited; Slater expenditures estimated from DMHRH records.

There was little if any change in the percentages of each of the accounts within each year's budget.

Chart 4



Between SFY 2001 and SFY 2002, DMHRH total expenditures grew by \$8.2M (11%), however, the distribution of total spending between services showed little variation. The largest percentage growth was experienced in inpatient services both in the community and at Slater Hospital. Community expenditures are reflected in the Community MH Program, Community MH Plan accounts and MH Rehab expenditures. DMHRH data systems do not permit a greater level of detail regarding the funding for specific services funded through DMHRH contracts, since the services are paid through grant-based contracts rather than unit rates. Some additional data are available in the Medicaid spending analysis shown in Chart 3.

The principle methods of funding mental health services by DMHRH are direct appropriations to Slater Hospital and contracts with Community Mental Health Centers. These contracts cover Medicaid (Table 6) and Non-Medicaid (Table 7) services. Medicaid payments to CMHCs had a 7.4% increase from SFY 2001 to SFY 2002 and totaled \$48,015,531 in SFY 2002. General Revenue, Block Grant and the PATH Grant funded \$7,236,241 in services in 2002.

Table 6 Community Mental Health DMHRH Medicaid Payments SFY 2001 – SFY 2002		
Agency	SFY 2001	SFY 2002
Northern Rhode Island	\$4,288,677	\$4,745,679
Community Counseling	\$5,811,407	\$6,249,118
Providence Center	\$7,568,656	\$7,703,672
Mental Health Services	\$6,720,569	\$7,128,025
Kent County	\$4,922,170	\$5,443,488
South Shore	\$3,635,254	\$4,000,498
East Bay	\$3,980,375	\$4,156,909
Newport County	\$2,856,804	\$3,505,223
North East Fellowship	\$2,832,111	\$2,870,349
Riverwood	\$1,908,247	\$1,988,722
North American Family Institute	\$189,664	\$223,848
Total *	\$44,713,934	\$48,015,531
* Variance from Comptroller; SFY01 = 1 and SFY02 = 10 Source: DMHRH-Mental Health Medicaid expenditure data.		

Table 7 Non-Medicaid Contract Expenditures FY 2002		
Community Mental Health Center	Community Support Services	General Outpatient
Community Counseling Center	\$631,450	\$188,258
East Bay CMHC	\$535,016	\$183,646
Kent County CMHC	\$723,284	\$227,173
Mental Health Services Inc	\$726,223	\$222,767
Newport County CMHC	\$472,463	\$122,910
Northern RI CMHC	\$693,232	\$211,345
Providence Center	\$1,256,892	\$393,913
South Shore CMHC	\$497,897	\$149,772
Total	\$5,536,457	\$1,699,784
<i>Source: DMHRH- Mental Health non-Medicaid data</i>		

DMHRH CLIENTS SERVED

Data systems for DMHRH do collect the numbers of consumers served and the numbers of contacts in key service types (General Outpatient and Community Support Services). Unfortunately, these counts of consumers are duplicated across agencies and services. DMHRH did provide unduplicated counts for all individuals served by the CMHCs, however this included all services, those funded by DMHRH, DCYF and other sources.

Table 8 Consumers Served in CMHCs by Fiscal Year						
Age	SFY 2001			SFY 2002		
	GOP	CSP	TOTAL	GOP	CSP	Total
0-17	8,195	0	8,195	8,426	0	8,426
18-59	9,055	6,115	15,170	9,440	6,321	15,761
60-64	245	306	551	240	285	525
65+	486	539	1,025	540	480	1,020
Unknown	15	7	22	6	4	10
Total	17,996	6,967	24,963	18,652	7,090	25,742
<i>*CSP = Community Support Population (adult clients with serious mental illness) *GOP = General Outpatient Population Source: DMHRH Staff</i>						

These data showed just under 25,000 individuals being served in the community in SFY 2001 and a 3% increase to 25,742 in SFY 2002 from all funding sources, including

commercial insurance; 16,746 of these individuals were over 18 in SFY 2001 and 17,306 in SFY 2002. It would appear at first glance that public mental health costs were rising faster than the population being served, however the lack of detail on the sources of funding for CMHC consumers does not support this conclusion. Data collection systems and reporting requirements for individuals served by DMHRH funds would help to address this problem and increase the level of accountability and transparency in the use of public funds.

CMHCs have defined service areas and provide services solely to those individuals living inside these areas. While more than 86% of community mental health center funding is covered by Medicaid, the level of per capita services and other resources may vary across counties. Most public mental health systems across the country have funded services incrementally, adding services and other increases to historical funding levels. To assess for the possibility of geographic disparity in the distribution of funds, the state should conduct a more detailed analysis of the need for mental health services and the distribution of resources by county. As new funds become available, all or a portion of them should be prioritized for areas with greater need.

DMHRH MEDICAID FUNDING

Like DCYF, DMHRH reports total spending for Medicaid and non-Medicaid mental health services in its state budget and other documents. To eliminate this duplication for community mental health services, Medicaid spending for the DMHRH funding code was requested from DHS staff to identify the Medicaid funds that currently support DMHRH mental health services for people in community programs. The data are summarized here, and similar to the DCYF data, supplemental analyses have been provided in the appendix sorted by various demographic characteristics.

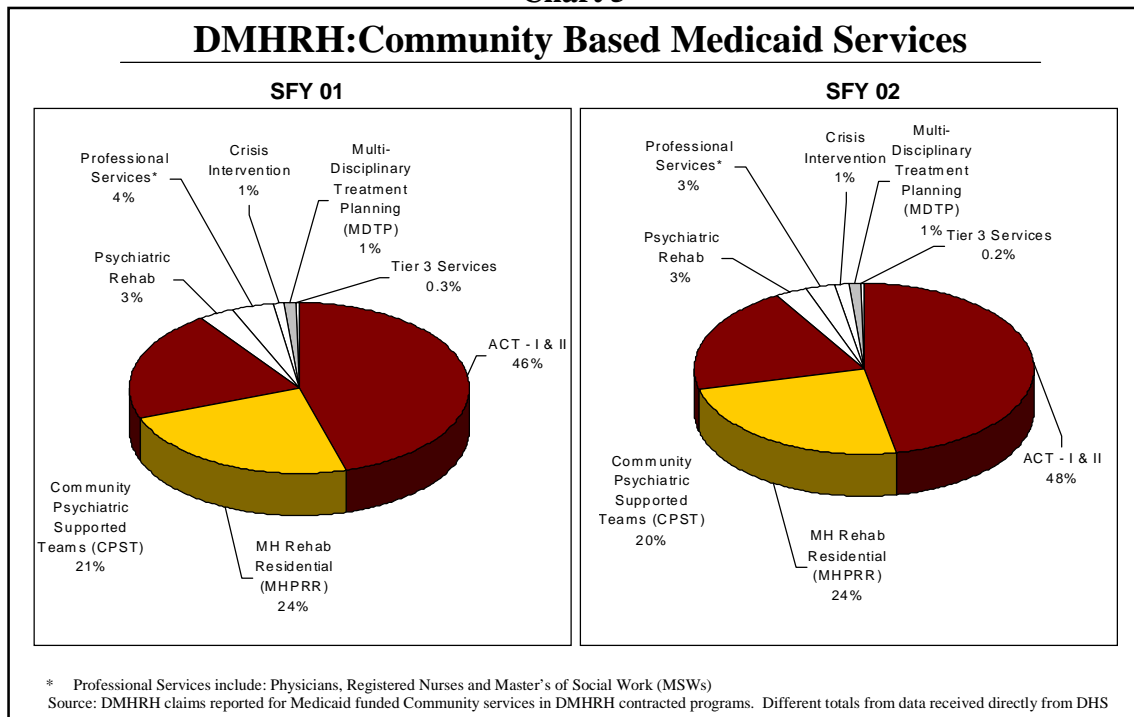
Total DHS reported Medicaid funding for community mental health services in DMHRH was \$43,956,496 and \$51,562,110 for SFY 2001 and SFY 2002 respectively, a 17% increase in funding⁸. Virtually all (95%) of these consumers were Disabled, with approximately 3% in a Special Needs category of assistance and 2% Aged. DHS staff provided a break down into the following service categories:

Table 9			
Total DMHRH Medicaid Expenditures By Service Type			
Type SFY 2001 – SFY 2002*			
Service Type	SFY 2001	SFY 2002	% Change
Behavioral Out	\$43,921,123	\$51,520,958	17%
Behavioral Sub	\$30,295	\$30,472	1%
HCBS	\$5,079	\$10,680	110%
Grand Total	\$43,956,496	\$51,562,110	17%
<i>Source: DHS – Medicaid Claims for DMHRH funding code.</i>			

⁸ DMHRH reported total Medicaid payments by service type as \$45,552,091 and \$47,296,292 in SFY 2001 and SFY 2002. DHS, however, reported \$43,956,496 and \$51,562,110 in each of these fiscal years.

As can be quickly seen, outpatient services are virtually all the services funded by Medicaid under this funding code for DMHRH consumers, and as a result, the categorization does not provide much useful information on the uses of funds. Inpatient services at Slater Hospital are separately reimbursed through Medicaid Fee-for-Service, where DHS assumes the state match. DMHRH provided more information from their records on the Medicaid billing from CMHCs under contract with DMHRH. This additional detail is included in the next chart. The spending levels did not reconcile with the data we obtained from DHS due to differences in the information systems, yet the percentages of funds are very likely the same⁸. This information provides important detail about the mix of services funded by Medicaid in the adult community mental health system.

Chart 5



Specifically, Medicaid funds three primary community based services to individuals served by DMHRH. In fact more than 90% of the Medicaid funds support RI ACT I, MH Psychiatric Residential Rehabilitation (MHPRR) and Community Psychiatric Supported Teams (CPST). Each of these services provides differing levels of support to consumers living in the community or in community based housing programs for those with mental illness. RI ACT I services provide different levels of intensity of coordinated case management for people with serious mental illness. Services are generally reimbursed on a per diem basis. MHPRR services are the active treatment and support services (counseling, casework, medication management, skill assessment and development, etc.) delivered to individuals living in Psychiatric Rehabilitative Residences. Services are reimbursed by Medicaid on a per diem basis. These are supplemented housing and room and board costs that are paid with client funds and with

some DMHRH support. CPST services are designed to maintain individuals in the community including treatment planning, case management, symptom self-management, coordination of income supports and other community services, etc. Services may be reimbursed on a per diem (for individuals living in a psychiatric residence not covered by MHPRR services) or per unit basis. Individuals covered by RI ACT I services are not generally eligible for CPST services. DMHRH has creatively developed these services to expand the Medicaid coverage for individuals in the community under the Rehabilitation Option of Medicaid.

In addition to community services funded by Medicaid, DMHRH receives Medicaid reimbursement for services at Slater Hospital. While the exact amount of funds received by Slater Hospital for mental health services was not separately reported by DHS, Medicaid Fee-for-Service for the disabled inpatient mental health services funded \$14.6M in SFY 2001 and \$15.8M in SFY 2002. The greatest percentage is likely to be Slater Hospital⁹.

SUMMARY

To determine the Medicaid contribution to state mental health spending within DMHRH, we had also requested data from DMHRH non-Medicaid Expenditures. We sought to verify these figures by using the state budget figures (Audited for 2001 and Unaudited for 2002) and subtracting the Medicaid funds from these totals. The numbers are close but vary across the fiscal years in different directions. This suggests that there may have been differences in accounting for the two fiscal years, perhaps related to Medicaid claims lag. In order to be consistent with the other data from DHS, we have elected to calculate the non-Medicaid portion by deducting Medicaid reported funding from the state budget figures. Thus the Medicaid and non-Medicaid spending for DMHRH services can be summarized as follows:

Table 10		
DMHRH Summary of Mental Health Funding		
	SFY 2001	SFY 2002
Non-Medicaid Community Services*	\$12,402,883	\$10,091,312
Medicaid Community Services	\$43,956,496	\$51,562,110
<i>Total Community Services**</i>	<i>\$56,359,379</i>	<i>\$61,653,422</i>
Inpatient – Slater	\$18,697,519	\$21,609,562
Total Mental Health DMHRH (plus Slater)	\$75,056,898	\$83,262,984
<small>* State Only includes General Revenue, Block Grant, certain federal grants and Disproportionate share – Calculated as a net of Medicaid funds from the State Budget</small>		
<small>** Variance from funding reported State Comptroller due to different data sources.</small>		

⁹ These Medicaid spending figures differ from the estimates included in Table 6 because Table 6 included all people (Medicaid and Non-Medicaid) with a mental health diagnosis who were placed in Slater Hospital.

Note these expenditures do not include all Medicaid funds for DMHRH consumers. Medicaid spending for services at Slater Hospital are included in Medicaid Fee-for-Service expenditures and DHS pays the state match for these services. This is another example of the complexity created by having multiple funding sources for community and inpatient services.

Per client costs were not able to be calculated since the unduplicated number of clients served by DMHRH was not available.

Department of Human Services (DHS)

Medicaid Fee-for-Service

The Medicaid Fee-for-Service (FFS) program provides services to individuals who are either not enrolled in managed care or covers services that are exempt from managed care. Expenditures grew significantly (by 30%) from 2001 to 2002 despite the fact that over the last number of years, DHS has sought to significantly expand enrollment in its managed care program, RItE Care.

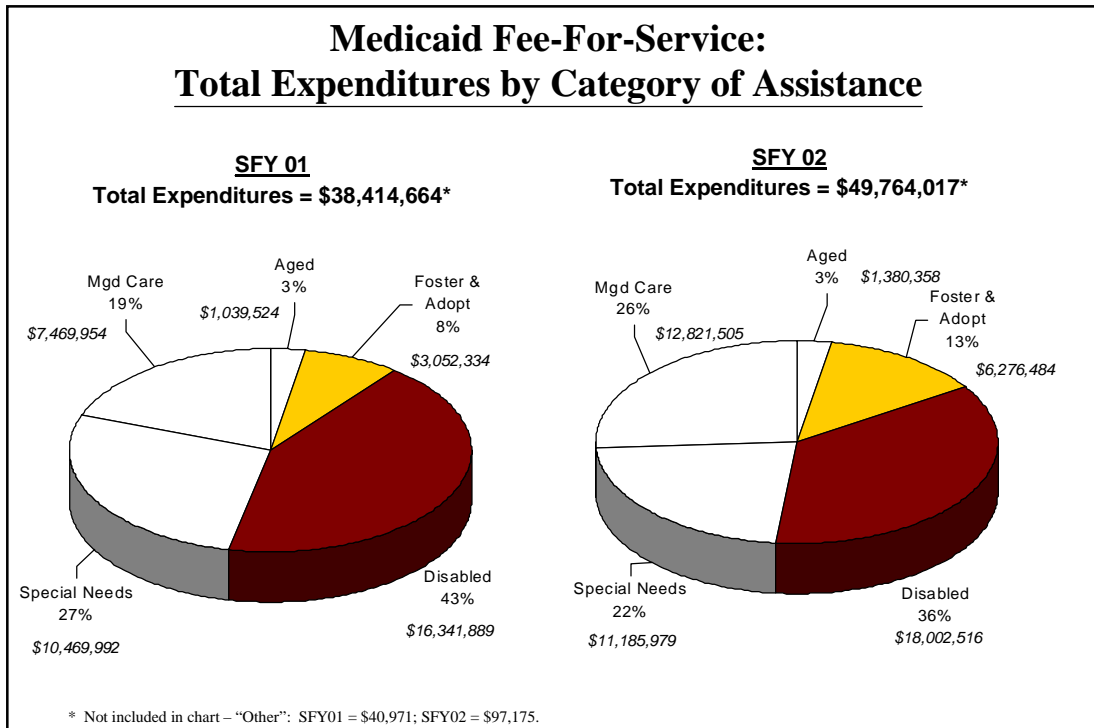
Medicaid Fee-for-Service expenditures, include the following:

- Medical Assistance services to adults over the age of 65;
- Medical Assistance services to individuals (adults and children) with disabilities;
- Medical Assistance services to Medicaid eligibles for services that are excluded from managed care, such as Children’s Intensive Services.

