



Georgia Department of Audits and Accounts

Performance Audit Operations

Russell Hinton, State Auditor

Leslie McGuire, Director

Why we did this review

The purpose of this review was to answer questions requested by the House and Senate Appropriations Committees. In a letter dated July 21, 2008, the committee chairs asked about three basic topics in regard to Child and Adolescent Mental Health: 1) the impact of the Fee-for-Service policy initiated April 2007; 2) the effectiveness of DHR's needs assessment process and changes to availability of children's mental health services over time; and 3) the utilization of appropriated funds. This report answers question one. The other questions are addressed in a report, Limited Review of DHR's Child and Adolescent Mental Health Program (08-37B), released in January 2009.

Who we are

The Performance Audit Operations Division was established in 1971 to conduct in-depth reviews of state programs. The purpose of these reviews is to determine if programs are meeting their goals and objectives; provide measurements of program results and effectiveness; identify other means of meeting goals; evaluate the efficiency of resource allocation; and assess compliance with laws and regulations.

Website: www.audits.state.ga.us

Phone: 404-657-5220

Fax: 404-656-7535

DHR's Fee-for-Service Model for Child and Adolescent Mental Health

Fee-for-Service has achieved some intended goals but has also produced issues that should be addressed

What we found

The Department of Human Resources' Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD) transitioned the funding method for many child and adolescent (C&A) community mental health services to the uninsured from a traditional Grant-in-Aid (GIA) mechanism to Fee-for-Service (FFS) in April 2007. Under GIA, providers received a fixed payment amount each month regardless of the services actually provided. With the change to FFS, MHDDAD began to pay providers a set amount for each individual service delivered. The change to FFS also coincided with a significant increase in the number of C&A community-based providers.

Our review found that FFS addressed two deficiencies of the GIA system: lack of accountability related to C&A funds and limited choice of providers. The FFS model ensures that payment is only provided for services to the C&A population, ending a practice of some providers using a portion of C&A GIA funds to provide services to other populations. It has also permitted a significant increase in the number of C&A providers. Prior to FFS, most services were delivered by one of 26 Community Service Boards (CSB). In fiscal year 2008, an additional 123 non-CSB providers served the C&A population.

We also found that the number of C&A receiving services increased after the adoption of FFS. A review of eight service areas (46 counties) found that six had an increase in the number of C&A served between the third quarters of fiscal years 2006

and 2008. The providers in the sampled areas served an additional 424 clients in 2008, a 35% increase.

While the FFS policy has been successful in some aspects, we also identified issues related to the policy that should be addressed.

- *Low Demand Areas* – The FFS policy does not provide an incentive for providers to offer services in areas with few consumers. Ten counties had ten or fewer C&A clients in fiscal year 2008 and another 21 counties had 25 or fewer clients. While markets are largely dependent on the number of consumers, their viability is also impacted by other factors, such as the distance from a provider's other markets, the level of services needed by the consumers, and the rates paid for those services.
- *Low Reimbursement Rates and Non-Billable Services* – The FFS reimbursement rates for the uninsured were aligned with Medicaid rates that were set in 1999 and later reduced by 10%. In addition, providers complained of non-billable services, especially activities related to coordination with other agencies. Providers are required to coordinate with other agencies, such as the schools, juvenile courts, DFACS, and DJJ; however, these non-medically necessary services are not reimbursable under FFS.
- *Additional Administrative Costs* – MHDDAD and providers have encountered an increase in administrative costs related to the policy. The vendor that processes claims, trains and audits providers, and maintains program data was paid more than \$10 million in fiscal year 2008. The CAMH Program paid \$8.3 million of this cost (approximately \$2 million were one-time items). Providers have also reported significant increases in administrative costs associated with both the FFS policy and the transition of many C&A to Medicaid care management organizations (CMOs). The providers stated that they have added significant time and staff to obtain prior authorizations and to deal with billing and payment problems.

We found that these issues could negatively impact the delivery of C&A services in some areas of the state. The transition to FFS has presented a financial challenge for CSBs, which remain the primary providers in many counties and the only providers in others. Recognizing the challenges of FFS, MHDDAD provided supplemental funding to providers in fiscal years 2007 and 2008. It should be noted that CSBs are also providers of other MHDDAD services, and many report that the transition to FFS has negatively impacted services to the other populations. As a result of these issues, MHDDAD should continue to evaluate whether the FFS policy will continue to foster service delivery in all areas of the state. The Division should also determine if and when the policy will be expanded to other programs.

In response to specific questions from the Senate and House Appropriations Committees, we found that CSBs have experienced significant declines in state and federal fund receipts since the transition to FFS and Medicaid care management organizations (CMOs). Our review of the financial records for a sample of ten CSBs found that, from fiscal years 2006 to 2008, C&A revenue declined more than 30% for all but one of the providers. In five instances the decline was greater than 50%. In addition, 15 of the 16 remaining CSBs we surveyed reported a similar experience, with most describing the revenue decrease as significant. Several providers indicated that the revenue received for the uninsured is not enough to pay for the cost to operate the child and adolescent mental health program and many expressed concern about the ability to continue offering C&A mental health services due to these financial losses.

Since the implementation of FFS, MHDDAD's per client cost for direct services has decreased significantly. Our review of nine CSBs found that the average cost to the state per uninsured consumer decreased for each of the CSBs when comparing third quarter fiscal year 2006 to fiscal year 2008, with decreases ranging from 42% to 89%. It is important to note that we analyzed the state's cost per client (CAMH funding to the CSBs), not the cost that each provider incurred per client. The state's cost per C&A recipient was especially high under GIA because providers were often using a portion of those funds on other populations.

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Purpose of the Special Examination

The purpose of this review was to answer specific questions requested by the House and Senate Appropriations Committees. In a letter dated July 21, 2008, the committee chairs asked questions about three basic topics in regard to Child and Adolescent Mental Health: 1) the impact of the Fee-for-Service policy initiated April 2007; 2) the effectiveness of DHR's needs assessment process and changes to availability of children's mental health services over time; and 3) the utilization of relevant appropriated funds. This report answers question one. The second and third objectives were addressed in a companion report, Limited Review of DHR's Child and Adolescent Mental Health Program (08-37B), released in January 2009. Details about our objectives, scope, and methodology related to this report are included in Appendix A.

This report has been discussed with personnel within the Department of Human Resources Division of Mental Health, Developmental Disabilities, and Addictive Diseases. A draft copy was provided for their review and they were invited to provide a written response, including any areas in which they plan to take corrective action. Their responses are included at the end of each finding.

Background

MHDDAD Organization

The Child and Adolescent Mental Health Program (CAMH) is administered by the Department of Human Resource's Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD). The Program consists of three subprograms: Community Services, Hospital Services, and Outdoor Therapeutic Program. Due to the nature of the request, this report discusses community-based services.

MHDDAD has five regional offices that serve as the primary contacts for service providers within their respective regions. O.C.G.A. 37-2-4.1, which establishes the regional offices, also mandates associated regional planning boards. The boards are responsible for "coordinated and comprehensive planning" for the region, under standards and procedures set by MHDDAD. The boards' role is limited to planning; the Division is responsible for the procurement of needed services.

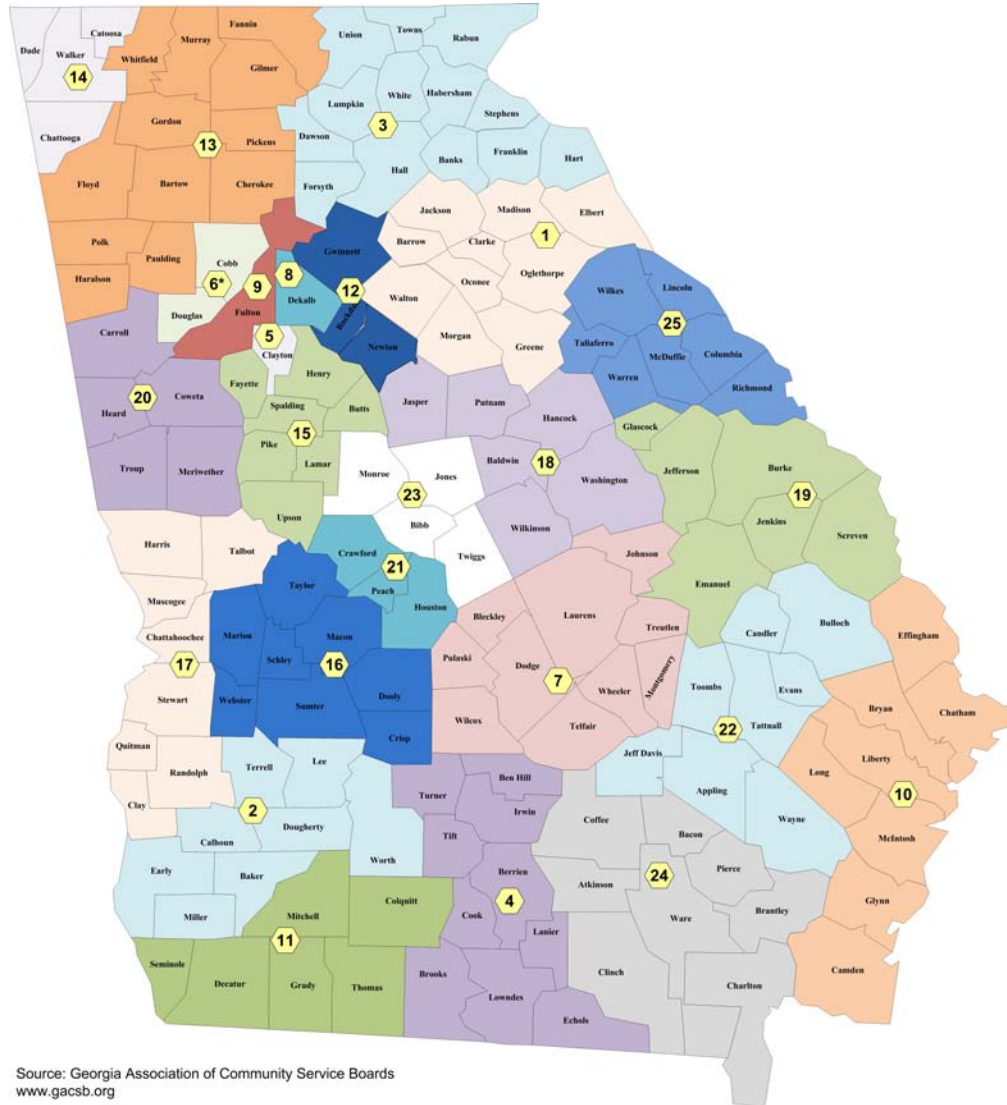
Community Mental Health Providers

MHDDAD contracts with approximately 150 providers of community mental health services for children and adolescents. The providers include all of the state's 26 quasi-governmental community service boards (CSBs).¹ The General Assembly created community service boards in 1993 with House Bill 100. CSBs are public corporations created "for nonprofit and public purposes to exercise essential governmental functions." Each CSB has a service area² consisting of specific counties (Exhibit 1). County governing authorities appoint most CSB board members.

