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Preparing for a Public Sector Mental Health Reform in New Mexico: The Experience of Agencies Serving Adults with Serious Mental Illness

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Abstract

In 2005, New Mexico began a comprehensive reform of state-funded mental health care. This paper reports on differences in characteristics, infrastructure, financial status, and available services across mental health agencies. We administered a telephone survey to senior leadership to assess agency status prior to and during the first year of reform. Non-profit/public agencies were more likely than others to report reductions or no changes in administrative staff. CMHCs were more likely to report a decline in their financial situation. Findings demonstrated that CMHCs, non-profit/public agencies and rural agencies were more likely to offer critical services to adults with serious mental illness in the first year of reform. The comprehensiveness of services offered by these types of agencies may be an advantage as the state moves to a core service agency approach.

Keywords

Rural; mental health; staffing patterns; Medicaid reform

Introduction

We examine the experience of direct service agencies in the first year of a major reform of publicly-funded mental health care in New Mexico. To understand the potential effects of this initiative, we review how prior Medicaid managed care (MMC) reforms affected the administrative costs of provider agencies. We then assess differences in the experience of non-profit/public agencies and community mental health agencies (CMHCs) during the first year of reform. Both types of agencies are more likely to deliver specialized services to adults with serious mental illness (SMI) in low-income and underserved states such as New Mexico. Finally, we examine the experience of rural provider agencies, since they comprise a fragile mental health safety net.

The President's New Freedom Commission on Mental Health (2003) identified disjointed funding and contradictory rules that guide service implementation under public sources as

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principal barriers to the seamless delivery of high quality care. In 2005, the New Mexico state government placed all publicly-funded mental health and substance use treatment services, previously financed by fifteen separate state agencies, under the management of a single for-profit corporation, ValueOptions New Mexico (VONM). This managed care company was tasked with developing and introducing uniform fee schedules, utilization review protocols, quality standards, service packages and billing and reporting requirements (Interagency Behavioral Health Purchasing Collaborative, 2005).

As New Mexico had existing unmet mental health needs, the explicit aims of this reform were to “do no harm” in the first year of implementation and then work toward enhancing access to services (Willging et al., 2007). During the first year, the state government prohibited any changes in payment rates for agencies. However, agencies were informed that the reform would eventually involve substantial changes in payment rates as well as in service provision and credentialing requirements. No additional funding would be forthcoming to offset the costs incurred by provider agencies in responding to these changes. The first year of reform would also involve little to no immediate change in their regular operations, therefore providing an opportunity to maximize the delivery of billable services and to reduce staff or increase administrative capacity to better weather future changes.

The reform was intended to increase system efficiency, partly through the consolidation of state funding for mental health services and the reduction of administrative costs borne by providers participating in publicly-funded programs. The state government expected that VONM’s implementation of standardized administrative requirements and processes for billing, utilization review, record keeping, and reporting would reduce these costs.

This study adds to the literature on Medicaid managed care (MMC) and large-scale system reform. Previous studies of MMC found that agencies often increase staff time or change their service array (Beinecke et al., 1999). Implemented in 1997, New Mexico’s first major statewide reform, MMC for physical and mental health services, increased administrative costs and burdens for direct service providers (Willging et al., 2005; Willging et al., 2008). Mental health agencies added administrative staff to respond to increasing paperwork and complex authorization requirements and to communicate with multiple managed care organizations. Few studies have examined the effect of an agency’s characteristics on their response to reforms that aim to establish internally consistent and comprehensive service delivery systems (Cohen & Bloom, 2000).

CMHCs, Non-Profit/Public Agencies and Rural Mental Health Agencies

CMHCs, non-profit/public agencies and rural mental health agencies play crucial roles in delivering intensive community-based services to adults with SMI. Our analyses therefore focus on these three agency characteristics (CMHC or not, ownership, and rurality). Since their creation following the Community Mental Health Construction Act of 1963, CMHCs have been the principal and often only source of comprehensive mental health outpatient services for adults with SMI in underserved areas (Cutler et al., 2003). The New Mexico Department of Health, which licenses CMHCs, reinforces this public health orientation by requiring the centers to offer consultation and crisis services in addition to therapeutic and psychosocial interventions.

Non-profit health care organizations comprise the largest proportion of the mental health system in low-income areas. They play key roles in developing innovative services that may be only marginally profitable (Schlesinger & Gray, 2006). With their mission to serve community needs, non-profit agencies are more likely to provide a full range of services, whereas for-profit agencies are more likely to consider the potential for net income in selecting specific services to deliver (Harrison & Sexton, 2004).