Medicaid FFS funding for mental health services for individuals not enrolled in managed care and individuals for whom the Medicaid state match is funded by DHS are reported here. Previous sections of the report have described the Medicaid Fee-for-Service funding for services provided and overseen by DCYF and DMHRH.

DHS pays the state match for some of the services to the DCYF and DMHRH populations including CIS services for youth and inpatient hospital services for the disabled.

Chart 6



FFS funding increased by 30% between SFY 2001 and SFY 2002 from \$38,414,664 to \$49,764,017. Overall, disabled services continued to have the highest proportion of total expenditures in both years, accounting for 43% and 36% in SFY 2001 and SFY 2002. Special Needs expenditures went from 27% to 22% of total expenditures, while Aged remained small but stable comprising 2% to 3% of total spending in both years.

Expenditures for Foster Care and Adoption more than doubled and managed care grew significantly; Foster Care and Adoption expenditures increased from 8% to 13%, or 51% over the two years. Managed care costs rose by more than 70%, accounting for 19% of FFS spending in SFY01 and 26% in SFY02.¹⁰

Table 11 Total Expenditures By Category of Assistance SFY 2001 – SFY 2002			
Category of Assistance	SFY 2001	SFY 2002	% Change
Aged	\$1,039,524	\$1,380,358	33%
Foster & Adoption	\$3,052,334	\$6,276,484	51%
Disabled	\$16,341,889	\$18,002,517	10%
Special Needs	\$10,469,992	\$11,185,979	7%
Managed Care	\$7,469,954	\$12,821,505	72%
Other*	\$40,971	\$97,175	137%
Grand Total	\$38,414,664	\$49,764,017	30%
* “Other” Category of Assistance includes: Ancillary; Behavioral Sub; Early Start; Other Pract; Outpatient and Physician Source: DHS-Medicaid claims for Other funding code.			

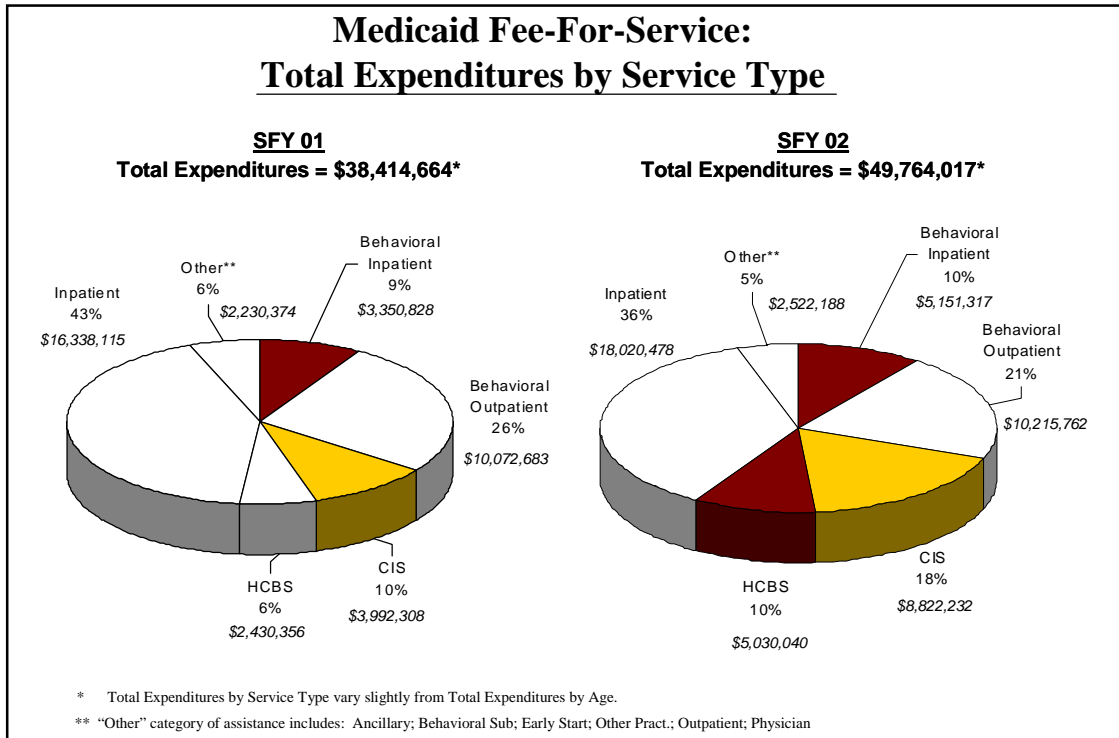
Chart 7 shows the distribution of Fee-for-Service expenditures by service type. Inpatient services were the largest single source of expenditures, ranging from \$16,338,115 in SFY 2001 to \$18,020,478 in SFY 2002, but the percentage of spending dropped from 43% to 36%. Behavioral outpatient services accounted for about \$10M each year, ranging from 26% of total expenditures in SFY 2001 to 21% in SFY 2002. ‘Other’ service expenditures, which include costs for Ancillary, Behavioral Substance Abuse, Early Start, Other Practitioners, Outpatient and Physician services also remained stable (5% to 6%) in both years. Home and Community Based Services (HCBS) increased significantly from 6% to 10% of the total expenditures.

Behavioral inpatient service expenditures increased, but its share of total spending remained at about 10% in both years. CIS (Children’s Intensive Services) expenditures experienced significant changes in spending. In SFY 2001, total spending for these

¹⁰ During this period, DHS went through changes to their accounting codes, largely as a result of the increasing enrollment in Rite Care of children from DCYF. As a result we have merged reporting for Adoption and Foster Care categories

Chart 7

**Medicaid Fee-For-Service:
Total Expenditures by Service Type**



services were \$3,992,308, however, in SFY 2002, CIS expenditures doubled and these services accounted for 18% of total spending in SFY 2002. As discussed earlier in this report, this increase in spending was due to a change in policy, whereby children receiving CIS services through DCYF were moved into RIt Care and as a result the financial responsibility (state match) for CIS services transferred to DHS. Spending growth for each service is shown in the table below.

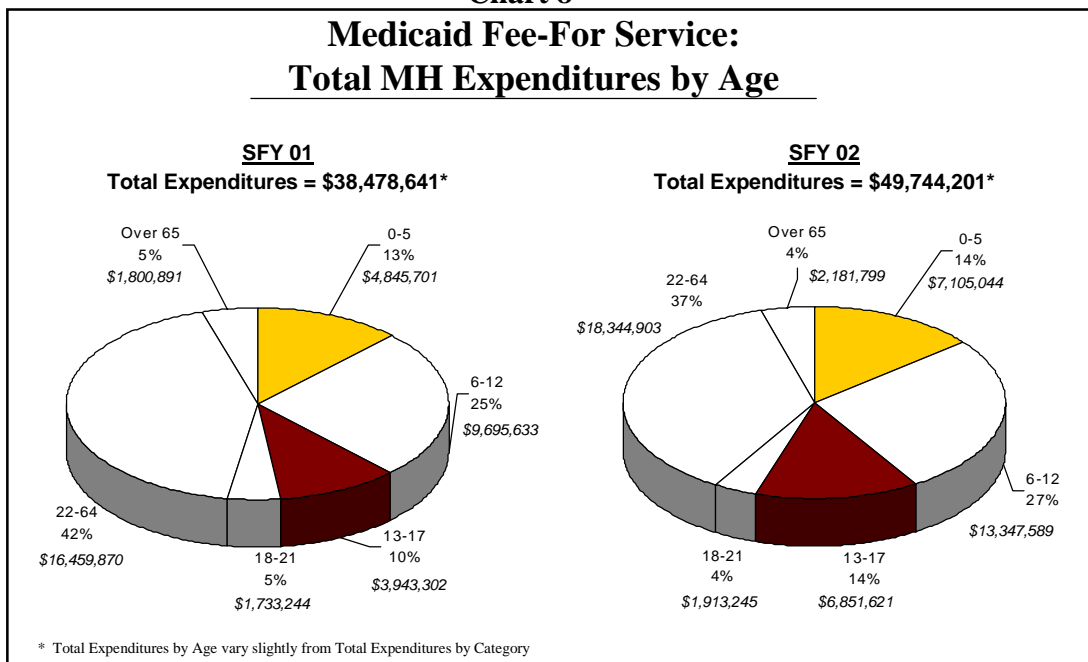
Service Type	SFY 2001	SFY 2002	% Change
Behavioral Inpatient	\$3,350,828	\$5,153,317	54%
Behavioral Outpatient	\$10,072,683	\$10,215,762	1%
HCBS (Home & Community Based Services)	\$2,430,356	\$5,030,040	107%
Inpatient	\$16,338,115	\$18,020,478	10%
Other	\$2,230,374	\$2,522,188	13%
CIS (Children’s Intensive Services)	\$3,992,308	\$8,822,232	121%
Grand Total	\$38,414,664	\$49,764,017	30%

Source: DHS-Medicaid claims for Other funding code.

Behavioral Inpatient, Home and Community Based Services (HCBS) and Children's Intensive Services (CIS) accounted for more than \$9.2M of the \$11.3M increase in services or almost 24% of the total 30% growth rate.

Total expenditure distributions by age (Chart 8) shows growth in the percentages of spending for all age groups of children under 18 between SFY 2001 and SFY 2002. The percentage of spending for adults, aged 22-64 declined by 5%, accounting for 37% of the spending in SFY 2002, though the overall expenditures increased. Spending for children, ages 0 through 17 grew from 48% to 55% of total spending. Spending increased by nearly 75% for 13-17 year olds. For individuals 65 and over, spending increased slightly but the proportion (5%) of total spending for this group declined to 4%. Again, these findings document changes associated with the growth in enrollment of high risk and high need children from DCYF and the exclusion of some services from a growing managed care population.

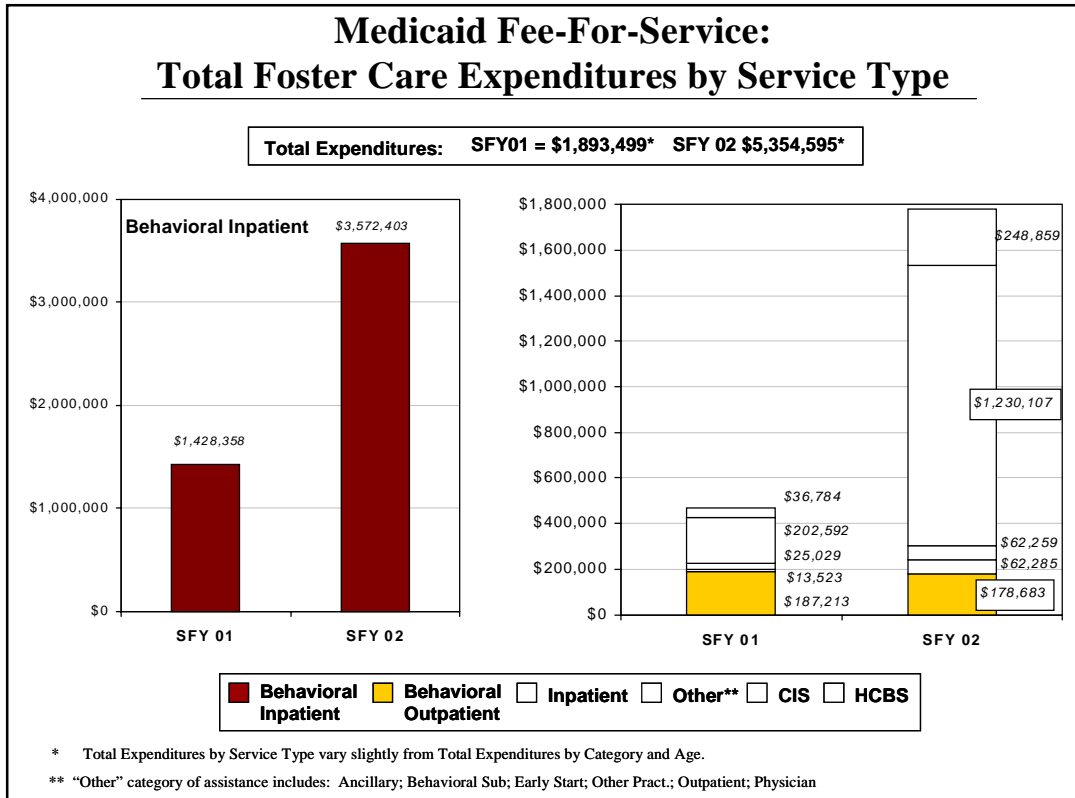
Chart 8



The charts below summarize services by Category of Assistance where the major growth occurred and where there were significant differences in the service mix. These include Foster Care, Disabled, Special Needs and Managed Care categories of assistance. By reviewing the differences in the mix of services funded for each category of assistance, some of the unique characteristics of the Medicaid Fee-for-Service benefit emerge.