¹ The Cobb and Douglas CSBs share administrative staff and operate as a single CSB in many respects.

² As of 2006, CSBs can go beyond their services areas to treat individuals from other parts of the state.

Exhibit 1 Georgia's Community Service Boards



- | | |
|--|--|
| 1 Advantage Behavioral Health Systems | 14 Lookout Mountain Community Services |
| 2 Albany Area CSB | 15 McIntosh Trail CSB |
| 3 Avita Community Partners | 16 Middle Flint Behavioral HealthCare |
| 4 Behavioral Health Systems of South Georgia | 17 New Horizons CSB |
| 5 Clayton Center Behavioral Health Services | 18 Oconee Center |
| 6 Cobb CSB/ Douglas CSB* | 19 Ogeechee Behavioral Health Services |
| 7 Community MH Center of Middle Georgia | 20 Pathways Center |
| 8 DeKalb CSB | 21 Phoenix Center Behavioral Health Services |
| 9 Fulton County Department of MHDDAD | 22 Pineland MH/DD/AD |
| 10 Gateway Behavioral Health Services | 23 River Edge CSB |
| 11 Georgia Pines CSB | 24 Satilla Community Services |
| 12 GRN CSB | 25 Serenity Behavioral Health Systems |
| 13 Highland Rivers CSB | * Cobb and Douglas have separate boards, but share administrative staff. |

CSBs have traditionally been MHDDAD's primary community provider of mental health, developmental disability, and addictive disease services. However, in recent years, MHDDAD's use of non-CSB providers has increased significantly. More than 100 new providers have been contracted since 2007. These providers are either non-profit or for-profit entities and may have been providing services to clients outside the MHDDAD system in prior years.

Most of the mental health services provided by MHDDAD contractors are categorized as either core or specialty services. Examples of core services include psychological testing; nursing assessment and care; and individual, family, or group outpatient services. Examples of specialized services include intensive family intervention; behavioral assistance; and structured residential treatment. The availability of these services varies by region. For a complete list of services, see Appendix B.

Child & Adolescent Mental Health Population

MHDDAD serves children and adolescents with serious emotional disturbance (SED). The SED population is defined as "persons from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities." Nationally, the Center for Mental Health Services (CMHS) estimates 8% of the child and adolescent population has a SED. Using the CMHS estimate, there are approximately 202,500 children and adolescents with SED in Georgia.

Depending on eligibility, the C&A mental health population served by MHDDAD can have services paid for by either the CAMH program, Medicaid, or PeachCare for Kids. In fact, the payer of service has been in a state of flux in recent periods for these populations. Currently, the MHDDAD system is the payer for four SED populations with different eligibility standards:

- **Uninsured** – C&A in parental custody who are not covered by either private or public insurance. Their services are paid for by MHDDAD.
- **Medicaid: Disabled** – C&A in parental custody but eligible for Medicaid because of a disability. Their services are paid for by federal Medicaid and state matching funds. The state share is paid by MHDDAD.
- **Medicaid: Foster Care** – C&A in the custody of the Division of Family and Children Services, making them eligible for Medicaid. Their services are paid for by federal Medicaid and state matching funds. The state share is paid by MHDDAD.
- **Medicaid: Low Income, Transitional** – C&A in parental custody who are eligible for membership in a Medicaid Care Management Organization (see below) but whose coverage has not started. This transitional period can be as long as 60 days from the date eligibility is determined. During that time, any services provided are paid for by MHDDAD.

Once a child has been identified as eligible for services, a comprehensive evaluation is performed to determine whether the child requires a) early intervention and crisis stabilization or b) ongoing support and treatment. This decision affects the range of services that will be provided and the timeframe for which they are authorized. Early intervention and crisis services are generally offered for 90 days or less. Authorization for ongoing support and treatment can be as long as 180 days before another evaluation is required.

Recent Changes to C&A Mental Health System

Prior to June 2006, MHDDAD primarily served uninsured children and those on Medicaid who were not in foster care. However, several events have occurred in the C&A mental health system in the past three years that have significantly impacted the mental health delivery system. These changes have included changes in MHDDAD's data collection, payment methods, populations served, and provider network. The C&A population has experienced transitions among the various government programs/payers for their provision of mental health services, changing the entities responsible for child and adolescent mental health services in Georgia.

- In January 2006, additional core providers were solicited to offer mental health services to areas of the state that were identified as not having a “fair-share” of service dollars for either adult services or C&A services. Twenty percent of “core” service funding was withheld from CSB provider contracts for fiscal year 2006 and the funds were utilized to procure more services from additional providers. For areas that did not receive a successful bid to provide services in the first round, a second procurement was solicited and these new providers began services on July 1, 2006. Contracts initially provided for six months of funding under the GIA funding structure; however, due to a delay in implementation, the provider contracts were extended from January 2007 until April 1, 2007.
- Beginning June 2006, the Department of Community Health (DCH) placed Medicaid-eligible, low income youth in parental custody, along with members of PeachCare for Kids, into Care Management Organizations (CMOs). This shift to CMOs was intended, at least in part, to expand the role of potential providers of service to the C&A population. The CMOs became responsible for coordinating and paying for the care of those populations.
- In July 2006, the MHDDAD data collection system moved from capturing enrollments to service encounters. Enrollments measured individuals who were eligible for services within a given period whether or not they actually received services. The new data collection system provided DHR with a mechanism to track the number of persons actually receiving services.
- In April 2007, MHDDAD moved from Grant-in-Aid (GIA) funding to Fee-for-Service (FFS) for most C&A community mental health services. Prior to the funding change, providers received a fixed monthly payment rather than funding in accordance with the individual services delivered. This change in reimbursement was intended to both increase accountability and to expand the provider pool.

- In July 2007, a federal mandate from the Center for Medicare and Medicaid Services (CMS) required that DHR unbundle services provided to C&A in its Levels of Care program. (Levels of Care paid a flat daily rate for residential services of a specific intensity.) In response to this mandate, MHDDAD now provides mental health services to youth in DFCS custody while “Room, Board, and Watchful Oversight” charges are paid by DFCS.

Activity Data

Exhibit 2 contains information on the number of individuals enrolled in CAMH services from 2004 to 2006, and individuals served in fiscal years 2007 and 2008. The drop between fiscal years 2006 and 2007 can be explained by two previously-discussed events. First, enrollment figures included children and adolescents approved to receive services from the provider, not necessarily individuals that actually received services during the reported year, so enrollment numbers do not reflect the actual number served.³ Second, enrollment figures also contained the portion of the Medicaid C&A population that, in 2007, began to receive services from CMO-contracted providers; therefore, DHR’s activity data no longer captures services to those individuals. The increase in individuals served in 2008 is partly attributed to the transition to documenting encounters as providers had a higher encounter submission error rate in 2007 which may have caused a slight undercount in that year.

Exhibit 2					
Activity Data – State Fiscal Years 2004-2008					
	Individuals Enrolled			Individuals Served	
	2004	2005	2006	2007	2008
C&A MH Community Services	41,004	40,064	40,543	17,197	25,240
Source: Governor’s Office of Planning and Budget, APS Healthcare KnowledgeBase					

Financial Information

As shown in Exhibit 3, state funds accounted for 89% of the Program’s total revenue. At the subprogram level, state funds accounted for 80% of the Outdoor Therapeutic Program (OTP), 88% of the Community Services, and 95% of the State Hospital Services. Federal and other fund sources combined provided the remainder of each subprogram’s revenue.

Program and subprogram expenditures are shown at the object class level. Community Services expenditures totaled 84% of the Program’s expenditures; State Hospital Services and OTP combined for the remaining 16%. Within the Community Services subprogram, contracts accounted for more than 90% of expenditures. These contracts totaled more than three-fourths of all Program expenditures. The other two subprograms spent a majority of their funds on personal services.

³ For example, an individual added to the enrollment list in May 2005 has one appointment in June 2005, and remains on the list during the following fiscal year – resulting in an inflated fiscal year 2006 count.

Exhibit 3
CAMH Revenue and Expenditures by Subprogram
Fiscal Year 2008

Revenue	OTP		Community		Hospital		Total	
State Funds	\$3,961,154	76%	\$66,789,950	88%	\$6,309,909	95%	\$77,061,013	89%
Federal Funds	143,138	3%	8,967,513	11%	0	0%	8,687,149	10%
<u>Other Funds</u>	<u>1,119,251</u>	<u>21%</u>	<u>471,321</u>	<u>1%</u>	<u>360,020</u>	<u>5%</u>	<u>1,315,461</u>	<u>1%</u>
Total Funds	\$5,223,543	100%	\$76,228,784	100%	\$6,669,929	100%	\$87,063,624	100%
Expenditures								
Personal Services	\$4,038,894	81.8%	\$4,508,454	6.4%	\$6,298,129	69.8%	\$14,845,476	17.7%
Regular Operating	783,334	15.9%	320,935	0.5%	2,497,709	27.7%	3,601,978	4.3%
Motor Vehicle	21,128	0.4%	14,213	0.0%	-	0.0%	35,341	0.0%
Equipment	12,000	0.2%	-	0.0%	-	0.0%	12,000	0.0%
Computer Charges	18,386	0.4%	3,872	0.0%	6,440	0.1%	28,698	0.0%
Real Estate Rentals	-	0.0%	66,693	0.1%	-	0.0%	66,693	0.1%
Telecommunications	23,917	0.5%	29,335	0.0%	25,448	0.3%	78,701	0.1%
Contracts	37,394	0.8%	65,031,620	92.9%	160,695	1.8%	65,229,708	77.7%
<u>Grants and Benefits</u>	<u>2,214</u>	<u>0.0%</u>	<u>2,120</u>	<u>0.0%</u>	<u>30,804</u>	<u>0.3%</u>	<u>35,138</u>	<u>0.0%</u>
Total Expenditures⁽¹⁾	\$4,937,267	100%	\$69,977,242	100%	\$9,019,225	100%	\$83,933,734	100%

(1) Total expenditures by subprogram are understated by \$534, when compared to the program expenditures reported by the State Accounting Office.