Rural areas have population and infrastructure characteristics that can impede development and retention of mental health services. Compared to urban areas, rural areas have fewer financial resources to fund services because of higher levels of unemployment and poverty and lower levels of insurance; therefore, specialty care is scarce (Hauenstein et al., 2007; Merwin et al., 2006). The dominance of a small number of agencies creates a rural mental health infrastructure that is sensitive to changes in financing and administrative requirements. Compared to their urban counterparts, agencies and individual providers in these less densely populated areas have less ability to offset Medicaid's lower payment rates and tight utilization controls with higher volumes of patients (Felt-Lisk et al., 1999).

This paper reports on the activities of mental health agencies in New Mexico during the first year of reform, a critical transition period in which they could prepare for future changes. The paper illuminates differences in infrastructure, staffing and funding likely to affect how agencies respond to changes. Intended changes included an expanded role for these organizations to function as core service agencies that coordinate and deliver a comprehensive set of community-based services. We expected that CMHCs, non-profit/public agencies and rural agencies would be more likely to have a "wait and see" attitude regarding reform due to their greater dependence on public monies. We hypothesized that the three agency types would be more likely to make no changes or reduce clinical and administrative staff. We also expected that they would be more likely to experience financial stress due to their reliance on reform-related revenue. Since this survey was fielded prior to major efforts to unify requirements for participants in public programs, our results present a baseline picture of agencies that treated adults with SMI.

Methods

Data in this paper were collected with the goal of learning about each agency's experience during the first year of the New Mexico reform. The 55-item survey asked about organizational characteristics, staffing patterns, administrative issues, financial issues, clinical care and perceptions of reform. This survey is one component of a 5-year, multi-method assessment that also employs ethnographic methods and secondary analysis to evaluate how reform affects access and quality of care for adults with SMI (Semansky et al., 2009; Willging, et al., 2008).

Survey Development

Survey questions were derived from systematic reviews of the contract between the state government and VONM (Interagency Behavioral Health Purchasing Collaborative, 2005), agency surveys used to study reforms in Massachusetts and Michigan (Beinecke, et al., 1999; Hodgkin et al., 2002), and input from several national experts in the field. Further information regarding survey development is available in a separate article (Semansky, et al., 2009). The PIRE Review Board approved the study.

Recruitment

We identified all mental health agencies (74 in total) that served adults with SMI, Medicaid enrollees, and indigent populations for participation in the statewide survey. Mental health agencies were contacted between August 2006 and January 2007. Doctoral-level research staff trained to consistently code and probe ambiguous responses administered the survey over the telephone, usually to the chief executive officer or the clinical director. The survey required an average of 45 minutes to complete. Sixty-six agencies agreed to participate in the survey, resulting in a response rate of 89%. We examined whether there was response bias. A Cochran-Mantel-Haenszel test indicated that for-profit agencies were significantly

less likely to respond than non-profit/public agencies ($p < .0001$). This was the only significant difference between responders and non-responders.

Measures

To define rurality, we use a dichotomized version of the Rural-Urban Continuum Codes (RUCC), which define counties as rural based on adjacency to larger economic centers and population size (Economic Research Service, 2005). With the small number of agencies in our survey, we simplified the RUCC's nine-level scale to a standard binary classification (urban or rural). Agencies were classified as 'urban' if they were located in a county with a RUCC Code of 1 to 3 and 'rural' if they were located in a county with a code of 4 to 9 (Vanderboom & Madigan, 2007).

In the agency survey, we asked about the percentage of revenue from different funders. Percentage of revenue from the reform was equivalent to the percentage of all revenue from contracts with VONM. The percentage of revenue from all public sources was derived by summing the percentage of revenue from contracts with VONM and from other public funding such as Medicare, the Federal Department of Housing and Urban Development and the State of New Mexico Corrections Department. We asked whether the agency offered each of 13 community-based services for adults with SMI: individual therapy, crisis services, individualized dual diagnosis treatment, evaluation, case management, family support services, medication management, illness management and recovery, psychosocial rehabilitation, intensive outpatient, supported employment, peer support, and supported housing. The financial health of agencies was measured by whether the agency had a surplus, deficit, or broke even in a State Fiscal Year (SFY).

Research Questions

In addition to the rural versus urban comparison, this analysis considers differences between non-profit/public agencies versus for-profit agencies and between CMHCs and non-CMHCs. We considered two research questions. First, are there differences across the three types of agencies that are likely to impact how agencies respond to more far reaching reform changes in subsequent years? These differences may concern infrastructure, revenue sources, financial health of the organization, staffing qualifications and available services that can affect the ability to respond to new utilization review, billing and reporting processes. Second, are there differences across the three agency types that lend insight into preparedness to address the extensive changes expected in later stages of reform, particularly the addition of new mental health services funded by non-traditional public sources (e.g., Aging and Long-Term Services Department and Mortgage Finance Authority) and the establishment of core services agencies?