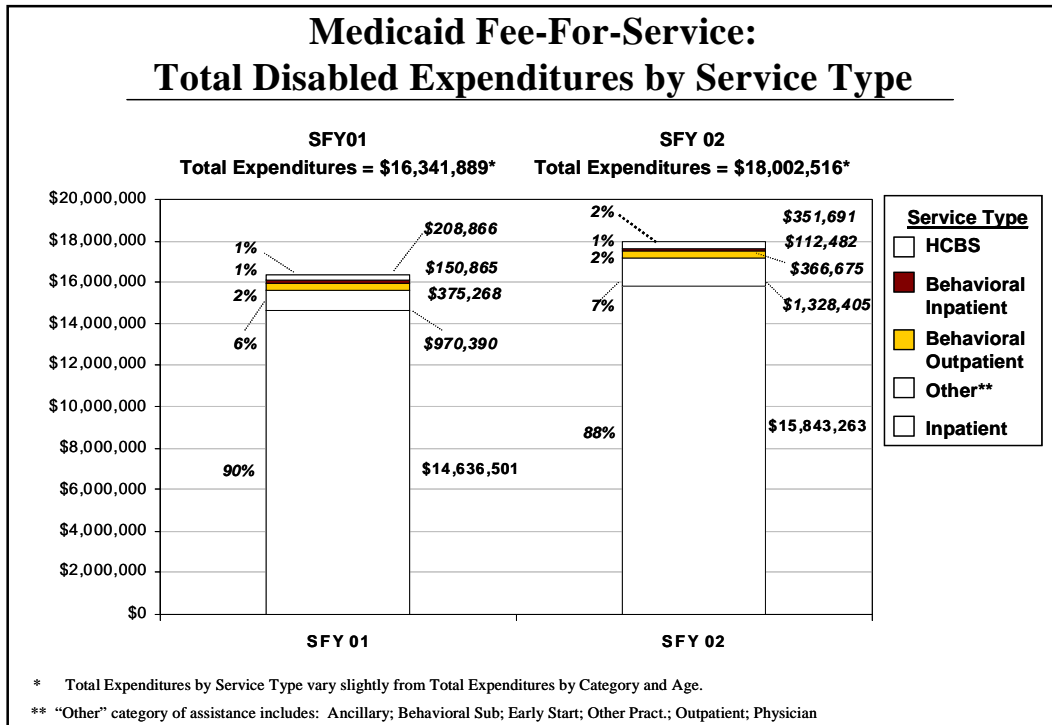
Foster Care expenditures showed significant growth in inpatient services. Note that DCYF Medicaid also provided significant funding for the inpatient benefit. CIS services and to a lesser degree, HCBS services also showed growth between SFY 2001 and SFY 2002. The growth in Fee-for-Services spending by DHS for these service types reflects the growth in RItE Care enrollment for many of these youth. In subsequent years, some of these costs were shifted over to RItE Care.

Chart 9



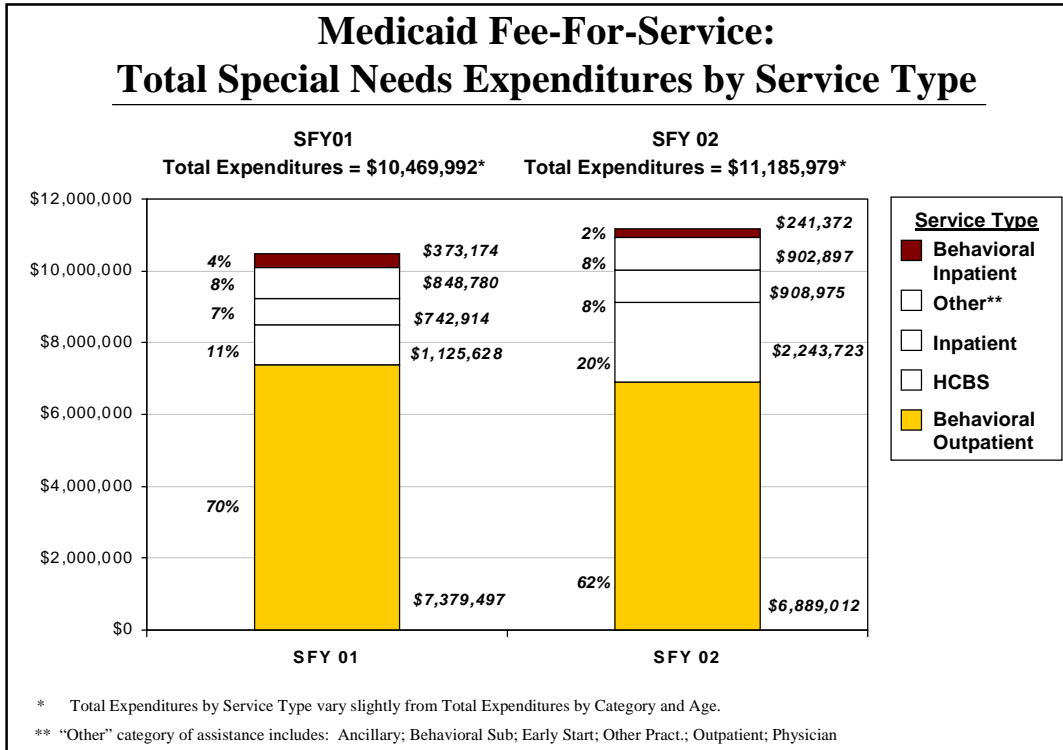
As shown in Chart 10, the highest percentage of Fee-for-Service Medicaid expenditures for mental health services to the disabled were for inpatient services. These are predominantly inpatient services at Slater Hospital where DMHRH provides services for the disabled.

Chart 10



Special Needs expenditures in Medicaid Fee-for-Service rose by 7% overall. Behavioral Outpatient services declined in spending by almost \$500K and by 8% of the overall spending. Home and Community Based services increased however by more than \$1M and by 9% of overall spending. Other categories of service remained relatively constant.

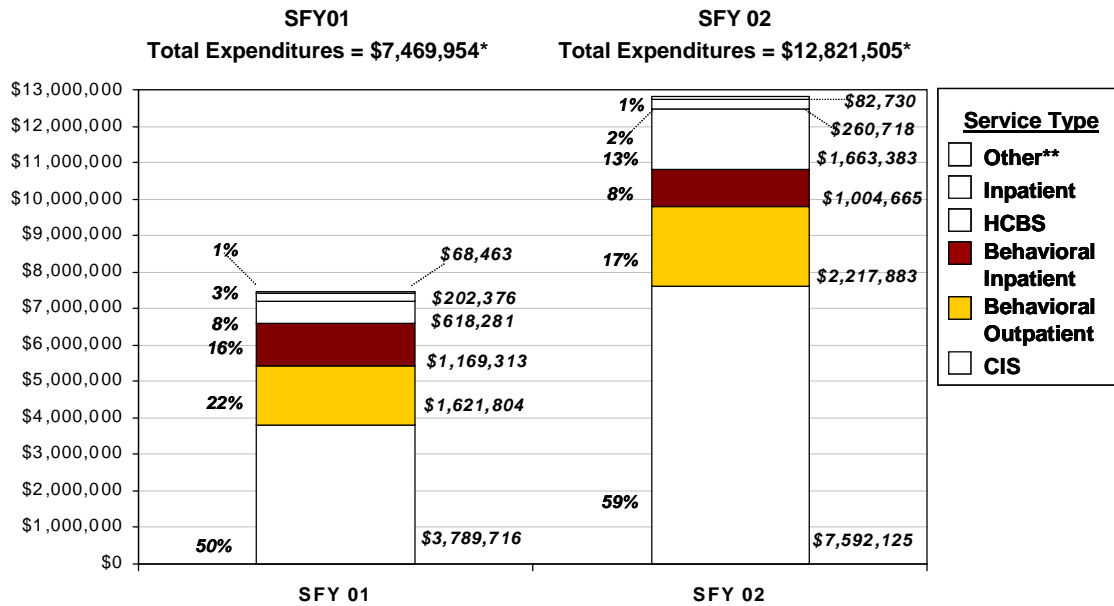
Chart 11



Fee-for-Service expenditures for individuals enrolled in Managed Care (Chart 12) rose by 72% in SFY02. The increase was primarily due to the doubling of costs for CIS services, which was due to the increased enrollment of DCYF children in Foster Care Adoption subsidy in RItE Care. In addition, Home and Community Based services for managed care enrollees increased by almost 170%.

Chart 12

Medicaid Fee-For-Service: Total Managed Care Expenditures by Service Type



* Total Expenditures by Service Type vary slightly from Total Expenditures by Category and Age.
 ** "Other" category of assistance includes: Ancillary; Behavioral Sub; Early Start; Other Pract.; Outpatient; Physician

SUMMARY

Total expenditures increased by 29% from SFY 2001 to SFY 2002 for Medicaid Fee-for-Service expenditures. This includes those individuals and services not enrolled in RItE Care, as noted earlier. However, the numbers of individuals served increased by a much smaller percentage. As a result, the cost per client increased by almost 32% for children and by almost 6% for adults.

**Table 13
Fee-for-Service Medicaid – Cost per Client**

	Total \$*	Clients	Cost/Client
SFY 2001 -Child	\$20,217,881	5,527	\$3,658
SFY 2001 - Adult	\$18,260,760	9,627	\$1,897
SFY 2002 - Child	\$29,217,499	6,058	\$4,823
SFY 2002 - Adult	\$20,526,702	10,250	\$2,003

* Total Expenditures by Age vary slightly from Total Expenditures by Category of Assistance and Service Type
 Source: DHS Claims Analysis

The very different mix of services for each category of eligibles highlights the different uses of funds and different benefits available to these groups under Medicaid Fee-for-Service expenditures. DHS should continue to clearly indicate the Medicaid services provided to enrollees who are excluded from managed care and the supplemental services provided by DHS through Fee-for-Service to different groups of managed care enrollees. This will help to clarify the scope of Medicaid benefits provided to the different populations covered by Medicaid and served by the different state agencies.



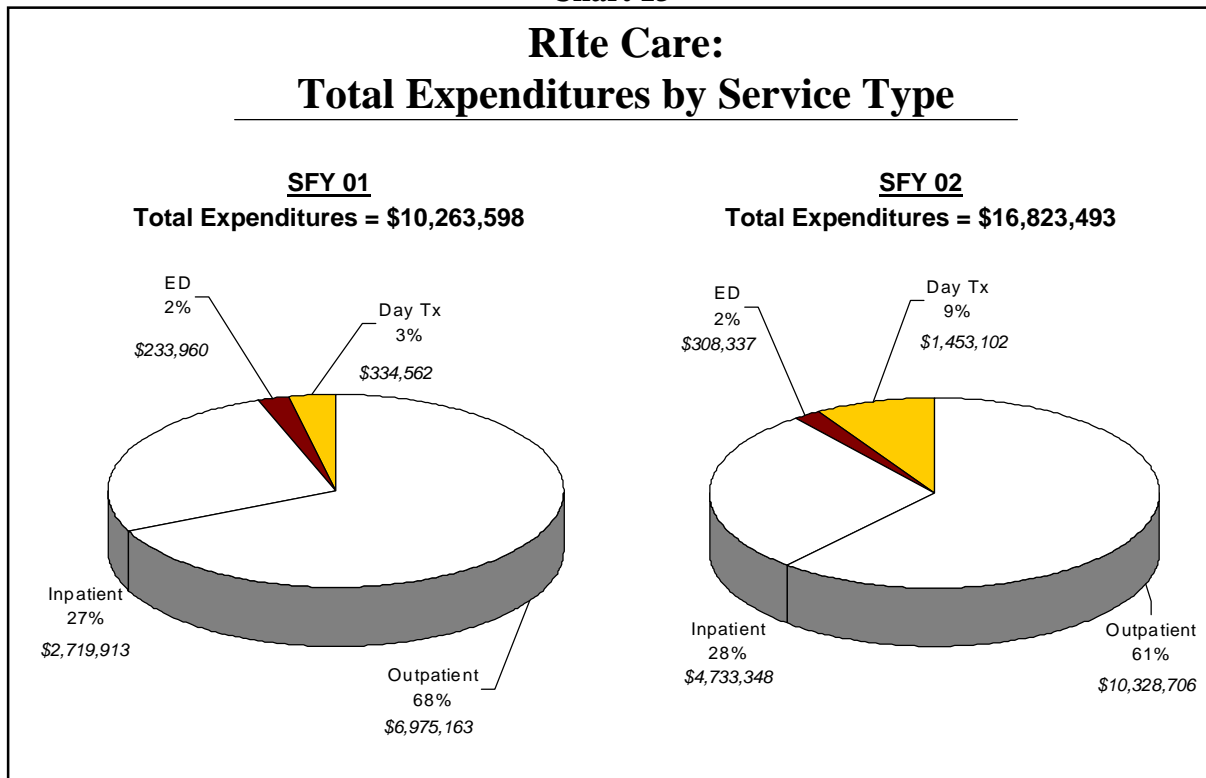
DHS: Medicaid Managed Care Rite Care

Rite Care data were provided by DHS from the encounter data submitted by Rite Care Health Plans and maintained by DHS. This database included claims paid by the Rite Care HMOs and the respective behavioral health benefit manager contracted for services. Services for mental health diagnoses were extracted and a summary prepared by DHS. The format for this summary was slightly different than other DHS data and while unduplicated counts were provided for each service, the totals were duplicated across services.

Total Rite Care enrollment grew by 5% over the two fiscal years. End of year enrollment for SFY 2001 was 111,624 and for SFY 2002 there were 117,024 enrollees at the end of the year. Many of the new enrollees were reported to be DCYF youth.

Rite Care mental health spending by the Health Plans increased substantially (64%) from SFY 2001 to SFY 2002, despite the relatively small increase in enrollment. All services experienced some increase in expenditures. Outpatient services dominated managed care spending and grew by 48% from SFY 2001 to SFY 2002. Outpatient services as a percentage of total spending, however, accounted for 68% of total costs in SFY 2001 and 61% in SFY 2002. Inpatient spending increased in SFY 2002, however the proportion of total spending remained relatively constant at 27% to 28% of total expenditures for both years.

Chart 13



MH ED services incurred a small increase but accounted for only 2% of total spending in SFY 2001 and SFY 2002. However, day treatment costs increased more than four times in SFY 2002, from 2% to 9% of total managed care spending.

Overall expenditures for Rite Care grew significantly across all age groups from SFY 2001 to SFY 2002. Age group 22-64 had the highest levels of spending in both years, and experienced an increase from \$6,031,710 to \$8,337,461, or 38% over two years. For all other age groups, expenditures were in most cases, twice as much in SFY 2002 compared to SFY 2001.