Source: FY08 DHR PeopleSoft 998 Subprogram Level Report

Transition to Fee-for-Service

Georgia's community mental health system has historically been funded by Grant-in-Aid (GIA). Under this system, providers are under contract to serve a certain number of individuals each month in exchange for a fixed monthly allocation of grant funds.

In 2004 and 2005, the Healthcare Audits Division (HAD) of the Department of Audits and Accounts released two reports on CSBs at the request of the Governor. Among other things, the reports found that GIA funds were not distributed according to need and suggested that the state consider a Fee-for-Service (FFS) model to ensure greater accountability. A FFS model is one in which providers are paid a fee for the actual services delivered to eligible individuals. The report noted, however, that DHR did not have adequate financial information to determine the appropriate fee amounts for successfully implementing FFS.

In response to the first audit released by HAD, the Governor created the Community Care for Behavioral Health and Developmental Disabilities Task Force as part of the Commission for a New Georgia. The Task Force was to "determine the current state of Georgia's public behavioral health and developmental disabilities delivery system and to develop a comprehensive implementable plan for improvement." In its July 2005 report, the Task Force recommended that MHDDAD adopt a FFS reimbursement model in order to pay for services rather than programs, ensure a fair distribution of funding to all providers, and to ensure the delivery of best practice treatment to all consumers. The Task Force noted that at the time that 33 states had

already moved from a GIA model to a FFS system.

In April 2007, MHDDAD implemented the FFS model in the CAMH Program. CAMH was the first program transitioned to FFS because it had a large disparity between GIA funds paid to providers and the number of C&A served. Under FFS, MHDDAD sets uniform rates for each service, with the rates matching those paid by Medicaid. The FFS method is used to pay for all core services, as well as Intensive Family Intervention (IFI) and residential services⁴ (as of January 2009). Other specialty services are still funded via GIA. (Appendix B includes the rates used to reimburse core and IFI services.)

MHDDAD's adult mental health services were to transition to a FFS reimbursement method by fiscal year 2009; however, the change has not yet occurred. Division officials have indicated that they are still assessing FFS and are not confident that providers are at the point that they would be able to operate under a broader FFS system.

⁴ For residential services, the FFS model is executed in the form of a per-diem payment. Short-term crisis services were not converted to FFS.

Findings and Requested Information

The Fee-for-Service policy has addressed deficiencies of the Grant-in-Aid system; however, we identified issues related to its implementation that may negatively impact the delivery of child and adolescent mental health services.

Deficiencies of the GIA system have been addressed by the move to FFS. The policy has resulted in greater accountability of funds paid to providers of child and adolescent mental health services and has increased consumer choice in portions of the state. The number of children and adolescents receiving mental health services has also increased since the policy's adoption. However, as currently implemented, the FFS method could ultimately result in reduced C&A mental health services in some communities.

The FFS reimbursement method increases accountability by ensuring that CAMH funds are used only for services to C&A and that the services provided to those C&A are appropriate. Under the GIA system, providers were paid a set amount each month regardless of how many children were actually provided services. This allowed providers to use C&A grant dollars to fund other services, such as adult mental health or developmental disabilities services. Under the FFS system, providers must account for each child treated and the intensity of services provided by receiving authorization for services over a period of time and then submitting documentation of the patient encounter. The policy has also led to significant improvement in MHDDAD's data regarding CAMH. Under GIA, MHDDAD received enrollment figures showing those eligible for service, but the information did not identify individuals that actually received services during the reporting period or which services were provided.

Implementation of the FFS model has also resulted in a larger number of CAMH providers and an increase in consumer choice. Most services were provided by 25 CSBs in fiscal year 2004, but an additional 123 non-CSB providers delivered services in 2008.⁵ The degree of choice depends on the area of the state. Multiple providers have been approved to offer C&A mental health services in most Georgia counties, but providers are not serving consumers in each contracted county. The expansion of consumer choice is greatest in metropolitan areas, with six metro counties having residents served by more than 50 providers. In more rural areas of the state, significantly fewer providers are available. In 15 rural counties (283 C&A served), core services were provided by no more than two providers. Eight of these 15 counties are located in the southwest region of the state.

We also found that the number of C&A receiving services increased after the implementation of FFS (see finding on page 15). A review of eight service areas (46 counties) found that six had an increase in the number served between the third quarters of fiscal year 2006 and 2008. The number served increased from 1,216 to 1,640 (35%).

While the FFS policy has been successful in these important aspects, we identified

⁵ Fiscal year 2008 data from DHR's claims processor indicates that CSB and non-CSB providers provided almost the same number of encounters to the uninsured. These encounters include those services reimbursed via FFS, the core services and IFI.

additional issues related to the FFS implementation that could potentially have a negative effect on the availability of CAMH services.

- **Low Demand Areas** – The free-market nature of a FFS policy does not lend itself to ensuring that services are provided in low demand areas of the state. O.C.G.A. 37-2-1 notes that the state has a responsibility to provide mental health services “to all its citizens.” While GIA provided no assurance that this standard was being met, the FFS policy produces an environment where providers are discouraged from offering services in areas where the likelihood of financial benefit is minimal. As shown in **Appendix C**, ten counties had ten or fewer C&A core consumers in fiscal year 2008 and another 21 counties had 25 or fewer. This figure includes all C&A consumers, both uninsured and non-CMO Medicaid.
- **Low Reimbursement Rates and Non-Billable Services** – When DOAA Healthcare Audits released its report recommending FFS, MHDDAD did not have adequate financial information to determine the appropriate fee amounts. It was recommended that MHDDAD determine the cost of providing services before setting FFS rates. However, the Division did not determine the costs of providing the services, instead choosing to set rates to mirror those paid by the state’s Medicaid program. The decision was reasonable given the state’s desire to ensure that providers would not be given an incentive to deem an individual uninsured (forcing payment with state funds) when the individual was actually Medicaid-eligible (payment consisting of approximately 60% federal funds). However, the decision also resulted in adopting rates that were last increased in 1999 and were reduced by 10% in 2003. Given their consumer population of Medicaid and uninsured youth, a vast majority of C&A mental health services provided by CSBs are reimbursed at these low rates. CSB providers assert and MHDDAD officials have acknowledged that the rates are low and may not cover the cost to provide the services.

In addition, not all services traditionally provided to the C&A population are billable under FFS. The services provided to the uninsured population are aligned with the same medically necessary services provided to Medicaid recipients. However, providers stated that GIA funding allowed them to pay for non-billable services, such as coordination with other agencies, that may not be considered medically necessary but are a requirement for the C&A population. It should be noted that O.C.G.A. 37-2-9 requires that “to the maximum extent possible, disability services provided by the division and the regional offices, hospitals, community service boards, and other public and private providers shall be coordinated with related activities of the department and judicial, correctional, educational, social, and other health service agencies and organizations, both private and public.” Currently, there is no method to bill for time spent coordinating C&A services with other agencies.

- **Additional Administrative Costs** – The majority of providers interviewed and surveyed by DOAA indicated they have experienced significant increases in costs attributable to FFS and Medicaid managed care. Providers must now navigate between four “insurers” – APS (MHDDAD’s claims processor) and three CMOs under contract with the DCH. In our survey, 15 of 20 CSBs reported additional costs related to FFS and 17 of 20 reported additional costs related to the CMOs. These costs are due to the additional administrative staff that obtain service

authorizations, submit payment claim forms, and navigate billing requirements. Requirements related to these activities may vary depending on the payer. Adding to the complexity, an individual's payer may change multiple times in a year, with an uninsured individual becoming a traditional Medicaid enrollee while awaiting CMO enrollment. Individuals also move between CMOs. Each time the payer changes, the provider has additional administrative work, including obtaining a new authorization for service delivery.

Finally, increased accountability and consumer choice require additional state spending. MHDDAD has additional costs related to the collection and maintenance of encounter data, as well as additional training, technical assistance, and audits of a larger number of providers. In fiscal year 2008, the CAMH program paid \$8.3 million to a contractor for these services. Division officials stated that approximately \$2.0 million of these costs were one-time and expect future annual costs to be closer to \$5 million.

Unless properly addressed, these issues could result in the closure or reduction of C&A mental health programs in some areas of the state. Five CSBs have reported intentions to limit service availability and another CSB stated it may drop all C&A services. MHDDAD officials have acknowledged that the FFS policy may result in some CSB providers discontinuing C&A services. While MHDDAD's primary concern should not be the viability of a particular provider but the availability of services for all C&A, the closure of a single program in some counties would lead to a disruption in services. C&A in 18 counties received core services solely from a CSB in fiscal year 2008,⁶ and CSBs serve a majority of C&A in other counties. Furthermore, 19 of 20 CSBs responding to our survey stated that C&A revenue no longer covers costs to provide services. If there are few youth to be served in those counties, there is little financial incentive for a new provider to enter that market.

An additional consequence of the transition to FFS is its reported impact on other CSB operations. Twelve (12) of 20 CSBs surveyed indicated that non-C&A populations or services have been affected by the change to FFS and the resulting decrease in C&A funding. They reported that the change to FFS has resulted in staff downsizing and a reduction in services in other programs such as adult mental health. One reason for the wide-ranging impact of the policy is that CSBs were using C&A GIA funds to supplement the costs of non-C&A programs and C&A funds were a significant revenue source for the CSB as a whole (see **Appendix D**).