Data Analysis

We used chi-square and t-tests to compare means and proportions across groups. We also performed Cochran-Mantel-Haenszel tests, in place of chi-square tests, for analyses involving small cell sizes. For the analysis of clinical staffing changes, we developed a three-level categorized version of the numerical clinical staff change, i.e., increase (positive number), no change (0) and decrease (negative number). The same categorization was applied to the measure of administrative staff changes. Similarly, for analyses of financial status, we recoded the three categorical responses into numbers: (a) loss = -1; (b) break even = 0; and (c) positive balance = 1. First, we performed a chi-square test on the mean changes in financial status by each classification variable in the year before and first year after reform for the entire sample. We then compared the mean changes in financial status for each agency before and after reform with a t-test. For example, one analysis assessed whether changes in financial status before and after reform differed between for-profit and

non-profit/public agencies. In the examination of available services offered, we report the proportion of agencies offering each service, both overall and within the three types. We also calculated the average proportion of each service offered. Logistic regression was used to identify predictors of agency adoption of computerized medical records and reduction in administrative and clinical staff. All authors certify responsibility for the study and report no conflicts of interest.

Results

Distribution of Agency Types

Overall, 41% ($n = 27$) of provider agencies were CMHCs. Thirty-five percent of responding agencies were located in rural areas ($n = 23$). CMHCs comprised a higher proportion of agencies in rural areas than urban areas (52.2%, vs. 34.9%, $\chi^2 = 2$, $P = .17$). Nearly two-thirds of agencies were non-profit, and a much higher proportion of agencies were non-profit in rural areas than in urban areas (91.3%, vs. 72.1%, $\chi^2 = 3$, $P = .07$).

Infrastructure

Computerized billing was widespread (89% of agencies), but computerized medical records less so (39% of agencies). CMHCs were more likely than non-CMHCs (68% vs. 39%) to be less than the median size of agencies ($\chi^2 = 5$, $P = .03$). A majority of agencies (62%) received state funding for indigent services. All CMHCs received state funding for services to the indigent compared to 54.2% of non-CMHCs ($\chi^2 = 29$, $P < .0001$). Non-profit/public agencies were more likely than for-profit agencies (68.6% vs. 35.7%) to receive state funding for indigent services ($\chi^2 = 5$, $P = .025$). No other statistically significant differences in these characteristics were found. Because the adoption of computerized medical records differed by both ownership and rurality, we ran a logistic regression model to assess whether being a rural agency or a non-profit/public agency had a greater impact. Neither characteristic was statistically significant (data not shown).

Finances, Staffing and Changes over Time

On average, agencies received 49% of their revenue from reform-related sources and 76% from public sources. The mean percentage of staff with clinical licenses was 53%. In these three domains, CMHCs differed from non-CMHCs in having a lower mean percentage of clinical staff with independent licenses (45.4% vs. 57.6%, $t = 2.54$, $P = .014$), and receiving higher mean percentages of revenue from reform-related sources (59.5% vs. 41.6%, $n = 54$, $t = -2.32$, $P = .029$) and all public sources (84.5% vs. 69.4%, $t = -2.36$, $P = .022$). Non-profit agencies/public agencies had a lower mean percentage of clinical staff with independent licenses (48.7% vs., 66.1%, $n = 58$, $t = 2.54$, $P = .014$). No other statistically significant differences in these characteristics were found.

At least half of agencies reported no change in administrative or clinical staff in SFY 2006 during the first year of reform. Twenty-nine percent of agencies increased administrative staff and 32% increased clinical staff, which in both cases exceeded the proportion reporting reductions. We conducted t-tests to determine whether administrative staffing changes differed within each agency type (e.g., rural compared to urban, etc.). Non-profit/public agencies were more likely to report reductions (14% vs. 0%) or no change in administrative staff (61.2% vs. 57.1%) compared to for-profit agencies, which were more likely to increase clinical staff (42.9% vs. 24.5%, $\chi^2 = 3$, $P = .077$). Controlling for CMHC and rural status, non-profit/public agencies increased clinical staff by 11 percentage points less than did for-profit agencies ($P = .02$).