Chart 14

**Rite Care:
Total Expenditures by Age**

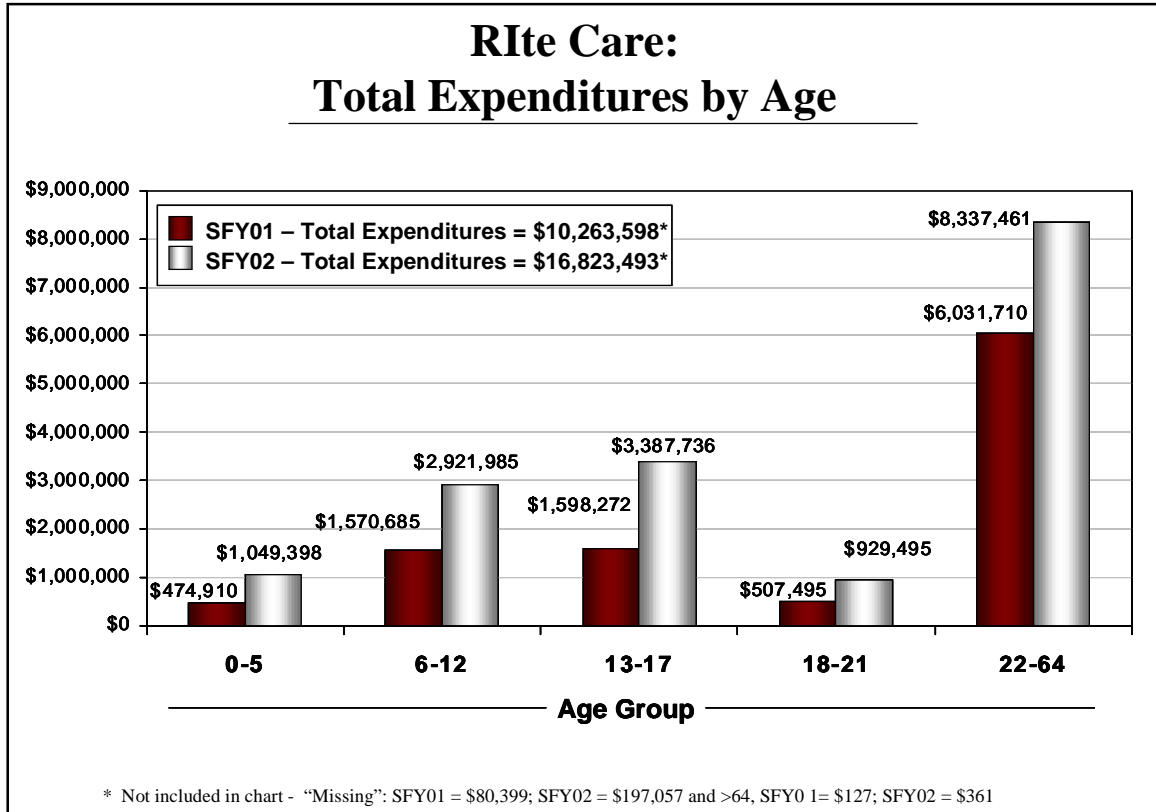
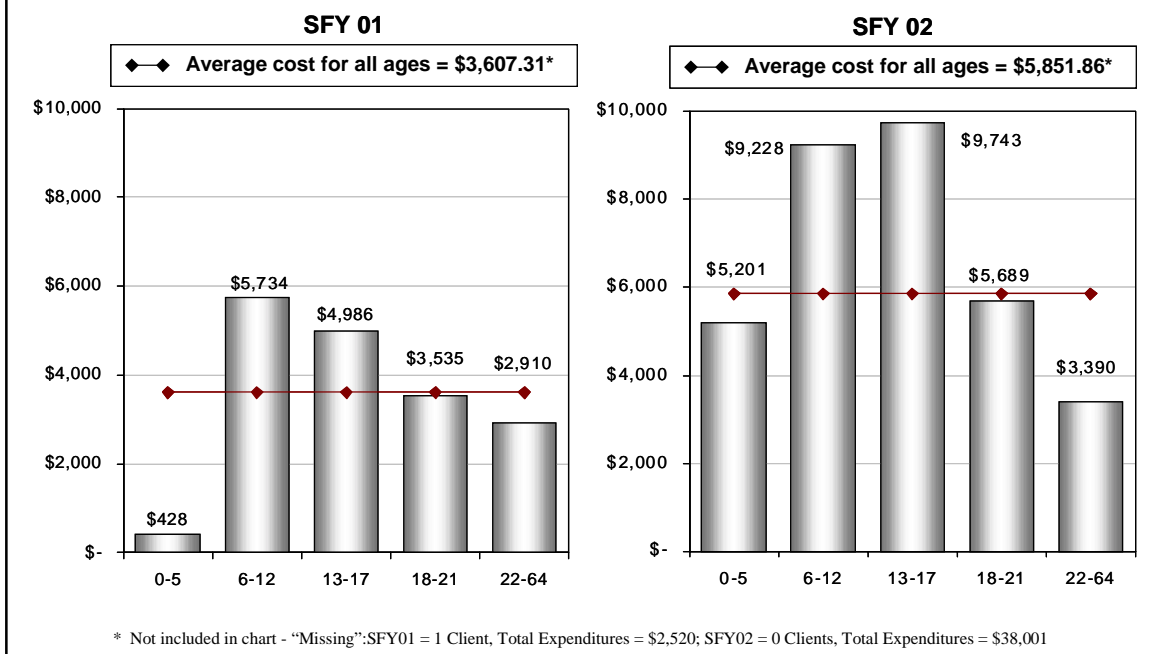


Chart 15

**RItE Care:
Average Inpatient Cost per Client by Age**

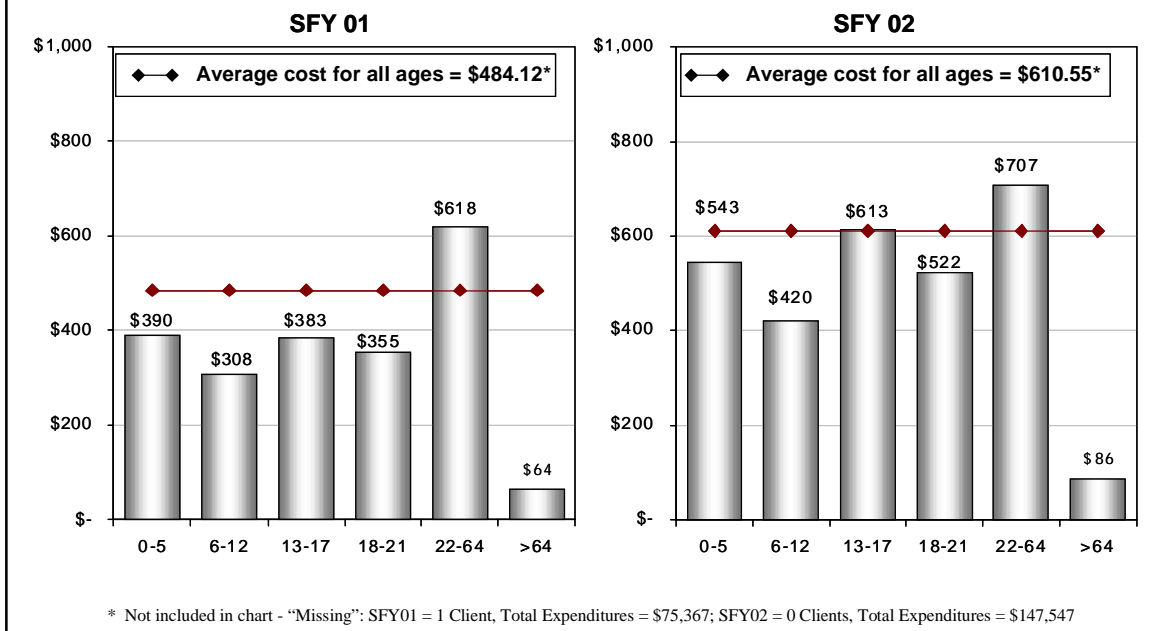


While inpatient expenses remained relatively constant in percentage terms, average inpatient costs per client (Chart 15) increased significantly by 62% between SFY 2001 and SFY 2002; for some age groups such as adolescents (ages 13-17), average costs more than doubled between years. Average inpatient costs increased more than ten times for children ages 0-5 from SFY 2001 to SFY 2002. Similarly, costs per client served almost doubled for youth 13-17 years old and increased 60% for 6-12 and 18-21 year olds. These increases were almost certainly the result of the enrollment of DCYF foster care youth in RItE Care between SFY 2001 and SFY 2002. Meanwhile, individuals from 22-64 years of age experienced the least growth in inpatient costs per client (17%) between SFY 2001 and SFY 2002.

In comparison to inpatient services, outpatient average costs per client served (Chart 16) increased by about 30% between SFY 2001 and SFY 2002. Costs per client rose throughout all age groups, in some cases significantly. Although, adults aged 22-64 had the highest costs per client served in both years, this group experienced the least growth (14%) from SFY 2001 to SFY 2002. Adults aged 65 and over are eligible for Medicare and thus are not eligible for RItE Care, however, some outpatient costs were reported for this age group. For children between ages 0-5 years old and 6-12 years old, average costs per client served rose by about 40%. Moreover, age groups 13-17 and 18-20 experienced the most growth, averaging between 60% for the former and 50% for the latter. As with the increases in inpatient costs that we saw for youth, the increases in outpatient spending were likely the result of the increasing enrollment of youth from DCYF into RItE Care.

Chart 16

Rite Care: Average Outpatient Cost per Client by Age



COST PER CAPITA AND PENETRATION

Overall, Rite Care mental health service costs per member month were calculated as \$12.08 pmpm for SFY 2002 based upon the reported service costs and the total monthly enrollment figures that were provided (but only available for SFY 2002). Note that this rate does not include the costs of administration and care management by the behavioral healthcare organization or the Rite Care Plan. Costs for each of the health plans and the behavioral healthcare organizations with which they contract with may vary significantly.

Despite changing enrollment, increasing use of inpatient services, higher costs per client served and increasing overall mental health costs, the outpatient penetration¹¹ rates for Rite Care remained somewhat stable from SFY 2001 to SFY 2002 at 13% and 14% respectively¹². Note that overall penetration rates could not be calculated because an unduplicated count of clients across all services was not available. Outpatient penetration, however, is likely to include most consumers and is a reasonable proxy for the overall penetration rates. It is also a rate that is above the average rate to other

¹¹ Penetration rates are a measure of access to care and are calculated here by dividing the number of unique individuals receiving services by the total number of individuals eligible for services. This denominator is generally expressed as the average monthly enrollment but is also sometimes calculated as the total number of individuals eligible for care at any point during the year.

¹² Year-End Enrollment figures were used for the Outpatient Penetration rate calculations: SFY 2001 = 111,624; SFY 2002 = 177,024. Average monthly enrollment would have been a lower figure and thus would have resulted in higher penetration levels, however the average enrollment data were not available for SFY 2001.

Medicaid Managed Care initiatives. (See section on Comparison Data.)

SUMMARY

In summary, RItE Care experienced significant growth in its mental health service costs between SFY 2001 and SFY 2002. Based upon our discussions with state officials and the nature of the spending growth, the increasing enrollment of youth in DCYF custody appears to be a major contributor to the increases. As these RItE Care costs were increasing, so also were other costs for services for this population, such as DCYF expenditures and CIS under Fee-for-Service Medicaid.



Department of Corrections

The Rhode Island Department of Corrections (DOC) is responsible for every adult under correctional supervision in the state. DOC provides mental health treatment including psychiatric medication to a portion of this incarcerated population through full time, part time and contracted mental health personnel to adults in the DOC correctional institutions. DOC was unable to provide specific utilization and cost data on the number of individuals receiving mental health therapy.

DOC reported that personnel costs for providing mental health services are approximately \$1 million per year. Specific data for each fiscal year was not available. These mental health costs are completely funded using state general revenues; there are no federal or other sources of revenue.

While not reported for other departments, DOC reported data on the spending and numbers of individuals receiving psychiatric medications. These are reported here because they give an estimate of the need for services that is not available from the other sources.

Table 14		
Department of Corrections – Adult Psychiatric Medication Expenditures and Utilization		
	CY 01	CY 02
Average # of Inmates Receiving Psychiatric Medications	580	721
Average Total Prison Population	3,348	3,394
Estimated Percent of Prison Population Receiving Psychiatric Medications	17.3%	21.2%
Cost of Psychiatric Medications	\$806,753	\$878,229
Average Cost per Inmate Receiving Psychiatric Medication per Year	\$1,391	\$1,218
<i>Source: Department of Corrections</i>		

The DOC data displayed above shows that 17.3% to 21.2% of the adult prison population in Rhode Island received psychiatric medication. Comparison data from the *2000 Census of State and Federal Adult Correctional Facilities* show that nationally an average of 10% of inmates in state prisons receive psychotropic medication.¹³ These estimates are

¹³ Beck, A. and Maruschak, L., *Mental Health Treatment in State Prisons, 2000*; Bureau of Justice Statistics Special Report, U.S. Department of Justice, July 2001, www.ojp.usdoj.gov/bjs.

somewhat lower than other national estimates for health plans, where as much as 20% to 30% of the covered population may receive psychiatric medications of one form or another. Of course, there may be significant differences in the formularies used by DOC and the formularies of other health plans. The costs for psychiatric medications per individual were \$1,391 in CY 2001 and \$1,218 in CY 2002.

The total cost per year for both personnel costs and psychiatric medications was approximately \$1.8 million in 2001 and \$1.9 million in 2002. Since our other data requests did not include the costs of psychiatric medication, DOC mental health service costs have been estimated at \$1 million per year. Given the nature and the scope of mental illness throughout the prison population, more detailed records of counseling and medication management costs should be provided in the future.

Department of Health

School Based Health Clinics

All of Rhode Island's seven school-based health centers are operated by Federally Qualified Community Health Centers (FQHC). The school-based health centers receive core support from state funds. Portions of those state funds are matched with Medicaid. The Centers have been successful in diversifying their revenue mix, with five of the seven Centers having secured outside sources of funding. Cash-match and in-kind contributions from schools and their medical partners are an essential component of the revenue mix. Centers bill third parties for services provided.

There are several models for mental health services at the Centers. In Woonsocket the operating agency contracts with a local community mental health provider for services. The mental health clinician provides services on site at the Centers. The mental health provider has been able to bill private insurances and Medicaid for some students totaling roughly \$14,000 a year. Also, in Woonsocket federal funds support a part-time psychiatric consultant to support the nurse practitioner particularly around psychiatric medication issues. The psychiatrist may see students on a limited base as appropriate.

In Providence, funding from the school department supports a part-time social services provider. The Center cannot bill for those services because the provider is not a credentialed social worker. In Pawtucket during SFY 2001-20002 the operating agency had one social worker on staff for two sites, however, billing costs cannot be obtained due to the change in operating agency. In Central Falls the Centers did not have a mental health provider on staff and referred students to an outside agency for mental health services. Currently, the Central Falls and Pawtucket Centers are operated by one agency and have two social workers on staff for three sites. They are able to bill for services.

Centers collect the number of services provided and not all centers are able to give specific categorical breakdown for those services. The behavioral health data for SFY 2001-2002 reflects a 28.4% decrease over a three-year period. Recruiting and sustaining sufficient staff to provide behavioral health care continues to be a struggle for the Centers. Students are generally seen one-on-one rather than in groups. Finding adequate space in already crowded school buildings is a major issue that drives this practice.

DHS sought to identify any mental health services billed to Medicaid under the local services funding codes. None were reported for SFY 2001 and SFY 2002. It was somewhat surprising not to find any claims for mental health services under the DHS Local Services Funding Code, though it may be that assessments and screening were performed as an EPSDT screen or another assessment, and those youth who were found in need of mental health services were either billed directly by the FQHCs to Medicaid or they were referred to Community Mental Health Centers.