MHDDAD should continue to evaluate whether the FFS policy will continue to foster service delivery in all areas of the state. The Division should consider whether an additional financial incentive is needed to ensure that C&A mental health services will be provided to all in need, regardless of location. This may require continued expansion of billable services, an increase in FFS rates (statewide or in targeted areas), or a coupling of FFS payments with a baseline or capacity grant (statewide or in targeted areas).

MHDDAD should also determine when and if the FFS model will be expanded to other programs. FFS was recommended as a model for MHDDAD services, not just

⁶ We found that providers were often not serving residents of all counties listed in their provider agreement.

C&A mental health. The Division chose to initially implement the policy for the C&A mental health program because it had the largest gap between funding provided and services delivered. While increasing provider accountability through the use of FFS was important, a conversion of CAMH meant a larger financial loss for providers than if another program had been converted. MHDDAD officials acknowledged that some providers might experience an increase in reimbursements if other programs were converted, while others would experience a decrease.

DHR's Response: *DHR stated that the FFS policy has addressed the deficiencies of the GIA system by ensuring "the provision of services is separated from utilization management, reimbursement is directly linked to services provided to the target population, and the provider pool is open to all willing and qualified providers." At the same time, DHR acknowledged that the FFS system has "shortcomings" to be addressed. DHR agreed that the payment system should "incentivize providers to serve all areas of the state, that reimbursement rates should be sufficient to allow for the delivery of high quality treatments, and that providers should be able to bill for coordination with other agencies and other 'non-medical' services. DHR has and will continue to work to ensure that these issues are addressed."*

DHR recognized that current rates "favor providers who can generate the necessary economies of scale" and agreed that these economies do not exist in all counties. DHR stated that it "continues to explore alternatives for financing behavioral healthcare services to these target areas."

DHR stated that it is working with the DCH to revise the rate structure for Medicaid, on which FFS rates are based. DHR initially believed that rates would be revised by the middle of fiscal year 2008 and now expects new rates to be approved for fiscal year 2010.

Finally, DHR stated that it has been adding "non-medical" services to its list of reimbursable services under FFS. According to DHR, this has included expanding the range of non-medical supports, adding behavioral supports, and adding structured activity supports as billable services. DHR also stated that the Center for Medicare and Medicaid Services has approved a Medicaid waiver for additional billable "wrap-around support services" for certain youth. DHR added that community service transition planning was added as billable in fiscal year 2009.

Community Service Boards have experienced a significant decline in state and federal funding since the transition to Fee-for-Service and Medicaid care management organizations.

Between June 2006 and April 2007, CSBs experienced significant changes in the methods of payments for virtually all of their child and adolescent clients. CMOs became responsible for coordinating and paying for youth enrolled in PeachCare for Kids and many on Medicaid, while DHR transitioned payments for uninsured youth from GIA to FFS for many services. The result of these changes has been a significant decrease in C&A mental health revenue, as well as an increase in administrative costs associated with additional authorization and billing requirements.

In order to assess revenue trends for community service providers, we reviewed fiscal

year 2006-2008 financial statements and/or records for ten CSBs. Our sample included CSBs in both urban and rural areas of the state, and those with both high and low levels of fiscal year 2006 GIA funding. Our sample was limited to CSB providers because many of the current non-CSB providers did not provide service to the MHDDAD population before the transition to FFS.

As shown in **Exhibit 4**, state and federal revenue for C&A mental health declined from 2006 to 2008 for all CSBs in our sample. For all but one CSB, the decline in revenue was greater than 30%, and for five CSBs the decline was greater than 50%. In addition, 15 of 16 CSBs surveyed reported a similar experience, with most describing the revenue decrease as “significant”. The revenue declines experienced by providers in our sample occurred for both the uninsured and Medicaid populations.

- **GIA/FFS Revenue** – In fiscal year 2006, the ten CSBs received \$17.8 million in GIA revenue to provide services to uninsured C&A. In fiscal year 2008, the combination of FFS and GIA revenue to serve this population dropped to \$6.3 million, a decrease of \$11.5 million, or 64.7%. Eight of the ten CSBs had a GIA/FFS revenue decrease of at least 50%. The revenue decrease would have been even greater had MHDDAD not provided supplemental funding during 2007 and 2008. As a result of financial distress experienced by providers, the Division provided additional funding to CSBs in the final quarter of fiscal year 2007 and to all providers in fiscal year 2008. Providers were capped at receiving no more than \$250,000. This additional GIA funding is reflected in the GIA figures in **Exhibit 4**.
- **Medicaid Revenue** – **Exhibit 4** shows that the CSBs also experienced significant, albeit lesser, decreases in Medicaid revenue.⁷ In fiscal year 2006, Medicaid revenue to these providers totaled \$12.6 million. Medicaid revenue dropped to \$8.3 million in fiscal year 2008, a decrease of \$4.3 million, or 34.1%. Three CSBs had a Medicaid revenue decrease of more than 50%, while two had slight increases.

Causal Factors

In an effort to identify the factors that impacted the change in CSB revenue for the period reviewed, we interviewed officials from six CSBs, surveyed the remaining 20 CSBs, and reviewed patient encounter data from the CSBs in our sample. We found that the revenue declines were the result of several factors, which varied depending on the revenue source. The most common factors cited for the decrease in GIA/FFS revenue were a lack of eligible uninsured clients, low reimbursement rates, non-billable services, and service authorizations. Service authorization and other billing issues related to the CMOs were frequently cited as reasons for the drop in Medicaid revenue. These and other factors are discussed in more detail below:

⁷ Medicaid revenue includes payments made by CMOs for Medicaid and PeachCare enrollees.

Exhibit 4 CSB Child and Adolescent Mental Health Revenue Trends Fiscal Years 2006 - 2008					
PROVIDER	FY2006	FY2007^{1,2}	FY2008	\$ Change FY06-FY08	% Change FY06-FY08
Advantage Behavioral Health CAMH Revenue	\$3,662,733	\$3,528,347	\$2,339,630	-\$1,323,103	-36.1%
Grant-In-Aid	\$1,826,408	\$1,454,160	\$146,948	-\$1,679,460	-62.7%
Fee for Service	\$0	\$44,727	\$534,667	\$534,667	
Medicaid/PeachCare	\$1,564,914	\$1,409,406	\$1,111,058	-\$453,856	-29.0%
Other ³	\$271,411	\$620,054	\$546,957	\$275,546	101.5%
Albany CAMH Revenue	\$1,988,557	\$1,509,369	\$992,962	-\$995,595	-50.1%
Grant-In-Aid	\$970,442	\$867,830	\$375,257	-\$595,185	-50.0%
Fee for Service	\$0	\$12,935	\$109,586	\$109,586	
Medicaid/PeachCare	\$835,454	\$398,036	\$324,558	-\$510,896	-61.2%
Other	\$182,661	\$230,568	\$183,561	\$900	0.5%
Cobb CAMH Revenue	\$3,796,447	\$3,196,143	\$1,842,793	-\$1,953,654	-51.5%
Grant-In-Aid	\$2,064,644	\$1,562,434	\$118,464	-\$1,946,180	-74.6%
Fee for Service	\$0	\$39,497	\$404,962	\$404,962	
Medicaid/PeachCare	\$1,129,364	\$905,521	\$930,981	-\$198,383	-17.6%
Other	\$602,439	\$688,691	\$388,386	-\$214,053	-35.5%
Dekalb CAMH Revenue	\$4,937,281	\$3,508,138	\$1,412,716	-\$3,524,565	-71.4%
Grant-In-Aid	\$2,955,915	\$2,233,339	\$542,271	-\$2,413,644	-78.8%
Fee for Service	\$0	\$0	\$84,416	\$84,416	
Medicaid/PeachCare	\$944,577	\$463,348	\$436,004	-\$508,573	-53.8%
Other	\$1,036,789	\$811,451	\$350,025	-\$686,764	-66.2%
Douglas CAMH Revenue	\$1,275,248	\$1,137,458	\$851,624	-\$423,624	-33.2%
Grant-In-Aid	\$388,553	\$389,678	\$98,556	-\$289,997	-26.4%
Fee for Service	\$0	\$10,833	\$187,333	\$187,333	
Medicaid/PeachCare	\$606,767	\$449,199	\$397,831	-\$208,936	-34.4%
Other	\$279,928	\$287,748	\$167,904	-\$112,024	-40.0%
Gateway CAMH Revenue	\$7,013,470	\$5,736,526	\$2,243,493	-\$4,769,977	-68.0%
Grant-In-Aid	\$3,201,121	\$2,863,628	\$392,879	-\$2,808,242	-73.3%
Fee for Service	\$0	\$0	\$461,870	\$461,870	
Medicaid/PeachCare	\$2,885,058	\$2,409,284	\$1,161,199	-\$1,723,859	-59.8%
Other	\$927,291	\$463,614	\$227,545	-\$699,746	-75.5%
Highland Rivers CAMH Revenue	\$5,574,387	\$4,903,718	\$3,095,319	-\$2,479,068	-44.5%
Grant-In-Aid	\$3,642,047	\$3,137,288	\$1,245,257	-\$2,396,790	-52.2%
Fee for Service	\$0	\$0	\$496,762	\$496,762	
Medicaid/PeachCare	\$1,866,862	\$1,727,499	\$1,282,457	-\$584,405	-31.3%
Other	\$65,478	\$38,931	\$70,844	\$5,366	8.2%
Ogeechee CAMH Revenue	\$2,015,573	\$1,605,815	\$1,376,868	-\$638,705	-31.7%
Grant-In-Aid	\$904,649	\$744,385	\$164,873	-\$739,776	-73.0%
Fee for Service	\$0	\$11,252	\$79,329	\$79,329	
Medicaid/PeachCare	\$1,057,892	\$831,782	\$1,065,390	\$7,498	0.7%
Other	\$53,032	\$18,396	\$67,276	\$14,244	26.9%
Phoenix Center CAMH Revenue	\$1,472,299	\$1,155,049	\$504,001	-\$968,298	-65.8%
Grant-In-Aid	\$902,912	\$631,612	\$39,216	-\$863,696	-84.1%
Fee for Service	\$0	\$12,102	\$104,217	\$104,217	
Medicaid/PeachCare	\$523,862	\$451,672	\$322,257	-\$201,605	-38.5%
Other	\$45,525	\$59,663	\$38,311	-\$7,214	-15.8%
Satilla CAMH Revenue	\$2,535,523	\$1,684,627	\$2,156,287	-\$379,236	-15.0%
Grant-In-Aid	\$966,780	\$835,104	\$234,000	-\$732,780	-26.6%
Fee for Service	\$0	\$0	\$475,206	\$475,206	
Medicaid/PeachCare	\$1,226,345	\$638,674	\$1,295,416	\$69,071	5.6%
Other	\$342,398	\$210,849	\$151,665	-\$190,733	-55.7%
Total CAMH Revenue for Sample	\$34,271,518	\$27,965,190	\$16,815,693	-\$17,455,825	-50.9%
Grant-In-Aid	\$17,823,471	\$14,719,458	\$3,357,721	-\$14,465,750	-64.7%
Fee for Service	\$0	\$131,346	\$2,938,348	\$2,938,348	
Medicaid/PeachCare	\$12,641,095	\$9,684,421	\$8,327,151	-\$4,313,944	-34.1%
Other	\$3,806,952	\$3,429,965	\$2,192,474	-\$1,614,478	-42.4%

¹ Fee-for-service payments reflect one quarter of billing in FY07. Some CSBs reported FFS and GIA revenue as a single GIA total.