Overall, more agencies experienced no change or a worsening of their financial situation compared to the year before reform, SFY 2005, and the first year of reform, SFY 2006 ($P < .0001$). Using the same paired t-test approach, we found that CMHCs were more likely than other agencies to have experienced a declining financial situation (17.1% vs. 26.9%, $\chi^2 = 3$, $P = .059$). Differences in change score between non-profit/public and for-profit, and between urban and rural agencies, were not statistically significant.

Behavioral Health Services Offered

Overall, the services most commonly offered by provider agencies serving adults with SMI were individual therapy (91% of agencies) and crisis services (82%), while the least commonly offered services were peer support (32%) and supported housing (30%). CMHCs offered significantly more of the 13 possible mental health services that we considered than non-CMHCs (78.4% vs. 48.2%, $t = -6.04$, $P < .0001$); non-profit/public agencies offered more services considered than for-profit agencies (63.8% vs. 48.2%, $t = -2.12$, $P = .04$). Finally, rural agencies offered more services than urban ones (69.4% vs. 55.8%, $t = -2.14$, $P = .04$). More detailed information on the specific services offered at the different types of agencies is available from the authors.

Limitations

This study has several limitations. Our sample is potentially not fully representative, because for-profit agencies were significantly more likely to refuse to participate. Because of the small number of agencies in New Mexico, we had to simplify the RUCC into a dichotomous measure of rurality, thereby losing the ability to examine gradients of rurality (Economic Research Service, 2005). In addition, the small number of agencies within the state limited our ability to identify differences as statistically significant.

Discussion

Our analysis supported several differences cited in the literature between non-profit/public and for-profit agencies. First, non-profit agencies were more likely than for-profit agencies to employ clinicians requiring supervision. Relying heavily on public funding, non-profit agencies tend not to have the revenue to cover the salaries of more expensive independently licensed staff (Ivey et al., 1998). Second, non-profit agencies were more likely to offer services for the seriously mentally ill (e.g., case management, medication management, psychiatric rehabilitation and supported housing) and to deliver a full range of services that are often less profitable than psychotherapeutic services (Harrison & Sexton, 2004). Third, for-profit agencies were less likely to receive funding from the state for uninsured adults with SMI. The lower level of for-profit participation in the state indigent program may be attributable to the requirement that funding recipients serve all uninsured patients.

The analysis identified the largest number of statistical differences between CMHCs and non-CMHCs, supporting the idea that CMHCs play a continuing historic role in delivering services to adults with SMI (Cutler, et al., 2003). Compared to non-CMHCs, CMHCs were more likely to accept indigent funding, receive a higher percentage of their revenue from reform-related and all public sources and to deliver specialized services for adults with SMI (e.g., case management, evaluation, medication management, illness management and recovery, psychosocial rehabilitation, supported employment, peer support and supported housing).

Overall, more agencies reported a loss in the first year of reform versus the year before reform, leaving them with fewer financial resources in subsequent years. In addition, non-profit agencies appeared to be cautious in terms of administrative and clinical staffing

decisions. CMHCs may have less flexibility in changing staffing and services, as indicated by the increase in the proportion of agencies whose financial status deteriorated in the first year of reform compared to the year before reform. The smaller staff size of CMHCs may intensify the impact.

Mental health services researchers have identified key differences between agencies in rural and urban areas. We found that rural agencies were more likely to offer a comprehensive array of services and less likely to specialize, a finding supported by other studies (Harrison & Sexton, 2004; Schlesinger, et al., 1996). No other statistically significant difference in agency characteristics or experiences was found between rural and urban agencies. A potential negative implication for the broader infrastructure within rural areas is that small providers may be prevented from competing in the marketplace, which could create difficulties in remaining fiscally solvent. Such providers may also experience pressure to expand populations served or to find larger agencies with which to collaborate or merge. Closer relations with other agencies may alter the missions and cultures of these agencies.

In sum, the New Mexico reform is at the forefront of initiatives to eliminate the fragmentation and duplicative regulations of publicly-funded behavioral health services. The President's New Freedom Commission on Mental Health (2004) recommends that the nation improve access in rural areas. An understanding of the characteristics of agencies delivering mental health care in rural areas is crucial to developing effective plans and programs to enhance access. Our analysis suggests that rural agencies, non-profit agencies and CMHCs should have competitive advantages in terms of offering comprehensive services because the reform favors core service agencies that deliver a full service array. In addition, CMHCs have lower staffing costs that give them a competitive advantage. However, the rural context will continue to create challenges for agencies in recruiting staff, delivering services over large geographic areas, and increasing service volume to offset rising costs. The ongoing experience of New Mexico's reform will offer critical lessons about the interplay between comprehensive reform initiatives and the rural mental health infrastructure.

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