Recommendations from DOH staff to strengthen capacity of the Centers to provide behavioral health include: increase the preventive health capacity of the Centers overall;

provide services in group settings as appropriate; contract with a psychiatrist to assess school behavioral health needs; develop formal linkages with schools of social work and psychology to increase capacity; and provide services by licensed credentialed providers to enable billing for these services.

School-based health centers offer a promising practice for mental health services for youth. The RI Departments of Health and Human Services are to be commended for their efforts to expand funding and availability of mental health services for youth in school settings. As the use of these services expands it will be more important to identify and separately track the mental health utilization and cost.

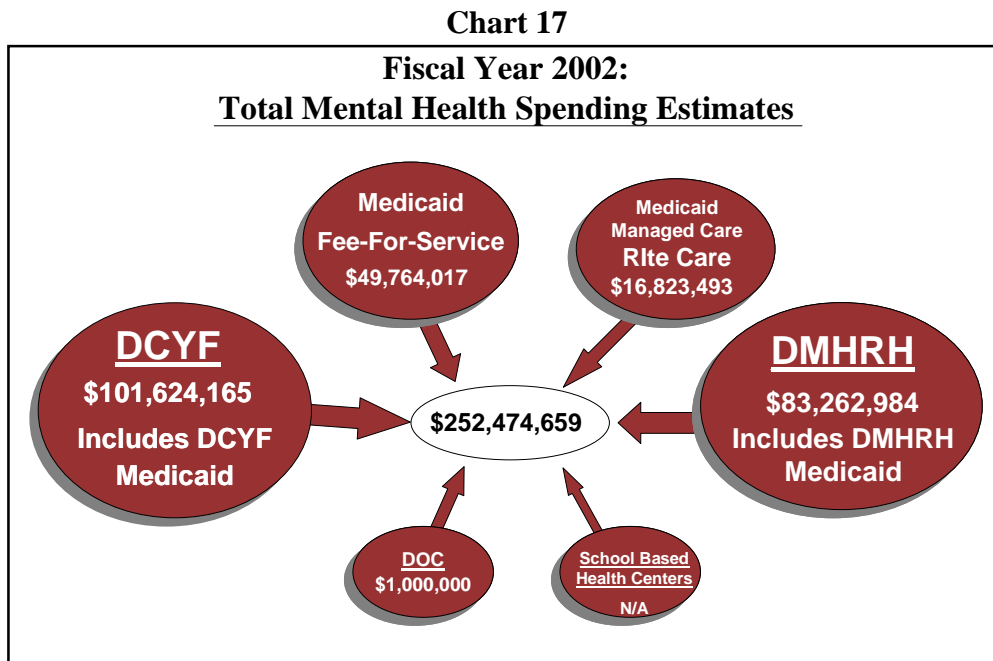


Rhode Island Mental Health Services

Total Expenditures

Based upon the preceding analysis and summary of claims, total expenditures for mental health services were \$220,809,667 in SFY 2001 and \$252,474,659 in SFY 2002. They increased by 14% across all funding sources between the two fiscal years. The increases occurred primarily in Medicaid related services – Fee-for-Service, RItE Care and in the Medicaid funding codes for DMHRH. Of the various Medicaid funding streams, only DCYF Medicaid showed a decrease in funding as DCYF youth were enrolled in managed care. However, overall DCYF spending increased by almost 6%.

Agency	SFY 2001	SFY 2002	% Change
DHS - Fee-for-Service Medicaid	\$38,414,664	\$49,764,017	30%
DCYF	\$96,074,507	\$101,624,165	5.8%
DMHRH	\$75,056,898	\$83,262,984	11%
RItE Care	\$10,263,598	\$16,823,493	64%
Department of Corrections	\$1,000,000	\$1,000,000	n/a
Department of Health (FQHCs)	n/a	n/a	n/a
Total	\$220,809,667	\$252,474,659	14%



Reimbursement Rates for Mental Health Services

As with many state mental health systems, reimbursement methods for mental health services in Rhode Island vary considerably depending upon the department and the type of service. For instance:

- DMHRH reimburses its services through several mechanisms: direct appropriation, grants, and unit rates. Line-item appropriations fund the state employees and facility costs at the Slater Hospital, and cost reimbursement grants fund the nine contracts with community mental health centers and other community agencies for the Non-Medicaid population. Since these costs are reimbursed under line-item contracts, they are not comparable from state to state. Slater Hospital does have a cost-based per diem rate used for Medicaid, Medicare and other insurance billing, however.
- DMHRH also funds the state share of costs for rehabilitative services to Medicaid eligible recipients. These services are reimbursed to providers on a unit rate basis and thus may be comparable to other rates for services, however, service definitions vary widely (e.g., RI ACT 1, etc.) and we were not able to find comparable services and rate methods.
- DCYF reports costs for line-item contracts with the eight CMHCs. Psychiatric Hospitalization services are billed to Medicaid and then charged to the DCYF budget for DCYF youth. Residential treatment services are reported in the DCYF Child Welfare budget and billed to DCYF who generates the Medicaid claims for services. Facility costs were not compared because the complexity of analysis was beyond the scope of this analysis.
- Department of Corrections funds mental health services for incarcerated individuals through staff and contracted positions in the correctional facilities.
- Local schools may deliver some mental health services but there were no claims by School Based Health Clinics for mental health diagnoses separately reported by Medicaid. It would seem that these services are referred to CMHCs or other providers and billed to Medicaid directly.
- Medicaid pays for services on a unit-basis, but again the complexity of company facility based services and rates were beyond the scope of this analysis. The rates for professional services are more directly comparable however.

Reimbursement rates for public mental health services have historically lagged behind commercial plans, until the widespread introduction of managed care. To investigate the adequacy of rates in Rhode Island, the rates offered by Rhode Island Medicaid and other agencies for professional services were compared with Medicaid rates of several neighboring states, including Massachusetts, Maine, Vermont, Connecticut and Illinois. For comparability purposes, wherever possible, rates were collected for states as of July 1, 2002. The biggest challenge to this relatively simple task was that the service categories for rates and qualifications for providers were quite different in each of the comparable states. As a result, the interstate analysis was limited to psychotherapy visits for a “one-hour” encounter (45 to 50 minutes in most states).

Public sector rates differ widely from state to state. In Rhode Island, rates also differed significantly between DMHRH, DCYF and Medicaid for comparable service types. The Department of Children, Youth and Families has been working to significantly increase its publicly funded outpatient mental health provider rates over a period of several years, and focused particular attention on increasing the rates during SFY 2002 and SFY 2003. The adjusted rates were put into effect in SFY 2004.

For instance, Physician Assessments (1.5 hours) in DMHRH were reported to be \$288 per visit and CMH Physician Assessments (1.5 hours) in DCYF were \$110. There are likely differences between the service expectations for the two agencies and yet the size of the difference between these fees is quite large. Similarly, differences existed with Physician visits for DMHRH at \$144 per visit and CMH Physician visits in DCYF for \$76 per visit.

Rates for services in other states compare as follows:

Table 16 Comparisons of MH Professional Rates		
Service	State	Rate(s)
Masters Psychotherapy –Social Worker		
	Rhode Island	\$68.00 - DMHRH \$43.00 – DCYF*
	Massachusetts - Masters	\$71.30 - MBHP \$70.88 – DMA
	Vermont - For DDMHS Agencies only	\$65.82 - 45 minutes
	Vermont Health Access	\$45.84
	Maine	\$42.40
	Connecticut – Clinic	\$41.52 per hour
	Illinois – Office	\$30.27 - 45-50 minutes
Psychologist – Counseling		
	Rhode Island	\$90.00 - DMHRH \$66.00 – DCYF*
	Massachusetts	\$72.35 – MBHP \$62.70 – DMA
	Vermont – Ph.D.	\$50.42
	Connecticut	\$45.00 per hour
Psychiatrist – Psychotherapy		
	Rhode Island – DCYF	\$76.00*
	Massachusetts	\$76.70 - MBHP - 45-50 minutes
	Vermont – Office of Health Access	\$76.47 - 45-74 minutes
	Maine	\$73.60 - 45-50 Min. No Med. Mgmt.
	Illinois – Psychiatric Consultation	\$66.82
	Connecticut	\$45.59
* New rates went into effect in August, 2003. The current rates are: Masters Psychotherapy-Social Worker = \$65.00; Psychologist –Counseling = \$80.00; Psychiatrist-Psychotherapy = \$95.00.		

Reimbursement rates for RIte Care plans were not available.

In general, Rhode Island rates for mental health services by professionals seem to be comparable to, and in some cases, more than those of other New England states. This does not mean that they are adequate and certainly across the country, mental health professionals have seen significant cuts in their reimbursement as a result of the growth of managed care and from cuts in commercial reimbursement. This has influenced the supply and availability of services in many areas, particularly rural areas of the country. The strong role played by Community Mental Health Centers who are reimbursed by DCYF and DMHRH through grants and contracts as well as Medicaid Fee-for-Service helps to maintain access to care across the state.



Comparison Data

Since 1999, at least two national efforts have been undertaken to collect and analyze data on key indicators for children's mental health from Medicaid agencies and state Mental Health Authorities¹⁴ and also from Medicaid Managed Behavioral Health Care systems¹⁵. In both projects, a series of administrative level indicators were used that measure the performance and effectiveness of mental health systems for children and adults and for the first time in a systematic way, these projects give state and county policy makers access to national benchmarks. Rhode Island participated in both studies.

The projects' purposes were to describe the existing performance of mental health systems in states and counties across the country; and to provide the opportunity for states and counties to compare their own performance data for other jurisdictions. By exploring such comparisons, important questions may be raised among stakeholders concerning priorities, methods, benefit structure, and system management. Moreover, systematically reviewing and comparing data for different systems can lead to productive discussions and the identification of opportunities for improvement.

For both projects, data were collected from state administrators using existing reporting mechanisms. A standardized data collection instrument was used and data on key performance measures were collected. While the data requests were standardized and as consistent as possible, the mental health systems themselves are in many cases quite different. As with this study, the data should be interpreted as measures of both system performance as well as measures of public policy and legislative priority for mental health services in each of the states and counties. Note that there were also differences in the data reported. For RIte Care, enrollment data were reported as Total Annual Enrollment (the unduplicated number of individuals enrolled) rather than the year-end data available in this study. Similarly, differences in the Children's Benchmarking data include the high rate of residential treatment spending for DCYF and the overlap of DCYF and Medicaid spending addressed in this study.

Two primary measures are presented below for comparison purposes. These are:

- Access – measured by penetration rates (the unduplicated number of people served divided by the total number of eligibles for service); and
- Expenditures – measured by expenditures per client served (expenditures divided by the total number of people served).

¹⁴ Dougherty Management Associates, Inc. "Children's Mental Health Benchmarking Project Third Year Report (2002), June 2003.

¹⁵ Dougherty Management Associates, Inc., "Medicaid Managed Behavioral Health Care Benchmarking Project" DHHS Pub. No. (SMA) 03-3844, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002.

MEDICAID MANAGED CARE

Access: The most broadly used measure of access for mental health services is the penetration rate for the health care plan. This is generally calculated as the unduplicated number of recipients of service divided by the average monthly number of individuals enrolled in the health plan. Penetration rates reported by states were collected in the SAMHSA Medicaid Managed Behavioral Health Care Project. On average, that study found a mean penetration rate of 11%. RItE Care data were reported in that study as an overall penetration level of 10% for SFY 2001. Note that the statistic was calculated differently by several of the states; in the RItE Care data the denominator was Total Annual Enrollment (reported in that project as 137,767) not average monthly enrollment. This would result in a lower penetration rate than the Outpatient penetration rates of 13% and 14% reported in this study which used year-end enrollment figures (of 111,624) for the calculations.

RItE Care psychiatric inpatient penetration rates in the SAMHSA study were reported as 0.5% while the national average was 1.0%. This rate was similar to rates reported by Oregon, Utah, Washington state and Los Angeles County.

Expenditures: The SAMHSA Medicaid Managed care project included RItE Care data showing inpatient expenditures per client served as \$3,668 per client and \$471 for outpatient services in SFY 2001. These are very similar to the SFY 2001 figures reported here of \$3,607 and \$484. Differences perhaps in the reporting methods and the time of reporting are likely to account for these minor differences. These are consistently lower than the national data of \$7,874 per client for inpatient services and \$1,186 for outpatient. They are generally consistent with the Massachusetts HMO data, however. Note that Rhode Island also reported a very low Average Length of Stay for inpatient services of 4.7 days (compared to the national average of 10.3 days, but similar to the length of stay for Massachusetts Medicaid HMOs). Differences in types of enrollees are likely the source of some of the expenditure differences, as RItE Care does not include SSI eligibles. Massachusetts also has a low level of SSI enrollment in their HMOs.

Overall mental health expenditures per enrollee served were reported in the SAMHSA study for RItE Care as \$675 for SFY 2001 compared to a mean of \$2,616. RItE Care was the lowest expenditure level reported in the study. Again, the differences in the enrolled populations are likely to account for some of these differences. Massachusetts HMOs reported an average of \$1,140. While the overall cost per client for SFY 2002 could not be calculated in this study, costs in SFY 2002 rose from 2001 levels by 30% in outpatient services and 62% for inpatient services.

CHILDREN'S MENTAL HEALTH BENCHMARKING PROJECT DATA

In Rhode Island, children receive mental health services from DCYF, Medicaid Fee-for-Service and RItE Care. The Children's Mental Health Benchmarking Project collected data on numbers of youth served and expenditures from each of these sources. The data are reported for the state Mental Health Authority (MHA) and for Medicaid. The costs

and counts are generally consistent with the data presented here, though both the MHA and the Medicaid data included DCYF Medicaid costs and clients.

Access: DCYF reported that the number of youth served was 26 per 1000 (population) for both SFY 2001 and 2002. This compares to the national average of 18 and 19 for the respective fiscal years. Medicaid penetration rates for youth were 9% in both years compared to the national averages of 7% and 9% in the two fiscal years.¹⁶

Expenditures: Expenditures reported by DCYF for the Mental Health Authority were extremely high when compared to other state MHAs. Rhode Island reported \$14,690 and \$15,909 per child served in SFY 2001 and 2002 respectively. This was way above the average MHA expenditure level for SFY 2001 of \$3,698 and for 2002 of \$4,122. Rhode Island Medicaid Expenditures per Child Served were the highest reported at \$9,809 and \$10,564 per child for SFY 2001 and 2002. This is compared to the national averages of \$3,144 and \$3,063 for the same periods. The high rates for both the MHA and Medicaid, which must be considered separately because of the overlap in Medicaid funding, are likely due to the reported costs of residential treatment and group care services which are not always included in mental health spending by other states.

SUMMARY

In conclusion, based upon the data that are available for comparison purposes, Rhode Island's RItE Care program appears to spend a significantly less per capita for mental health services than other Medicaid Managed Behavioral Health programs, though this is likely due to the primarily TANF enrollment in the plan and a limited benefit that is supplemented by Medicaid FFS spending for some eligible groups (e.g., foster care and managed care). Costs have been rising as RItE Care enrolls more DCYF youth. Based upon the available data, Children's Mental Health expenditures are some of the best funded in the country and yet the inclusion of all Child Welfare Residential Treatment and Group Care costs increases the overall expenditures significantly.