² Low-income Medicaid-eligible C&As in parental custody stopped receiving services under MHDDAD's Medicaid Rehab Option in June-Sept 2006 and

³ Other funds include client fees, private insurance, contracts, etc.

Source: CSB Financial Statements and Revenue Records (Unaudited Figures)

- **Overestimation of Need** – DHR officials, as well as several providers, indicated that the number of uninsured C&A in need of service may have been overestimated when transitioning to FFS. Providers stated that most consumers that they encounter have some form of public or private insurance. This is supported by the fact that DHR officials expected to expend significantly more on FFS services than actual claims have required. This impact on CSB's total revenue has been partly mitigated by the fact that DHR distributed a portion of these “unused” funds to providers through supplemental GIA payments.
- **Low Reimbursement Rates** – As noted earlier, the FFS rates paid for the uninsured clients are set to match Medicaid rates that were initially set in 1999 and later reduced by 10%. These rates are contrasted with the C&A mental health GIA that both MHDDAD staff and several CSBs considered to be providing more than enough funds to cover the cost of services. Several CSBs acknowledged that the GIA previously received for this population was used to supplement the cost of providing services to other groups. Therefore, even if fees had been set to cover the cost of delivering C&A services, the providers would still have seen a C&A revenue decrease.

While these rates are also used for the Medicaid population, this factor does not explain the decrease in Medicaid revenue. Even if the rates are insufficient, they were in effect for the Medicaid population for the entire period reviewed.

- **Non-Billable Services** – Many providers indicated that they must invest a significant amount of time providing required, but non-billable, services to C&A consumers. As noted earlier, providers are required to provide services that are not reimbursable such as coordinating C&A cases with other agencies, including the Department of Juvenile Justice, the Division of Family and Children Services, schools, and juvenile courts. Providers also noted that an increasing amount of services are community-based instead of clinic-based, but time spent traveling cannot be billed via FFS.
- **Service Authorization and Billing Issues** – Providers pointed to a complex service authorization environment resulting from the transition to FFS and Medicaid managed care as a factor in both decreased revenue and increased administrative costs. Providers are required to obtain authorization in advance of service delivery. In this environment, providers must interact with two or three CMOs for the Medicaid C&A and a MHDDAD contractor for the uninsured. Providers expressed frustration with both the added administrative requirements of this environment and the inconsistent authorization standards for identical services among and within these organizations. CSBs noted that the same individual may switch from one payer to another, and when this is not immediately known, the services provided after the transition are not reimbursed because the new payer had not issued its own service authorization. In our survey of CSBs, problems such as high volumes of claims denials, claims mispayments, and payment delays were reported.

Another factor that impacts revenue in a FFS environment is the number of clients served. However, we found that the change in clients served between fiscal years 2006 and 2008 did not always have a corresponding effect on CSB revenue. For example, one CSB served 20% more Medicaid clients but had a Medicaid revenue

decrease of nearly 39%. Another served 37% fewer Medicaid clients but had a revenue increase of 6%. Instead, during the transition period, the factors above had a much greater impact. See Appendix F for total of uninsured and Medicaid clients served by the providers in our sample.

Increased Provider Costs

In addition to declining revenues, almost all surveyed CSBs reported an increase in costs associated with the transitions to FFS (15 of 20) and Medicaid managed care (17 of 20). Five of the six remaining CSBs that we interviewed also indicated that costs have increased since the FFS and managed care policy changes. Providers we attributed these increases to additional administrative work required to conduct business in a FFS/managed care environment. In one instance, a CSB created an entirely new business unit dedicated to “coordinating revenue” and expanded the number of administrative staff needed to operate from 3 to 11 full-time employees for the service area.

It should be noted that one CSB has already discontinued a CMO contract due to irresolvable issues related to authorizations and unpaid claims. Another four CSBs are still undecided as to whether they will renew some or all CMO contracts, citing significant delays in receiving payments and problems obtaining authorizations.

DHR’s Response: In its response, DHR agreed that the decline in CSBs’ GIA/FFS revenue was primarily due to the FFS implementation. DHR stated that the CSBs in our sample provided only 30% of their contracted C&A mental health services in fiscal year 2006 and that remaining funds were used for non-billable services, capacity funding, and to subsidize other programs and payer sources. DHR expected that state funding to providers would decline with the change in the reimbursement model. DHR also stated that the expansion of provider pool (56% of FFS payments were to non-CSB providers) and the removal of certain services (such as single point of entry) from CSBs contributed to the revenue decline. DHR also noted that the Medicaid payments managed by DHR dropped from \$41.3 million in fiscal year 2006 to \$11.5 million in fiscal year 2008. This was due to the movement of many C&A to CMOs. In response to the service authorization and billing issues with CMOs, DHR stated that it is “unable to comment on issues regarding the relationship between CMOs and their providers, as CMO contracts are managed by DCH.”

The number of uninsured clients served increased significantly in six of eight service areas reviewed. The remaining areas saw a moderate decrease in the number served.

Our review found that the implementation of the FFS policy led to an overall increase in the number of children and adolescents receiving services. In a sample of eight service areas, six had an increase in the number of residents served between fiscal year 2006 and 2008. The primary CSB in five of the service areas served a larger number of clients after the adoption of FFS, but other providers had an increase in seven of eight areas (one had no change).

In order to determine whether the number of uninsured C&A clients has increased or decreased since the implementation of the FFS policy, we analyzed activity data in

eight service areas that provide CAMH services to 46 Georgia counties. We obtained third quarter unique client encounter data for fiscal years 2006 and 2008 from the primary CSBs in the sampled service area.⁸ To estimate fiscal year 2006 encounters for other providers in the service area,⁹ we used a combination of MHDDAD enrollment records and an estimate of the uninsured in the service area. Finally, fiscal year 2008 encounter data for the other providers were obtained from claims submitted to MHDDAD. We limited our scope to only the third quarter because MHDDAD personnel indicated that data quality issues (related to the FFS start-up) likely existed during earlier quarters in 2008 and, at the time of our analysis, the lag time allowed for submitting claims would not permit a review of more recent claims. Our analysis excluded residential services because they were not funded via FFS.

Service Area Trends

Exhibit 5 shows the change in the number of uninsured C&A clients served during the third quarter in fiscal year 2006 compared to the same period in 2008. In six of eight service areas, the number of uninsured clients increased significantly (between 44% and 86%), while the number in the remaining two service areas decreased modestly (between 11% and 22%). It is worth noting that in four of the six service areas that increased the number of C&A served, most of the increase occurred with the primary CSB provider for the service area, not with other providers. However, in the instances when a service area experienced a decline in clients served, the CSB providers accounted for the loss for the area.

Exhibit 5
Uninsured Clients by Selected Service Areas
Third Quarter Fiscal Years 2006 and 2008
(Excludes Residential Services)

Service Area (# Counties Served)	Primary CSB Provider ¹				Other Providers ²				Service Area Totals			
	FY06	FY08	#Chng	%Chng	FY06	FY08	#Chng	%Chng	FY06	FY08	#Chng	%Chng
Brunswick (8)	139	240	101	72.7%	9	35	26	288.9%	148	275	127	85.8%
Albany (8)	28	57	29	103.6%	6	6	0	0.0%	34	63	29	85.3%
Swainsboro (6)	34	49	15	44.1%	2	17	15	750.0%	36	66	30	83.3%
Waycross (8)	115	197	82	71.3%	3	6	3	100.0%	118	203	85	72.0%
Cobb/Douglas ³ (2)	246	216	-30	-12.2%	10	158	148	1480.0%	256	374	118	46.1%
Athens (10)	200	261	61	30.5%	9	40	31	344.4%	209	301	92	44.0%
DeKalb (1)	234	113	-121	-51.7%	80	166	86	107.5%	314	279	-35	-11.1%
Warner Robbins (3)	94	47	-47	-50.0%	7	32	25	357.1%	101	79	-22	-21.8%
8 Service Areas (46)	1090	1180	90	8.3%	126	460	334	265.1%	1216	1640	424	34.9%

1. The **FY06 and FY08 Primary CSB Provider client counts** are taken from CSB records and **do not control** for the client's county of residence.

2. The **FY06 Other Provider client counts** are an estimate using DHR's enrollment data and **do control** for the client's county of residence. The **FY08 Other Provider client counts** are taken from APS and **do control** for the client's county of residence.

3. Two CSBs share an administrative office, and the encounter data for those two CSBs are presented as one service area.

Sources: CSB and APS Encounter data and DHR Enrollment data

⁸ Two CSBs in our sample – Cobb and Douglas – share administrative offices and reported encounter data as one entity. We were unable to analyze the two CSBs' service areas separately, resulting in an analysis of eight service areas served by nine CSBs.

