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June 5, 2008

Dear Health Policy Advocate,

We want to take this opportunity to alert you, an opinion leader concerned about healthcare, to recent developments at the state and federal levels that may significantly impact the financial condition of New Hampshire's ten Community Mental Health Centers (CMHCs). Changes in the structure of the State's Medicaid reimbursement system have the very real potential to reduce the CMHCs' operating revenues below levels which can be sustained and, if left unchecked, will likely lead to serious cutbacks in services and perhaps closure of some centers.

Specifically, the Centers for Medicaid and Medicare Services (CMS) has proposed retroactive changes in how case management is defined and how providers are reimbursed for case management services. The NH Department of Health and Human Services (DHHS) now has bundled a rate for case management services, which obligates centers to provide wide variety of services that support the clinical treatment plan and supports the person's ability to live in community.

The proposed Targeted Case Management approach eliminates the bundled rate and offers unit-based reimbursement for case management services under more restrictive definitions. This doesn't come close to covering the cost of the range of mandated services centers provide that were, until now, supported by the bundled rate. Such a change could lead to as much as a 40% reduction in CMHC reimbursements, which is clearly insufficient for the centers' operations, especially when reimbursement from Medicaid is approaching 80% of total revenues for some programs. The change was implemented on March 3, 2008 and the final rules are not due to be available until August 15, 2008. In addition, state law requires the centers to care for any eligible individual who presents himself or herself regardless of the ability to pay, which, in many cases, mandates the provision of non-reimbursed services.

We invite you to read the enclosed white paper giving more detail on the problem.

As we are sure you can appreciate, the financial impact of these changes is potentially overwhelming, and we are at the mercy of federal regulators and state budget constraints. Throughout this process we will continue our mission of providing critical mental health services to our communities, but we must also be mindful of the fiduciary responsibilities we have as non-profits.

Over the next several weeks we will keep you informed of developments as they occur. If in the meantime you have questions or concerns, please feel free to contact us.

Sincerely,

Jay Couture, MHA
Executive Director, Seacoast Mental Health Center
Chair, Community Behavioral Health Association

For more information, please visit our website: www.nhcbha.org

BEHAVIORAL HEALTH SERVICES IN NEW HAMPSHIRE

Stress on the Non-Profit Delivery System

June 5, 2008

Introduction

Mental health services in the New Hampshire Medicaid system are primarily provided through ten geographically diverse, private, non-profit community- based mental health centers. Under the State Medicaid Plan, behavioral health services are part of the core Medicaid benefit and NH seeks to maximize the use of Medicaid funds to support these services .

RSA 135-C, which established this framework, also requires the ten community mental health centers (CMHCs) to provide services for all NH citizens who present themselves for care whether they are eligible for Medicaid, have other resources or have no resources. As a result, the centers, by virtue of their designation as CMHCs per RSA 135-C, are required to provide a significant amount of free care. Much of the State's obligation to provide mental health care to Medicaid recipients has therefore been shifted to these non-profit centers.

For some programs, reimbursement from Medicaid is approaching 80% of total revenues. Please refer to the enclosed brochure for a description of the CMHCs and the services they will provide to nearly 50,000 NH residents this year.

Eligibility for CMHC Services

To qualify for services in the NH Behavioral Health system, adults must be diagnosed with one of the eight approved mental health diagnoses as defined in the Diagnostic and Statistical Manual of Mental Disorders IV, also called the DSM IV, and meet the required level of functional impairment as a result. There are three categories of eligible clients:

1. "Severe and Persistent Mental Illness (SPMI):" Has mental illness as defined by the DSM, has functional impairment, and requires services – all for more than one year.

2. "Severe Mental Illness (SMI):" Known or suspected to have a mental illness defined by the DSM, has functional impairment, and requires services – all for less than one year.

3. "Low Utilizer" groups: Can be SPMI or SMI, but either refuses services, receives services through another system such as the Developmental Disabilities system or New Hampshire Hospital, or no longer meets the criteria for SPMI or SMI, but needs services to prevent a relapse. Services for low-utilizers are "capped" by DHHS.

Children are eligible if they have a "serious emotional disturbance" or personality disorder, and exhibit a "serious psychosocial dysfunction" according to DSM standards. Medically-based eligibility determinations for adults must be performed by a qualified professional every year, and every six months for children.

Financial Structure:

Medicaid is viewed as the principle source of funding for behavioral health services administered by the State. People in need of community mental health services who do not immediately qualify financially for Medicaid are placed in the Medicaid In and Out Program and have a "spend down" amount they need to incur before they are eligible for Medicaid. However, community mental health centers have sliding fee scales and will not deny services to those in need who cannot pay. In these cases, the centers look to other funding, including community organizations and business donors, grants, and private giving.

The Medicaid system is a shared program between the states, which are responsible for care and a portion of the costs, and the federal government, which funds a portion of the care and regulates the system to ensure that states are providing care according to its benefit and payment guidelines. For the most part, state governments, including NH's, do not actually provide community mental health care, but rather contract with providers. The ultimate responsibility to care for eligible Medicaid recipients, however, is that of the state government.