¹⁶ Penetration rates are always lower for youth than the combined figures reported for RItE Care, since mental health symptoms are usually not exhibited in the early years of childhood.

Conclusion and Recommendations

CONCLUSION

Rhode Island's Mental Health System has gained national attention particularly for the delivery and financing of care for individuals with serious and persistent mental illness and children with serious emotional disturbance. DMHRH and DCYF are organized to provide a comprehensive set of services that integrate Medicaid funding for services with a full array of community based and intensive levels of care. Particularly impressive are the aggressive use of the Medicaid Rehabilitation Option within DMHRH as a funding vehicle for community based services, and the integration within DCYF of Behavioral Health, Child Welfare, and Juvenile Justice Services. DMHRH provides a range of services in the community that have helped to move individuals out of the state hospital over the last twenty to thirty years.

As with most mental health systems across the country, Rhode Island has added new services and developed financing strategies that have changed over the last decade, particularly as managed care has been implemented within Medicaid. Many of the complex features of the "financing map" we have described in this report are the result of these changes in services and funding streams. This is not at all unusual in government programs or in business for that matter; however, reporting systems need to be revised periodically to account for these changes. The goal of any financial and utilization reporting system should be to permit population-based (rather than program-based) reporting of service utilization and costs with a minimum of overlap between funding streams. The recommendations outlined below will help to move the state in this direction.

RECOMMENDATIONS

Recommendations for changes in reporting and funding for each of the key state agencies are outlined in the sections that follow. Taken together they should permit a more comprehensive view of financing for the individuals served by the public mental health system in Rhode Island.

DCYF:

- Separately report on costs for inpatient services for mental health services and other long-term care services for children with developmental disabilities, even if inpatient services codes are used by both.
- Develop methods with DHS to routinely report on the mental health utilization of DCYF children enrolled in RIte Care. This should include the costs of services provided under RIte Care premiums as well as the costs of CIS services and any other services excluded from managed care for these youth.

- Separately report on RItE Care premiums for DCYF youth, indicating DCYF funds used (if any) to provide the state match for these services.
- Separately report on the residential and group care services funded in the Children's Behavioral Health Program, Children's Mental Health line-item of the state budget. The current reporting method understates the level of residential service costs reported by DCYF. Separately report in-state and out-of-state utilization.
- Build on the extensive and comprehensive capabilities of the DCYF data system to provide more detailed reporting of utilization and costs for DCYF youth as well as overall utilization of service by different demographic groups, including racial and ethnic groups and regional differences. This should include both Medicaid eligible and state funded services.

DMHRH:

- Develop data systems that will permit the reporting of community service utilization and cost by consumer, rather than by agency or program. Since the vast majority (~85%) of DMHRH community services are funded by Medicaid, integrate these data systems to more readily permit an analysis of consumers and services funded by Medicaid and those that are non-Medicaid. Ensure that data on utilization and access to services are collected and reported by diagnostic condition as well as race, ethnic group and region of residence.
- Develop data systems to more routinely report on the mental health utilization and billing at Slater Hospital.
- Develop, in collaboration with DCYF, cost reporting standards and procedures for Community Mental Health Center grants and contracts that allow for a more systematic review of the mental health funding at the agency level.

DHS:

- Develop a routine, perhaps quarterly or semi-annual, set of reports that summarize mental health service spending and utilization across all Medicaid funded services. This report should sort costs and numbers of recipients of service by health plan, funding source codes, category of assistance, age, and service type. It may be periodically necessary to provide special reports by provider and other criteria as a part of oversight and quality improvement activities.
- Provide reporting on a quarterly basis to DCYF and DMHRH on the services and the number of individuals paid for with DCYF and DMHRH Medicaid funds. A version of this kind of report may be prepared for accounting and appropriation purposes, however it also seems relevant to and should be distributed to program managers and policy makers.
- Clearly differentiate those services funded under Medicaid Fee-for-Service, such as CIS services, that are excluded from and yet supplement the services provided by RItE Care. The utilization and costs of these services should be included in planning for the RItE Care population. Similarly there are other services, such as services at Slater Hospital, that are delivered to DMHRH and DCYF.

DOC:

- Collect information on the actual utilization of services by individual served.
- Identify mental health needs that are currently unmet in the correctional system and design ways to meet those needs in collaboration with existing mental health providers.

DOH:

- Collect data, in collaboration with DHS, on the provision of mental health services by health centers and school based health clinics.
- Identify effective ways to coordinate services between the health centers and CMHCs and other mental health specialty providers. Track referrals that are made to these and other specialty healthcare providers.

OVERALL:

- Integrate agency data systems with Medicaid data systems, developing a single service taxonomy across all agencies. Many of the issues encountered in collecting and consolidating the data for this report could be addressed with a new service taxonomy and accounting procedures.
- Conduct a more complete review of the consistency of rates for certain professional services across different funding streams identifying the reasons for the differences.
- Perform an analysis of regional mental health funding for children and adults, using wherever possible, the region of residence of the individual to identify the regional spending, rather than the allocation of funds to CMHCs or other providers. Compare the current spending with estimates of the need for mental health services. Review the regional disparities and conduct a gap analysis to identify any sources of variation, unmet need for services and ways to reduce both.
- Perform a similar analysis of spending for different racial and ethnic groups and seek to reduce any apparent disparities in access or utilization of services.
- Periodically conduct a review of the administrative costs at all levels of the mental health system.
- Wherever possible, as we have tried to do in this report, reports should be presented graphically to make them more accessible to advocates and planners.
- As a part of the state mental health plan, prepare a statement (perhaps bi-annually) on the financing and utilization of public mental health services for adults and children across all state agencies similar in scope to this report. Provide comparisons with and changes to the information contained in this report and modify the report format to meet the needs of advocates and planners within state government, local agencies and advocacy organizations.
- Ensure that the CMHS State Mental Health Block Grant Planning process is fully integrated with all planning efforts for public mental health services within the state. This should include all publicly funded mental health services to adults and children with Medicaid and non-Medicaid funds.
- Adopt a statewide policy of fiscal transparency in the mental health system, routinely providing reports that describe and clarify the extent and scope of

services so that advocates and policy makers can make decisions and recommendations with the same information.

Rhode Island may be the smallest state in the union, but it has been one of the most committed to the effective design and funding of an integrated delivery system for mental health. The state has a unique blend of public and private institutions, a very strong system of community mental health centers, non-profit residential treatment and community providers for children and dedicated and well-trained professionals. While small, the state is diverse: it has an urban center with rural areas of the state; extraordinary wealth exists on many areas of the coastline with extreme poverty in the inner city and rural areas; and there is a diversity of ethnic and racial groups. Collectively, these factors require careful planning and oversight of the mental health delivery system sometimes with a similar level of complexity to much larger states.

Taken together, more than \$250 million dollars was spent in state fiscal year 2002 on publicly funded mental health services for children and adults with a combination of state and federal funds. Considerably more is spent and paid for by commercial health plans, Medicare and self-pay. The size of this investment and the growth of funding between 2001 and 2002 suggest that there are opportunities for improvement in the delivery, quality and efficiency of mental health services in Rhode Island. Clear and comprehensive data on the current utilization and financing of the system can help to define the boundaries of and opportunities for change in this challenging fiscal climate. It is hoped that this report can also inform Rhode Island's current efforts to consolidate and integrate health and human service financing and service delivery systems. The commitment and the capability are there. The needs of adults and children with mental illness have never been greater.



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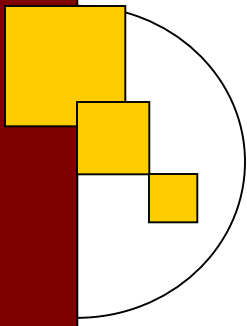
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Rhode Island

Public Mental Health Financing Study

Appendices

Appendix A

LIST OF CONTACTS

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Department of Mental Health, Retardation, and Hospitals

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Rosemary Reilly-Chammat

Department of Corrections

Bree E. Derrick, Principal Planner
Dr. Fredric Friedman, Clinical Director of Psychology/Mental Health
Pauline Marcussen, Medical Records Administrator

Appendix B

DCYF STATE BUDGET RECONCILIATION

As a part of this review, information was collected directly from state agencies and then verified with other public documents, such as the costs reported for SFY 2001 and SFY 2002 in the Rhode Island 2004 State Budget.

The review of DCYF identified expenditures for Children's Behavioral Health Services which at first appeared inconsistent with the mental health spending reported. Some of these problems are simply the result of the names of the accounts used for reporting costs. For instance, Children's Mental Health spending shown in the State Budget included costs such as personnel costs of the Children's Behavioral Health Services Unit, certain residential and group care services that are administered by the behavioral health unit but which serve other populations, and other costs. We were not able to get a full accounting of all these costs in the time available, however staff were clear that they separated out the appropriate mental health costs. The Psychiatric Services line item included inpatient costs generally consistent with the numbers reported by DHS as the DCYF Medicaid funding code. However, as we noted in the discussion above, more than half of this inpatient spending was for long term care for behaviorally involved, developmentally disabled youth in the care of the department. As a result, it was adjusted.

In summary, we believe that the mental health expenditures reported to us are a fair and reasonable presentation of those costs based on the accounting systems currently in use.

	SFY 2001 – Actual	SFY 2002 - Unaudited
Children's Mental Health	\$23,229,309	\$27,231,169
Psychiatric Services	\$15,757,913	\$13,374,614
Local Coordinating Council	\$20,000*	\$20,000*
CBH Educational Services	\$1,134,091	\$1,581,147
<i>Subtotal Behavioral Health</i>	<i>\$40,141,313</i>	<i>\$42,206,930</i>
Board and Care (from Child Welfare)	\$70,943,668	\$81,243,552
Total	\$111,084,981	\$123,450,482
<i>Source: RI 2004 State Budget * - DCYF reported that in 2001 spending was \$1,589,000 and in 2002 spending was \$1,642,000.</i>		

DCYF MEDICAID ADDITIONAL ANALYSIS

In the following charts, we have provided additional analyses of Medicaid spending for DCYF youth. These charts supplement the primary analysis presented in the main report and yet because of the changes in funding policies and increasing enrollment of DCYF youth in RItCare, the changes from SFY 2001 to SFY 2002 are also quite difficult to interpret. We present them here so as not to confuse the earlier analysis while also providing a glimpse of the complexity of the financing of services to DCYF youth.

Medicaid DCYF expenditures stratified by age show the majority of expenditures (54%) in SFY 2001 were for children ages 6-12. However, the proportion of spending for this age group declined significantly in SFY 2002 to represent only 45% of total expenditures. This decrease in spending was likely attributed to the increased enrollment of adoption subsidy youth in Managed Care (the mental health spending for these youth is separately reported in RItCare). In addition, there was a substantial decrease in spending (almost 70%) for children ages 0-5, and a slight decline in spending for 13-17 year olds. In comparison, expenditures increased notably for 18-21 year olds with spending nearly doubling in SFY 2002 to \$2,490,055.

Chart C-1

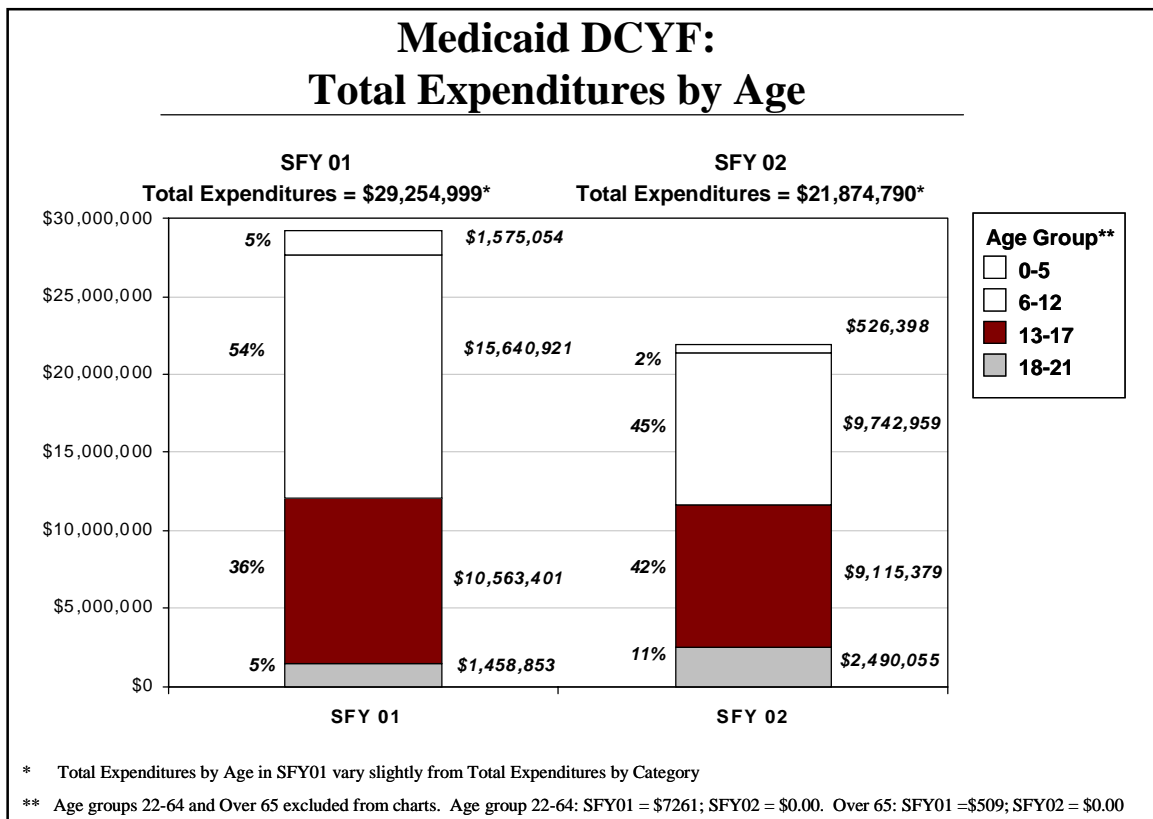
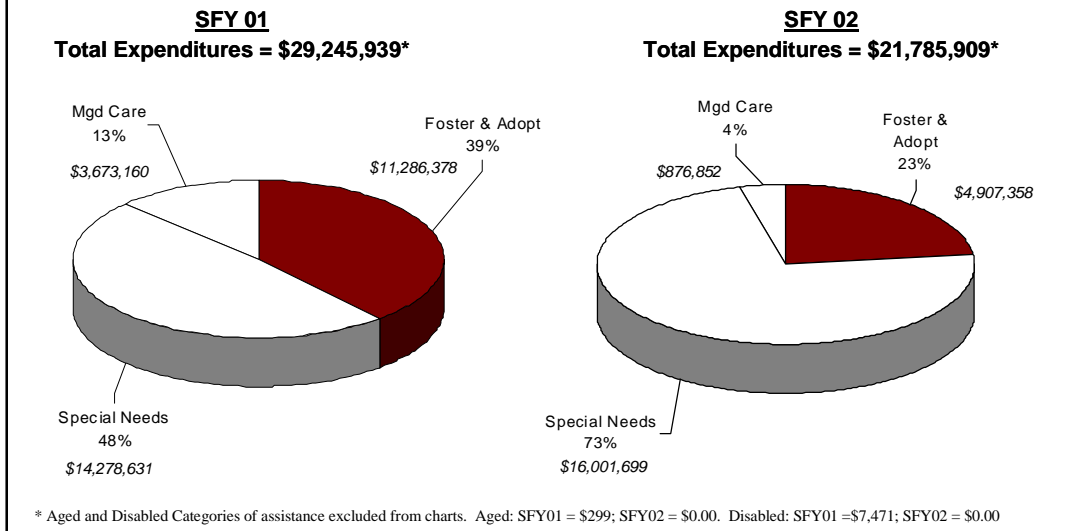