⁹ Other providers in a service area include non-CSB providers, as well as CSBs whose traditional catchment area does not include the counties in our sampled service area.

Provider Trends

Some of the CSBs in our sample experienced an increase in the number of uninsured clients served between fiscal years 2006 and 2008, while others had decreases. Five of the primary CSBs in our sample had increases of more than 30% and three of these experienced increases greater than 70%. Conversely, three of the CSBs in our sample had a decrease in the number of uninsured clients served in fiscal year 2008. In two instances, the decrease was at least 50%.

As a group, the other providers in our sample service areas served significantly more uninsured in fiscal year 2008 than in 2006. In almost all instances, the increase was greater than 100%. Of those served by other providers, 375 of 460 (82%) clients were seen by non-CSB providers; the remaining 85 clients (18%) were served by CSBs that are not the primary CSB for that service area. In urban areas, the other providers were most likely to be non-CSB providers (e.g., 151 of 166 in DeKalb; 154 of 158 in Cobb/Douglas). In rural service areas, CSBs played a proportionally larger role in serving clients (e.g., five of six in Albany seen by CSBs; 14 of 32 in Warner Robbins.)

In the service area discussion above, we analyzed the data to determine whether a service area's location in an urban or rural area of the state correlated strongly with its upward or downward trend in clients served (see Appendix E for a map). We found that this designation was not a reliable indicator of trends in numbers served. Similarly, the provider's urban or rural location did not correlate with a specific trend in clients served.

DHR's Response: DHR stated that its analyses confirm an overall increase in the number of uninsured clients served since the adoption of the FFS policy. It also noted that the number of consumers served under FFS each quarter continues to increase.

The average cost to the state per client receiving CAMH services has drastically decreased since the implementation of the FFS policy.

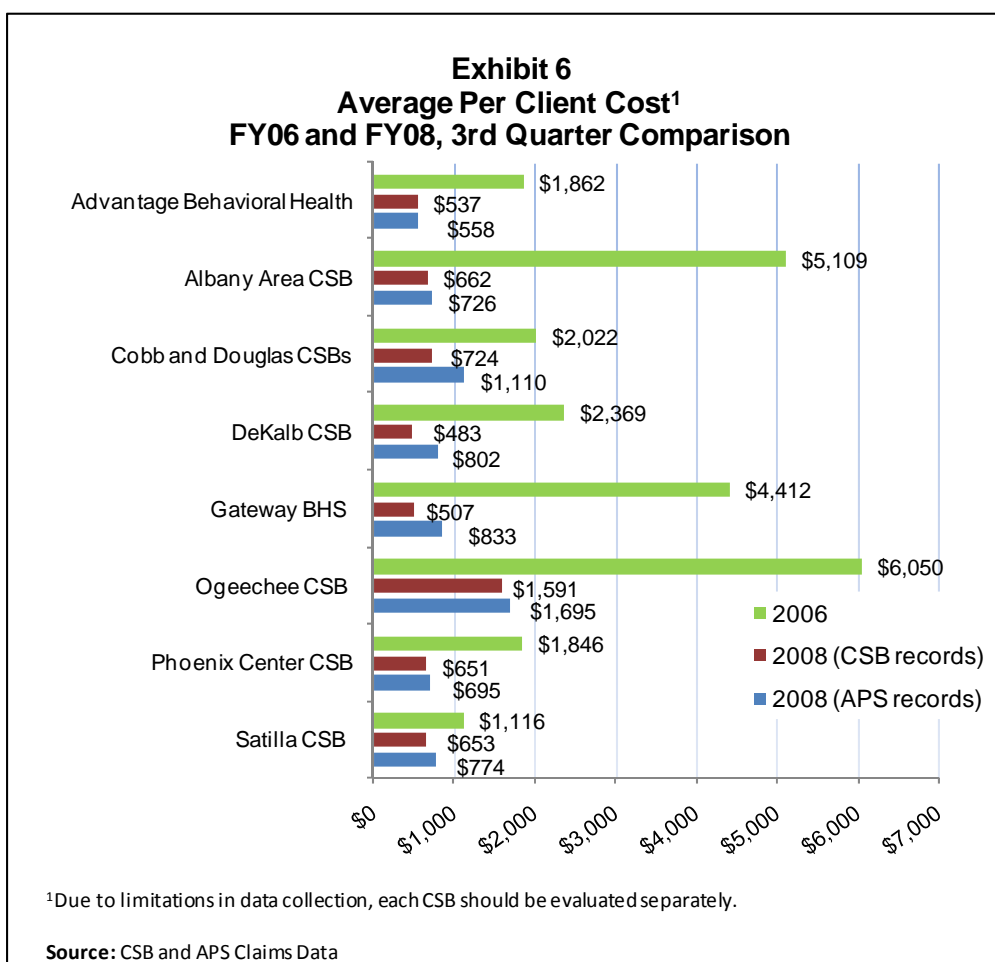
The state paid each of the CSBs in our sample considerably less per uninsured C&A client under FFS than it had previously paid under GIA. The decreases in per client costs to the state ranged from 42% to 89% when using CSB encounter data.

It is important to note that we analyzed the state's cost per client, not each provider's costs of providing C&A services. The state's cost per C&A client was especially high under the GIA system because providers were often using a portion of those funds to serve other populations. Providers explained that C&A mental health was well-funded under GIA and that some of the funds would go to supplement programs that did not pay for themselves, such as adult mental health. As a result of C&A funding being spent on other populations, the cost per uninsured C&A client is artificially high.

To document the change in the average per client cost of C&A mental health services prior to and after the implementation of the FFS policy, we examined the amounts paid by MHDDAD for the delivery of C&A mental health services to the uninsured

for a sample of nine CSB providers.¹⁰ The review was limited to direct services delivered via GIA and FFS and did not include state-level administrative costs and contracts. We excluded expenditures for residential services from our analysis and used client counts established in the finding on page 15. This better isolated the cost trend attributable to the change in reimbursement method.

We conducted two per client cost calculations because of discrepancies that existed between two data sets with fiscal year 2008 client counts. One set (CSB) was taken from the CSB provider information systems, just like the 2006 data. The other set (APS) was taken from the MHDDAD’s claims payer records. This source reported fewer clients when compared to the CSB records in all instances.¹¹ The degree of the discrepancy between CSB and APS records varies by provider. The magnitude of the discrepancy is reflected in the difference in each CSB’s 2008 per client costs to the state.



¹⁰ State-level per client cost data was not available. Our sample of CSB providers covers 46 Georgia counties. The counties are urban, suburban, and rural. In addition, two CSBs in our sample – Cobb and Douglas – share administrative offices and reported encounter data as one entity. We were unable to calculate a cost per recipient for these two CSBs separately, resulting in an analysis of eight averages.

¹¹ APS data only includes encounters for which payments are approved. It does not include unauthorized or non-billable services.

Exhibit 6 shows the results of our per client calculations for the third quarters of fiscal years 2006 and 2008. For all nine CSB providers, the state expenditures for services decreased during the transition from GIA to FFS. In some instances, this decrease was significant. The Ogeechee CSB records, for example, suggest a nearly \$4,500 decrease in cost per client, a decline of nearly 75%. The remaining CSBs show a similar downward trend in funding received from the state per client, with Satilla reporting the lowest percentage drop at approximately 42%. It should be noted that CSB personnel that we spoke with did not indicate that they were spending less per client. In fact, they often pointed to additional costs associated with FFS and Medicaid managed care.

While the analysis indicates a clear decline in the state's cost per client, there are limitations in how the results should be used. For example, it is inappropriate to make comparisons of per client expenditures among the various CSB providers. Each CSB captures client count data in a method that is unique to that provider. As such, cross-provider comparisons are inappropriate to the degree that service records are captured differently. It is more appropriate to compare each provider's fiscal year 2006 and fiscal year 2008 figures when evaluating the effect that the transition to FFS has had on the cost per client.

The decrease in cost per client associated with each CSB can be impacted by several factors. For instance, a CSB's fiscal year 2006 figure is affected by the degree to which it received excess GIA funding in relation to C&A clients served. The gap between GIA funding and clients served varied among providers. Also, in the current FFS environment, the state will correctly incur a different cost per client for each CSB due to a variation in clients and services delivered.

DHR's Response: *DHR stated that, prior to the FFS policy, C&A providers were "earning only one-third of the contract amount for core services through the provision of billable services to uninsured consumers." DHR noted that this leads to an artificially high ratio of the number of consumers served to the amount earned, whereas FFS "ensures that the dollars earned actually reflect provision of services to consumers in the target population." DHR emphasized that the decrease in funding per client does not indicate that C&A clients are receiving fewer services under the FFS model.*

Department of Audits' Response: It is true that our analysis did not indicate that the reduction in funding per client is a result of fewer services. Our analysis did not include a review of the level or type of services provided but was limited to determining the state expenditures per client served.

Appendix A: Objectives, Scope, and Methodology

This special examination of the Child and Adolescent Mental Health Program (CAMH) within the Department of Human Resources (DHR) was conducted to satisfy a request submitted by the Senate and House Appropriations Committees on July 21, 2008.

The request addressed one major objective: to determine the impact of the Fee-for-Service (FFS) policy on Child and Adolescent Mental Health Services. The specific questions to address this objective are listed below.

- A. **Annually, how many children have been served in the community in the 5-year period prior to the implementation of the FFS policy and what was the average cost per recipient? Annually, how many children have been served since the implementation of the FFS policy and what is the average expenditure amount per recipient?**

Program-wide data was unavailable prior to fiscal year 2007 because DHR had no mechanism to track the number of persons actually receiving services. Therefore, we determined how the number served changed in eight service areas¹² by using CSB encounter data to identify how many uninsured C&A living in each service area were served by the CSB assigned to that area in fiscal year 2006 and fiscal year 2008. To identify the number of clients served by non-CSBs in fiscal year 2006, we used a methodology approved by DHR that applied a percentage of total uninsured CAMH clients enrolled with non-CSB providers in fiscal year 2006. Furthermore, we used APS claims records to identify the number of clients served by non-CSBs in fiscal year 2008. Finally, for each service area, we compared the total uninsured served by CSBs and non-CSBs in third quarter fiscal year 2006 to the total served in the same quarter of fiscal year 2008. The scope was limited to only the third quarter of fiscal years 2006 and 2008 because DHR personnel indicated that serious data quality issues (caused by the FFS start-up) likely existed during other quarters in fiscal year 2008 and, at the time of our analysis, the lag time allowed for submitting claims would not permit a review of more recent claims.