As an example, DHHS rules and State contracts with the CMHCs require that emergency services shall be available 24 hours a day, 7 days per week and are accessible to clients anywhere in the region served by the provider. CMHCs are only reimbursed if insurance covers the service; Medicaid does provide some reimbursement but caps the payment at 1.5 hours no matter how much longer it might take. Because most centers now use virtually all of their general funds for the Medicaid match, there is no fiscal support to cover emergency services for the un- or underinsured who do not have the ability to pay.

While this gap has always been a challenge for the centers, a series of financial events have emerged to create a serious increase in this cost-to-revenue-coverage gap. As result, the delivery system for Medicaid's behavioral health care is close to failure, exposing the State to a health care crisis.

The Emerging Crisis

A combination of changes in federal reimbursement rules relative to how the State has chosen to structure Medicaid reimbursement, medical inflation, and commercial insurers' shifting of costs and risks to behavioral health providers, has very quickly developed and is putting great stress on the financial structure of the non-profit centers. Left unaddressed, the foundation of New Hampshire's behavioral health care delivery system is at serious risk of failure.

These recent developments include the following:

- Federal rules: A new federal rule on billing for targeted case management may mean about $20M in losses for NH's ten community mental health centers over the next year. Some members of Congress have criticized the rule, which took effect March 3rd, as a backdoor way of changing Medicare and Medicaid (CMS) without public or congressional input or approval. Adding to the concern over this development is that the final rules for the rate methodology are not due to be enacted until August, and will be retroactive to March 2008. It could create a financial impact that will cause an immediate disruption to the centers' ability to serve clients and will create a public health predicament that State officials will have to rapidly address. The CMHCs support the one-year moratorium on the rule introduced by a bipartisan group of sponsors in Congress on March 14th; however, no final action has been taken on this measure.

- Decreased State funding: A recent report from the NH Center for Public Policy Studies shows that for the period of 2008-2009, recipients of community mental health services have increased by 5% while State funding increased only 2%. We have not kept pace.

- Budget cuts: Cuts to the Department of Health and Human Services (DHHS) budget have already been made this year due to decreased State revenue. DHHS provides the community mental health centers with over half of their funding, most of which is matched by federal Medicaid funds. The expectation is that even deeper cuts may be on the way as the Legislature grapples with the budget deficit. Virtually every dollar in general fund cuts to mental health centers results in two dollars lost from total revenue.

- Medicaid cost-shift: In FY2007, the State shifted $4.5M in Medicaid costs to the centers. The cost-shift comes about as a consequence of the previously described Medicaid In and Out program requiring recipients who make more than $594 per month to meet a monthly spend-down.

- Residential Treatment Program Collapse: Another symptom of the funding crisis is seen in the drastic reduction in the availability of in-patient beds in NH. The number of beds at designated receiving facilities (DRFs) dropped from 101 to only 12 in the past eight years; and the number of beds in acute psychiatric residential treatment programs (APRTPs) fell from 52 to 17 between 2000 and 2003. Catholic Medical Center in Manchester announced just last week that it will shut down its inpatient psychiatric unit on July 1st. Some individuals in need of residential support are now directed to the state hospital where per diem costs are very expensive. Still others fall out of the health care system altogether and end up in correctional systems at the state or county levels.

- Insurance costs: Since 1990, insurers have increased premium costs to employers, causing some to increase deductibles and co-pays for employees and others to become self-funded plans which are allowed to reduce benefits for mental health care despite New Hampshire's strong parity law. This trend has created a population of under-insured who now outnumber the uninsured in our region.

Summary

These state, federal and insurance changes do not eliminate the requirement of community mental health centers to provide state-mandated services or the need for behavioral health services, but only shift these costs to others. The reality is that these non-profit centers cannot continue to absorb losses, and may have to reduce the availability of services, eliminate consumer programs or even close completely, if these trends continue.

The ten community mental health centers operate as separate and independent organizations. Each of these non-profits has a volunteer board with fiduciary duties regarding the management, investment and expenditure of the funds received by the center for its community purposes. The impacts of the financial cost shifts have already begun to affect the centers' operations. One CMHC has already eliminated 8 staff positions in 2008 and has reduced benefits to employees. More cuts are expected.

The financial strain will have similar impacts on all the centers, with the largest financial event likely to be triggered by determinations surrounding the CMS targeted case management rules. The first impacts will be seen in the centers' operations, the need to reduce staff and potentially limit care. The centers will begin to execute reductions and program closures, and many vulnerable Medicaid recipients will begin to not receive care.

As this reduction in care emerges, management of the behavioral health care system will unravel. People in need of mental health care will begin to present themselves at hospital emergency rooms and local welfare agencies. In addition, local law enforcement and state and county correctional institutions will see an increase in incidents and admissions, as untreated mental health issues manifest themselves.

Once the community mental health centers are not capable of operating an effective behavioral health care system for Medicaid recipients, it will fall upon DHHS to meet the federal requirements of the State Medicaid Plan.

Conclusion

The NH behavioral health system as implemented by the ten community mental health centers is an integral part of "safety net" for NH citizens. However, budget and regulatory constraints put on the centers by the state and federal governments now threaten to undermine the very core of the system. Limiting or eliminating services to those in need will only create larger societal and financial problems in the future. State leaders and NH's Congressional delegation need to work together to find a fix for the current crisis before irreversible harm is done.