Chart C-2

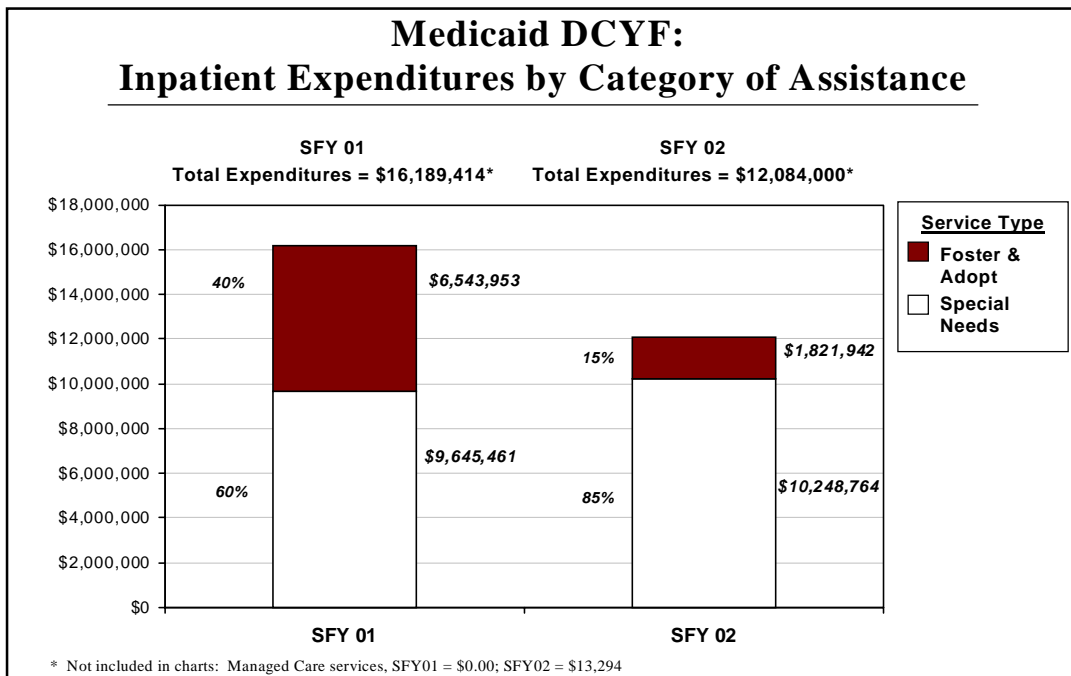
**Medicaid DCYF:
Total Expenditures by Categories of Assistance**



Mental health expenditures for managed care enrolled youth decreased dramatically by 75% from SFY01 to SFY02. Foster and Adoption expenditures for mental health services were combined due to a coding error between the two study years. Expenditures for these categories of assistance decreased significantly by 57% from SFY01 to SFY02. By contrast, total Special Needs expenditures grew by 12%. In both years, Special Needs had the highest proportion of total expenditures and comprised about half of total spending in SFY 2001, and almost three-quarters in SFY 2002. “Other” expenditures included Aged and Disabled categories of assistance and were, not surprisingly, very low for DCYF youth in comparison to other categories in SFY 2001. Zero expenditures for both categories were reported in SFY 2002.

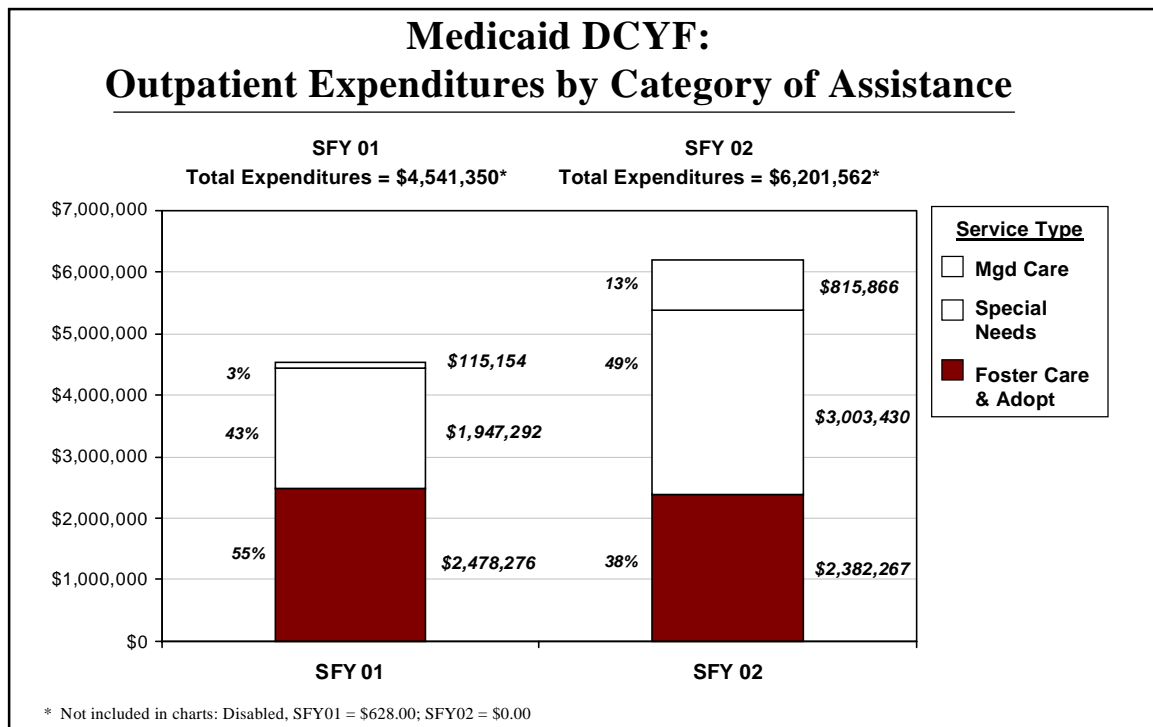
Chart C-3

**Medicaid DCYF:
Inpatient Expenditures by Category of Assistance**



DCYF Medicaid Inpatient spending declined dramatically between SFY 2001 and SFY 2002 as a result of the increased enrollment of youth into managed care. There was almost no spending for managed care because the inpatient services for these youth were funded by RItE Care and DHS (Medicaid Fee-for-Service). In fact, by SFY 2002 the vast majority of inpatient spending was for Special Needs youth, much of which was for services categorized as inpatient but which were for long-term care at the special units at Bradley and Butler Hospitals. Special Needs' expenditures grew from 60% of the total in SFY 2001 to 85% in SFY 2002, though this reflected a modest 6% increase in actual spending. By contrast, after experiencing a 70% (\$4.7M) decline in expenditures between SFY 2001 and SFY 2002, Adoption and Foster care services accounted for only 15% of total inpatient spending in SFY 2002.

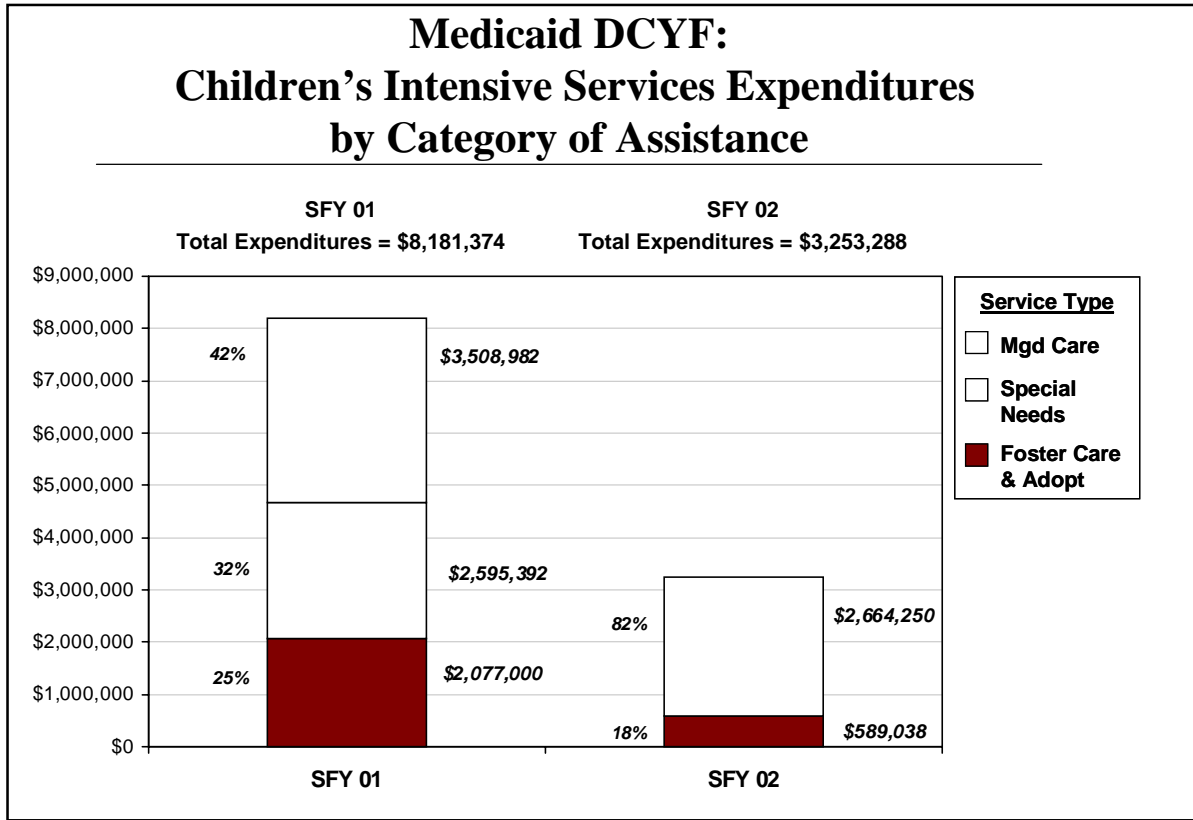
Chart C-4



In comparison to inpatient spending, outpatient expenditures showed greater variation and significant changes between categories of assistance from SFY 2001 to SFY 2002. Foster and Adoption service spending had the highest proportion of total expenditures in SFY 2001, but decreased by 15% between the two years, from 55% in SFY 2001 to 38% in SFY 2002. We understand that some of this reported decrease may be related to changes in accounting and service codes associated with the increased enrollment of youth in managed care.

Special Needs expenditures increased in SFY 2002 to account for the highest proportion of total expenditures. Outpatient expenditures for this category of assistance ranged from 43% in SFY 2001 to 49% in SFY 2002. Managed care accounted for the least amount of spending in SFY 2001, 3% (\$115,154) and 13% (\$815,866) respectively. However, in SFY 2002, spending increased dramatically for this category of assistance; Managed care expenditures rose more than 80% to account for 13% of total outpatient expenditures.

Chart C-5



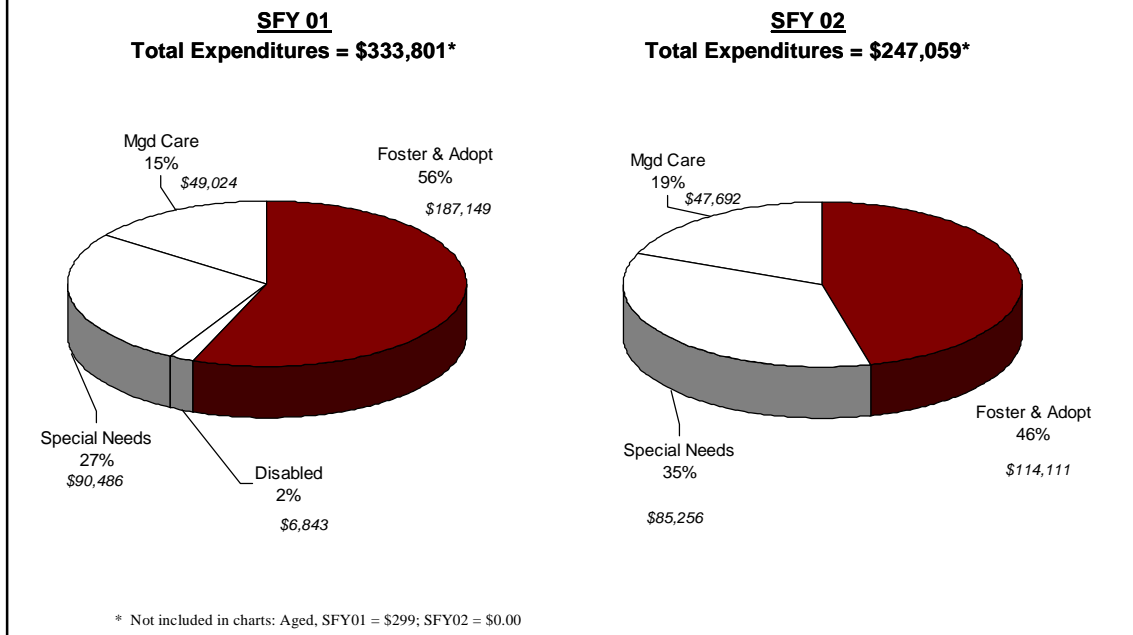
Two major changes occurred in CIS expenditures between SFY 2001 and SFY 2002. First, total spending decreased by more than 60% in SFY 2001. Secondly, there was considerable change in spending distributions amongst categories of assistance from one year to the next.

Although, managed care accounted for 42% of total spending in SFY 2001, the largest portion of total CIS expenditures, the category reported zero expenditures in SFY 2002. As children were enrolled in Rite Care, the payment rules for funding for CIS services for these youth moved the funding responsibility over to DHS. As it became clear to DHS that this was occurring, an agreement was negotiated with DCYF to have DHS assume this funding.