In calculating the average expenditure amount per recipient of CAMH services, due to the time required to collect the data, we limited our scope to a sample of nine CSB providers that provide CAMH services to 46 of 159 Georgia counties. Many of the current non-CSB providers did not provide service throughout the period, while the CSBs have a long-established history as community service providers. For the same reasons stated above, the scope was limited to only the third quarter of fiscal years 2006 and 2008.

We obtained financial data from DHR indicating the amount in GIA and FFS

¹² Two CSBs in our sample – Cobb and Douglas – share administrative offices and reported encounter data as one entity. We were unable to analyze the two CSBs' service areas separately, resulting in an analysis of eight service areas served by nine CSBs. In addition, one CSB in our original sample captured encounter data in a significantly different manner from the other CSBs, which resulted in an artificially high number of uninsured clients that distorted our analyses and any comparison of the CSBs. For this reason, one CSB was not included in the analyses of the number served and average expenditure per client.

funds paid to each provider in fiscal year 2006 and fiscal year 2008. We excluded residential services from these analyses because this service – although important to the program – is not funded via FFS and was, therefore, not impacted by the transition in reimbursement method.

We then isolated expenditures for C&A mental health services that were previously paid for with Grant-in-Aid but are now funded with Fee-for-Service and used client counts established in the finding on page 16. Only including services that moved from Grant-in-Aid to Fee-for-Service in the analysis better isolates the cost trend attributable to the change in reimbursement method. Then, we divided the total number of uninsured C&A served into the total GIA/FFS revenue paid (excluding payments for residential services) to determine an average cost per client for the quarter. A second average was calculated for fiscal year 2008 using APS encounter data (MHDDAD's claims provider) which reported fewer clients when compared to the CSB records in all instances. The magnitude of the discrepancy between CSB and APS records varies by provider. The magnitude of the discrepancy is reflected in the degree of difference in fiscal year 2008 per recipient costs.

- B. Have community service providers, such as community service boards, seen a decline in their state/federal fund receipts since the transition to a Fee-for-Service system? If so, is this shift attributable to the Fee-for-Service system and specifically which aspects of this system (such as loss of children/clients to Care Management Organizations, problems with billing, low reimbursement rates, services not covered by the current reimbursement rate system, etc)?**

To address these questions, we limited our scope to 10 of 26 CSBs because, as stated previously, CBSs were providing services both prior to and after the FFS implementation. We reviewed fiscal year 2006 through fiscal year 2008 because it was during this period that payment for mental health services for the uninsured and Medicaid-eligible child and adolescents were changed to Fee-for-Service and managed care, respectively. We obtained unaudited CSB financial records specifically highlighting how the amount in GIA/FFS and Medicaid revenue changed from fiscal years 2006-2008.

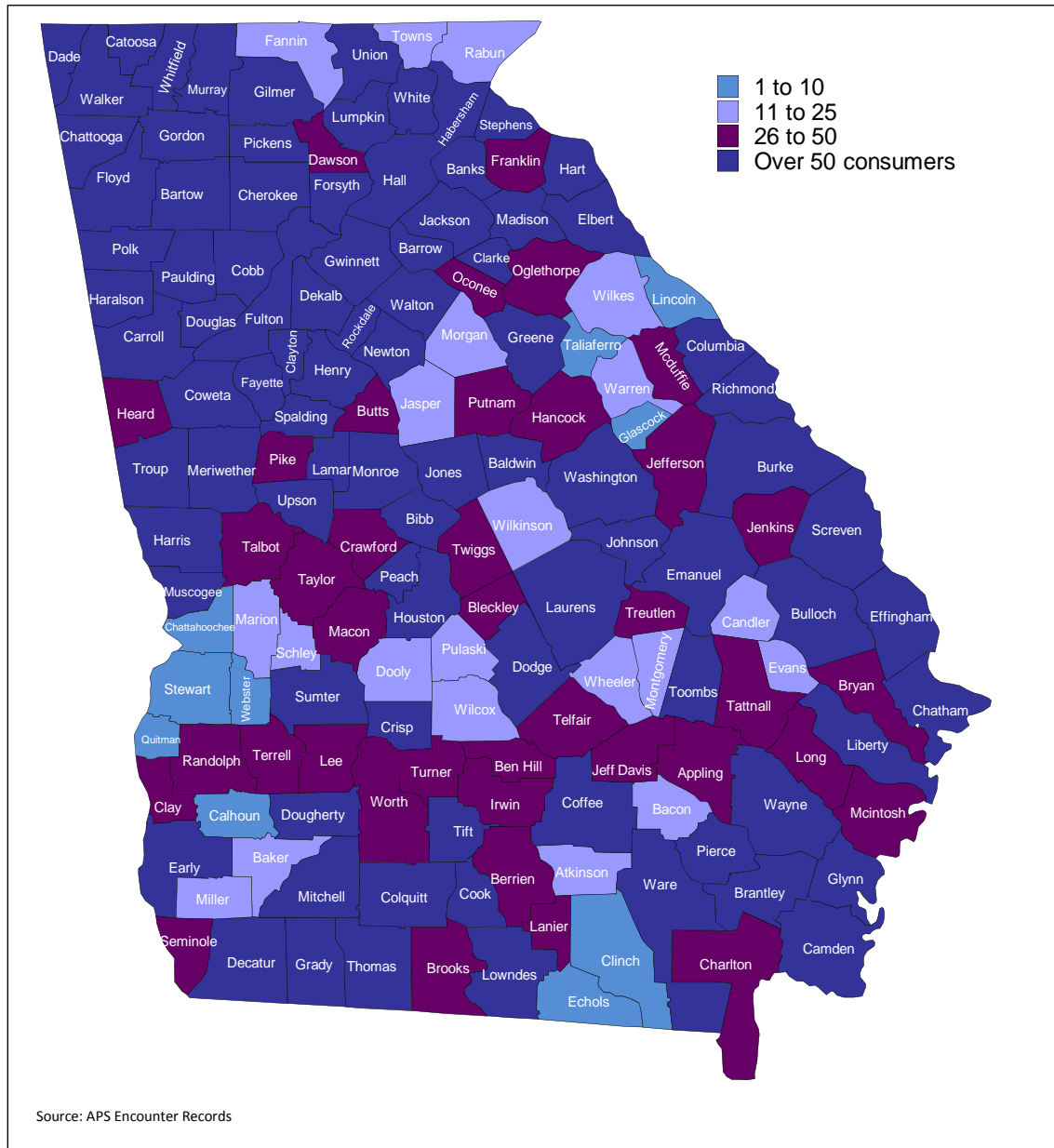
It should be noted that in large part, we relied on encounter data files provided by CSB staff from their information systems for this analysis and expenditures files provided by DHR. We did not evaluate the effectiveness of the general or application controls of the information systems that produced this information, and we did not conduct any work to directly test the reliability of the data (e.g., accuracy or completeness).

We conducted this project in accordance with Performance Audit Division policies and procedures for non-GAGAS engagements. These policies and procedures require that we plan and perform the engagement to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our project objectives.

Appendix B: Fiscal Year 2008 Service Descriptions and Reimbursement Rates

FY2008 Core Services and Reimbursement Rates		
Service Name	Description	Rate
Community Support Individual	Planning, coordination, and monitoring activities are provided to the youth in order to promote stability and build toward age-appropriate functioning in his or her daily environment. Community Support staff serve as the primary coordinator of behavioral health services.	\$16.69
Crisis Intervention	Time-limited and present-focused services directed toward the support of a child who is experiencing an abrupt and substantial change in behavior. The service is designed to prevent out-of-home placement or hospitalization and may involve the youth's family.	Clinic-Based - \$23.96 Out of Clinic - \$27.00
Diagnostic Assessment and Individualized Resiliency Planning	A comprehensive clinical assessment that determines a diagnosis and assists in screening for and ruling-out potential co-occurring disorders. An Individualized Resiliency Plan is developed based on goals identified by the individual with involvement from the youth's responsible caregiver. Required within the first 30 days of service.	\$23.56-\$94.24 ¹
Family Counseling	A licensed clinician provides systematic interactions between the individual consumer, staff, and the individual's family members directed towards the achievement of specific goals defined by the Individualized Resiliency Plan.	\$20.78
Family Training	A mental health professional provides systematic interactions between the individual consumer, staff, and the individual's family members directed towards the achievement of specific goals defined by the Individualized Resiliency Plan.	\$20.78
Group Counseling	A licensed clinician provides therapeutic services in a group setting that are intended to achieve specific goals defined by the Individualized Resiliency Plan.	\$14.30
Group Training	A mental health professional provides therapeutic services in a group setting that are intended to achieve specific goals defined by the Individualized Resiliency Plan.	\$14.30
Individual Counseling	A licensed clinician provides therapeutic services to the youth that are intended towards achievement of specific goals defined by the Individualized Resiliency Plan.	\$34.70-\$104.10 ²
Medication Administration	Administration of an oral or injected medication. Requires a physician's order and supervision.	\$24.67
Nursing Assessment and Health Services	Assessments, evaluations, education, monitoring and care provided by a licensed nurse during the course of a youth's treatment.	\$24.44
Physician Assessment and Care	Specialized medical and/or psychiatric services provided to a youth by a licensed medical physician with behavioral health training that support the youth's Individualized Resiliency Plan.	\$33.69-\$132.13 ³
Pharmacy	Includes dispensing prescribed medications and youth, family, and staff education and monitoring to ensure safe and effective use of medications. Services are not reimbursed by MHDDAD.	N/A
<p>¹Behavioral Health (MH/AD) Assessment and Service Plan Development are reimbursed at \$23.56. Psychological testing by a Clinical Psychologist is reimbursed at \$94.24.</p> <p>²Rate varies depending on length of session and whether it is interactive. The high end of range is for a 75-80 min session of Interactive Individual Psychotherapy.</p> <p>³Rate for psychiatric diagnostic exam and psychotherapy varies depending on the credentials of the practioner providing care (e.g. Physician, Physician Assistant, Nurse Practitioner, etc) , length of session, and whether the service is interactive. Lower rates in range are for pharmacologic management services.</p> <p>Source: FY2008 MHDDAD Provider Manual and FY2008 MHDDAD Services & Rates Table</p>		

Appendix C: Number of Core Consumers per County, FY08

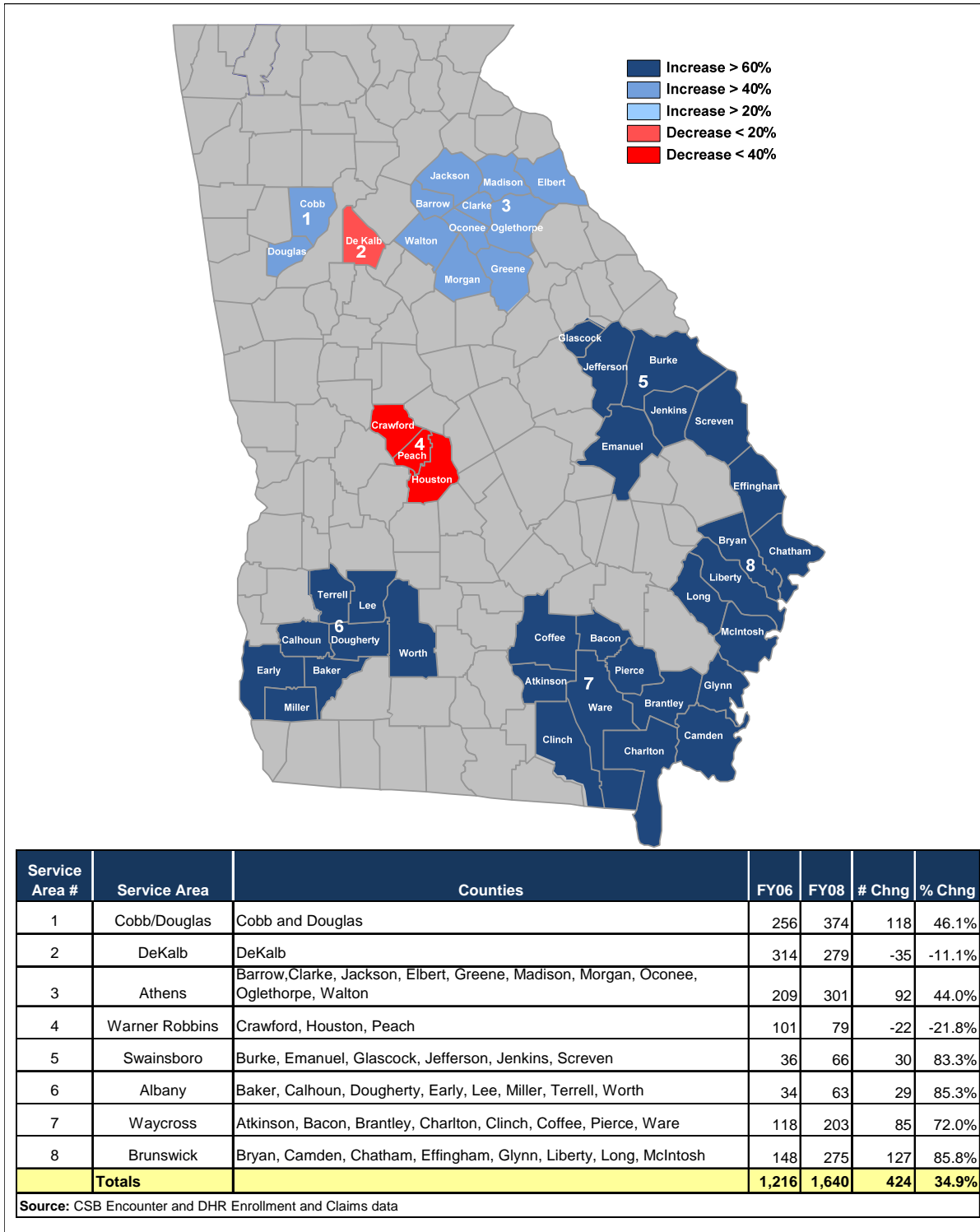


Appendix D: Comparison of CAMH Revenue to Total CSB Revenue, FY06-FY08

PROVIDER	FY2006	FY2007	FY2008	\$ Change FY06-FY08	% Change FY06-FY08
Advantage Behavioral Health CSB Revenue	\$28,289,949	\$27,723,847	\$29,637,800	\$1,347,851	4.8%
CAMH	\$3,662,733	\$3,528,347	\$2,339,630	-\$1,323,103	-36.1%
% of Total Revenue	12.95%	12.73%	7.89%	-	-
Albany CSB Revenue	\$16,064,816	\$17,227,976	\$16,073,055	\$8,239	0.1%
CAMH	\$1,988,557	\$1,509,369	\$992,962	-\$995,595	-50.1%
% of Total Revenue	12.4%	8.8%	6.2%	-	-
Cobb CSB Revenue	\$24,904,831	\$23,666,338	\$22,527,875	-\$2,376,956	-9.5%
CAMH	\$3,796,447	\$3,196,143	\$1,842,793	-\$1,953,654	-51.5%
% of Total Revenue	15.2%	13.5%	8.2%	-	-
Dekalb CSB Revenue	\$33,644,374	\$31,266,624	\$31,063,459	-\$2,580,915	-7.7%
CAMH	\$4,937,281	\$3,508,138	\$1,412,716	-\$3,524,565	-71.4%
% of Total Revenue	14.7%	11.2%	4.5%	-	-
Douglas CSB Revenue	\$4,913,082	\$4,111,561	\$4,184,820	-\$728,262	-14.8%
CAMH	\$1,275,248	\$1,137,458	\$851,624	-\$423,624	-33.2%
% of Total Revenue	26.0%	27.7%	20.4%	-	-
Gateway CSB Revenue	\$30,621,632	\$27,701,665	\$33,781,526	\$3,159,894	10.3%
CAMH	\$7,013,470	\$5,736,526	\$2,243,493	-\$4,769,977	-68.0%
% of Total Revenue	22.9%	20.7%	6.6%	-	-
Highland Rivers CSB Revenue	\$35,454,256	\$30,194,853	\$31,391,589	-\$4,062,667	-11.5%
CAMH	\$5,574,387	\$4,903,718	\$3,095,319	-\$2,479,068	-44.5%
% of Total Revenue	15.7%	16.2%	9.9%	-	-
Ogeechee CSB Revenue	\$11,386,734	\$9,922,254	\$9,559,022	-\$1,827,712	-16.1%
CAMH	\$2,015,573	\$1,605,815	\$1,376,868	-\$638,705	-31.7%
% of Total Revenue	17.7%	16.2%	14.4%	-	-
Phoenix Center CSB Revenue	\$9,416,755	\$10,956,603	\$7,651,216	-\$1,765,539	-18.7%
CAMH	\$1,472,299	\$1,155,049	\$504,001	-\$968,298	-65.8%
% of Total Revenue	15.6%	10.5%	6.6%	-	-
Satilla CSB Revenue	\$18,290,808	\$16,700,948	\$21,657,848	\$3,367,040	18.4%
CAMH	\$2,535,523	\$1,684,627	\$2,156,287	-\$379,236	-15.0%
% of Total Revenue	13.9%	10.1%	10.0%	-	-
Total Revenue for Sample	\$212,987,237	\$199,472,669	\$207,528,210	-\$5,459,027	-2.6%
CAMH	\$34,271,518	\$27,965,190	\$16,815,693	-\$17,455,825	-50.9%
% of Total Revenue	16.1%	14.0%	8.1%	-	-

Source: CSB Financial Statements and Revenue Records

Appendix E: Changes in Clients Served for Select Areas, FY06 to FY08



Appendix F: Changes in Total Number Served for Select Providers (Including Residential Services)

Provider	FY06 CSB Data ²	FY08 CSB Data ²		FY08 APS Data ³	
	Total Served	Total Served	Total Served % Change	Total Served - Uninsured	Total Served Uninsured %
Advantage Beh Health CSB (Athens)	1,100	1,117	1.55%	-	
Uninsured	200	261	30.50%	251	25.50%
Medicaid	923	865	-6.28%	-	
Albany Area CSB	390	376	-3.59%	-	
Uninsured	28	60	114.29%	52	85.71%
Medicaid	347	328	-5.48%	-	
Cobb and Douglas CSBs¹	1,324	987	-25.45%	-	
Uninsured	246	216	-12.20%	141	-42.68%
Medicaid	1,060	786	-25.85%	-	
DeKalb CSB	1,006	530	-47.32%	-	
Uninsured	234	124	-47.01%	68	-70.94%
Medicaid	808	426	-47.28%	-	
Gateway BHS CSB	1,555	1,325	-14.79%	-	
Uninsured	140	240	71.43%	146	4.29%
Medicaid	1,348	946	-29.82%	-	
Ogeechee CSB (Swainsboro)	480	361	-24.79%	-	
Uninsured	34	49	44.12%	46	35.29%
Medicaid	429	309	-27.97%	-	
Phoenix Center (Warner Robbins)	345	394	14.20%	-	
Uninsured	94	49	-47.87%	44	-53.19%
Medicaid	271	324	19.56%	-	
Satilla CSB (Waycross)	1,061	733	-30.91%	-	
Uninsured	115	197	71.30%	166	44.35%
Medicaid	871	549	-36.97%	-	
Total Served by CSB	7,261	5,823	-19.80%		

¹Two separate facilities with one administrative office. Therefore, available encounter data combines both CSBs.
²Payor categories are not mutually exclusive; therefore Uninsured and Medicaid categories may not equal total number served.
³Due to Department of Community Health CMOs now serving a significant number of Medicaid C&As previously served by MHDDAD in FY06, APS Medicaid numbers are not reflected in this Appendix.

Source: CSB and APS Encounter Records

For additional information or for copies of this report call 404-657-5220 or see our website:
http://www.audits.state.ga.us/internet/pao/rpt_main.html