CIS services for Foster and Adoption youth also declined dramatically; spending in SFY 2002 declined to less than one third the level of SFY 2001 on CIS services. Special Needs spending did not increase but its share grew from 32% in SFY 2001 to 82% in SFY 2002 as a result of the decline in other services. These youth were not enrolled in managed care.

Chart C-6

Medicaid DCYF: Early Start Expenditures by Category of Assistance

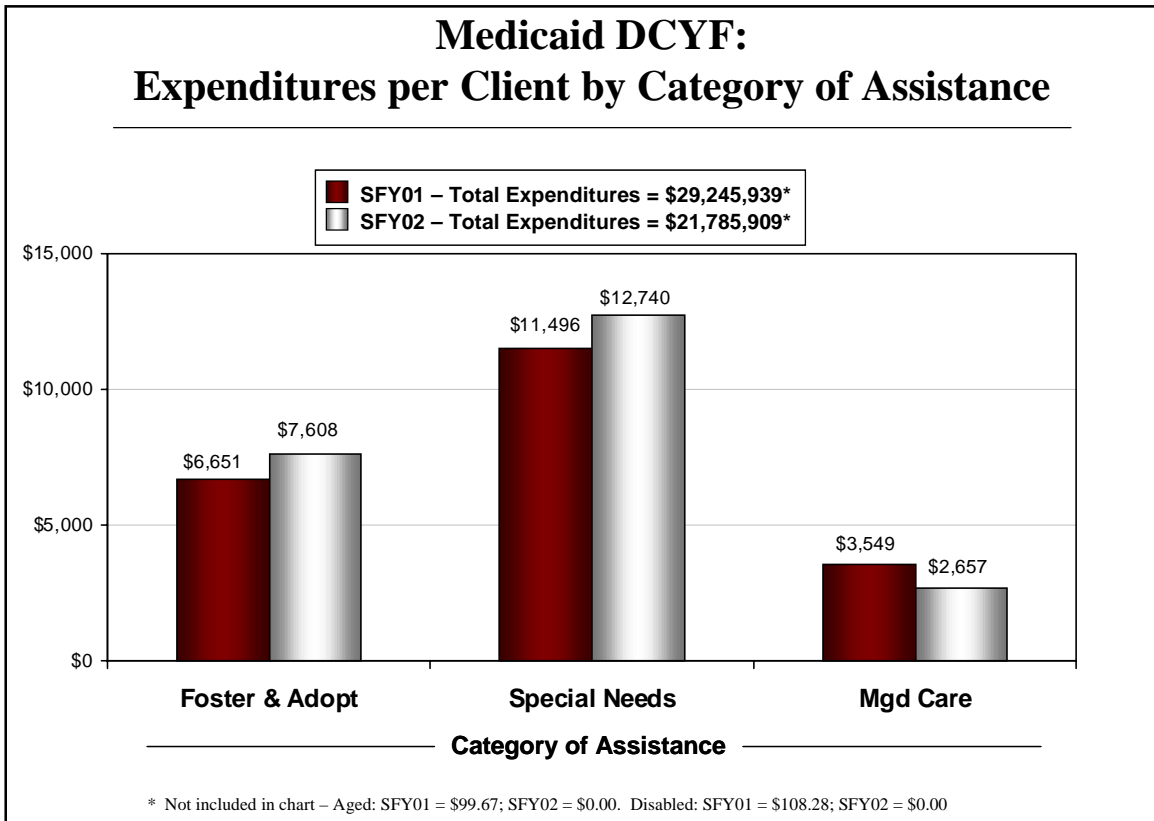


Early Start funding provides mental health services for at risk three and four year olds, as well as a range of other educational and social services not funded by Medicaid. The Early Start services to DCYF youth are shown in the chart above.

Total expenditures are small and decreased by 26% between SFY 2001 and SFY 2002, with spending ranging from \$333,801 in SFY 2001 to \$247,059 in SFY 2002. In SFY 2001, Early Start expenditures were distributed throughout all categories of assistance, with the obvious exception of the Aged category.

Adoption and Foster services had the highest proportion of spending in both years; in SFY 2001 these services accounted for over half of total expenditures (56%). However, spending for these services decreased by 6% in SFY 2002, accounting for 46% of total expenses. The Disabled category reported the least amount of spending in SFY 2001 (2%) and reported zero expenditures in SFY 2002. Although, managed care and Special Needs categories both experienced slight reductions in expenditures, their share of total spending increased due to the redistribution of expenses amongst the categories.

Chart C-7



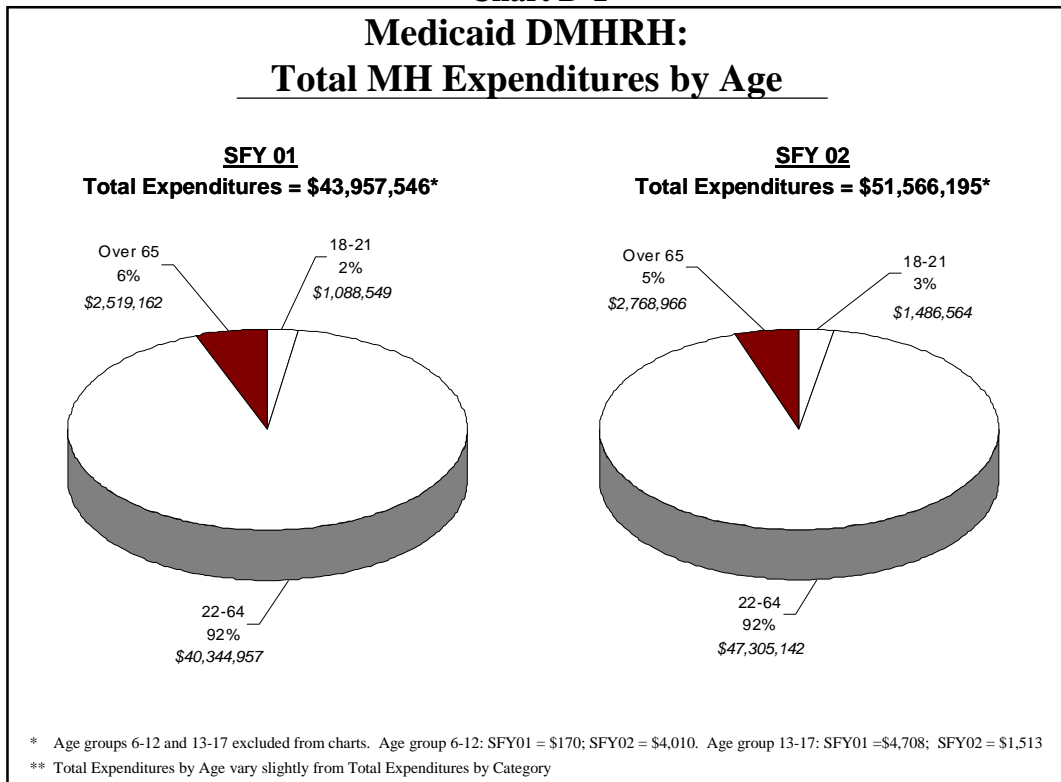
In general, the degree of expenditures per client in each category of assistance reflects the proportions of total Medicaid DCYF expenditures that are allocated to each category. For instance, Special Needs had the highest share of total expenditures in SFY 2001 and SFY 2002, and had the highest costs per client over both years. In comparison to other categories included in this measure, Special Needs spent at least 30% more per client in SFY 2001 and 40% more in SFY 2002. The level of this spending was due primarily to the very high spending for inpatient services. On average, Foster and Adoption services spent approximately \$7,000 per client in both years, whereas managed care had much lower costs per client in both years.

Appendix D

DMHRH MEDICAID DATA

Medicaid DMHRH spending distributions by age remained the same for all age groups from SFY 2001 to SFY 2002, though overall expenditures increased by 17%. As expected, the majority of expenditures in both years were for adults, ages 22-64 (92%). For age group 65 and over, spending ranged from 5% to 6% of total mental health expenditures, while age group 18-21 accounted for only 2% to 3%.

Chart D-1



As can be seen on the next chart, the overall DHS expenditures for DMHRH services increased 17% between SFY 2001 and SFY 2002, from \$43,956,496 to \$51,562,110, 95% to 96% of the DMHRH Medicaid expenditures were for the Disabled category of Assistance in both fiscal years. Presumably these services are for individuals disabled by reason of their mental illness. Expenditures for disabled individuals grew significantly by 17% between SFY 2001 and SFY 2002. A higher percentage of growth was seen for individuals with Special Needs, yet this represented only 3% of the total DMHRH Medicaid expenditures.

Chart D-2

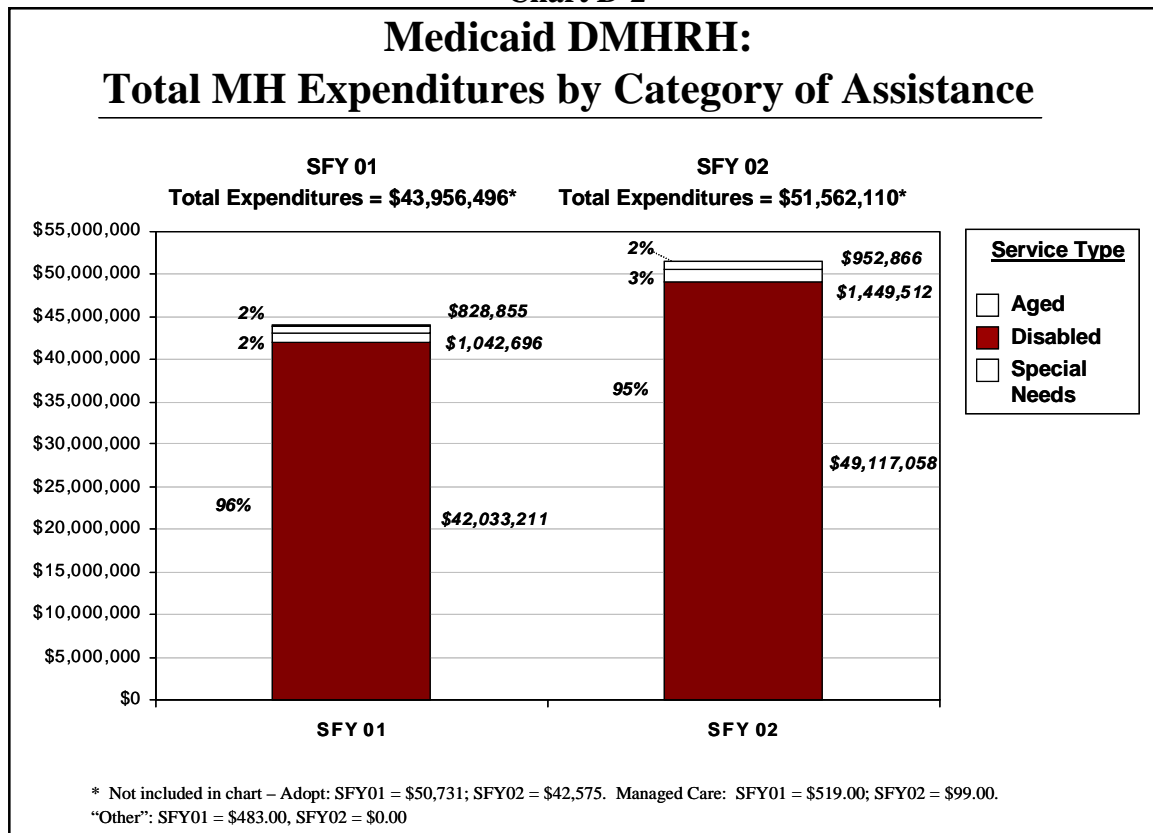
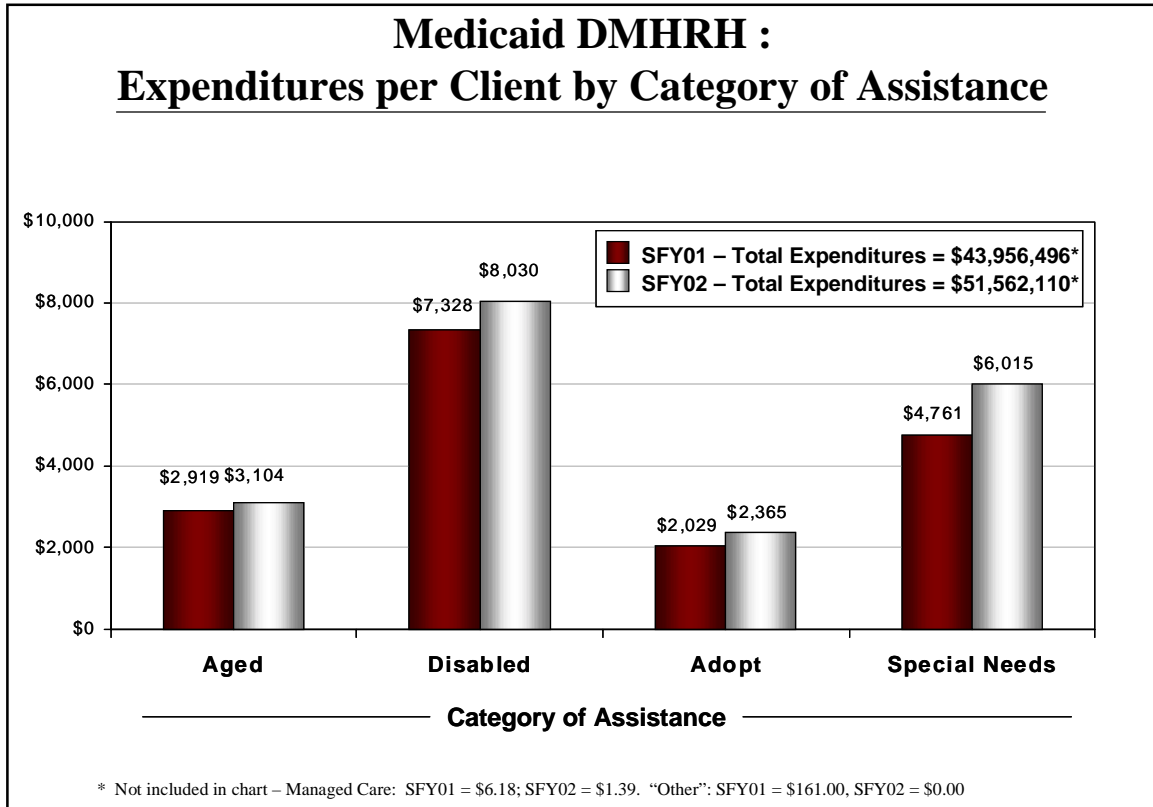


Chart D-3



As expected, Disabled and Special Needs categories of assistance had the highest expenditures per client served in SFY 2001 and SFY 2002. Between fiscal years, there were marginal increases in expenditures per client for all categories of assistance; however, Disabled costs were at least twice as more per client than Aged and Adopt categories. In SFY 2002, Disabled expenditures per client were about three times greater in comparison to Aged and Adopt categories, and Special Needs costs per client were approximately twice as more than Aged and Adoption services.