NH Community Behavioral Health ASSOCIATION

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NH House Budget Proposal
Mental Health: Impact Statement

Budget Summary: Bureau of Behavioral Health facts and impacts associated with NH House Amendment to HB 1 & HB 2, the State Operating Budget.

FACT:
3,400 children currently diagnosed with Serious Emotional Disturbance (SED) will be eliminated from the mental health system. The required definition change will permanently eliminate from Medicaid and State law relative to access to care at Community Mental Health Centers (RSA 135-C:13) access to care for children with serious emotional disturbance.

IMPACTS:
These are children with a Severe Emotional Disturbance who require services. They will be at high risk for harming themselves or others in the community without services, will require frequent hospitalizations, will also have increased contact with law enforcement and hospital emergency departments, and may require costly out of district placements for educational and/or residential care. The costs for serving this group of individuals will be completely cost-shifted to: family members, special education and local school budgets, hospital emergency departments, and hospital inpatient units including New Hampshire Hospital (NHH), which will lose all capacity and law enforcement. [i] Costs of "service" alternatives are more restrictive and more costly.

Some of the savings associated with this reduction may be shifted to NHH as children, unlike adults, do not lose their Medicaid when they are admitted to an IMD (institute for mental disorders, i.e., NHH) so the State would be paying a general fund match for all inpatient stays for Medicaid-covered children.

NH will likely be found in violation of the Americans with Disabilities Act (ADA) and Olmstead[1] for failure to provide community based services that prevent institutional care, which will result in a Federal lawsuit. Communities are likely to have safety concerns.[ii] The State will risk litigation or regulatory penalties by failing to comply with the Federal EPSDT (Early Preventative Screening Diagnosis and Treatment) regulations under which all Medicaid insured children shall be provided medically necessary care. The House-proposed Budget offers no guidance on how these children should be discharged from the system. It is likely that because of ethical and clinical obligations, and to avoid harm to the individuals, and litigation, the Community Mental Health system providers might have to continue care without being paid for some period of time.

[1] The 'integration mandate' of the Americans with Disabilities Act requires public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

There remains serious concern that these reductions violate federal law relative to ensuring maintenance of effort (MOE) by the state. An adverse finding on this matter could cost the State additional federal dollars.

As a federal program, some measure of those deemed no longer eligible will likely appeal their determination, leading to a significant number of appealed cases and litigation for the both the Community Mental Health Centers and the State of NH.

The significant reduction in Medicaid individuals served at the Community Mental Health Centers resulting from this and other budget cuts will eliminate 400 – 500 direct service jobs.

FACT:

3,540 Adults with a Severe Mental Disability, including those diagnosed with severe mental illness and those diagnosed with severe and persistent mental illness, will be eliminated from the mental health system. The required definition change will permanently eliminate access to care for these adults from Medicaid and State law relative to access to care at Community Mental Health Centers (RSA 135:C:13).

IMPACTS:

These are individuals with a Severe Mental Illness who require services. They will be at high risk for harming themselves or others in the community without services, will require frequent hospitalizations, will also have increased contact with law enforcement and hospital emergency departments, and the costs for serving this group of individuals will be completely cost-shifted to: family members, hospital emergency departments, hospital inpatient units including NHH which will lose all capacity, and law enforcement.[iii]

Cost for care in non-NHH inpatient units would be billed to and covered by Medicaid for inpatient care to treat psychiatric issues as well as any physical and medical issues that may arise from self harm such as a suicide attempt.

Two methods for implementation of this reduction have been outlined by DHHS:

A. In one scenario adults with SMI would no longer be eligible. This would mean that someone being discharged for a first hospitalization from NHH would not be eligible for services at a CMHC, since the only covered category for adults would be SPMI (severe and persistent mental illness) which is a category that cannot be applied until you have been diagnosed as SMI for one year.

B. The second scenario presented would require that any adult who is designated as SMI or SPMI (eligibility designations that are currently valid for two years) and does not meet the criteria for four consecutive weeks would be discharged. There is no clarity on how this would work or what additional administrative burdens would be required to re-assess eligibility on a constant basis and then terminate treatment when someone with a chronic mental illness is doing better for a short period of time. Questions arise for the CMHCs such as the risk of creating a worse situation for these individuals. This would be analogous to terminating treatment for a diabetic or a person who requires dialysis because they have had four good weeks of assessments. Also, what is the legal liability for a prescribing physician when care is terminated, particularly if there is no primary care for the client or if the primary care will not prescribe psychiatric medications such as atypical antipsychotics.

NH will likely be found in violation of the Americans with Disabilities Act (ADA) and Olmstead for failure to provide community-based services that prevent institutional care, which will result in a Federal Law Suit. Communities are likely to have safety concerns.[iv]
These adults with serious mental illnesses will likely see deterioration in their condition that might eventually cause them to become sick enough to re-qualify for more expensive mental health treatments. Some of these clients would successfully commit suicide. Others may become involved in the criminal justice system. Inpatient care and incarceration would ultimately cost taxpayers more money.
There remains serious concern that these reeducations violate federal law relative to ensuring maintenance of effort (MOE) by the state. An adverse finding on this matter could cost the state additional federal dollars.

As a federal program, some measure of those deemed no longer eligible will likely appeal their determination, leading to a significant number of appeal cases and litigation for the both the Community Mental Health Centers and the State of NH.

The significant reduction in Medicaid individuals served at the Community Mental Health Centers resulting from this and other budget cuts will eliminate 400 – 500 direct service jobs.

FACT:
700 Adults whose mental illness is currently under control, who are low utilizers of the system, but who could become more severely ill, will be eliminated from the mental health system

IMPACTS:

The definition of this group of individuals who will be eliminated from the system is found in rules (He-M 403): A CMHP shall determine that an adult has SMI or SPMI with low-service utilization if he or she:

(1) Has a mental illness but no longer meets all the criteria for SPMI or SMI and receives services that are designed to prevent relapse;

Elimination of this category will result in relapses requiring more costly, more restrictive care such as inpatient services at community hospital emergency rooms, inpatient units and/or NHH. The cost of these services outside of NHH would be covered by Medicaid and in NHH by general fund dollars at a rate far greater than for services provided in the community to prevent relapses. Currently this eligibility category is limited to $4,000 per year of service. One inpatient stay could far exceed that cost.

(2) Has functional impairments that are due to a developmental disability or receives services primarily through another agency such as a provider for persons with developmental disabilities or New Hampshire hospital; or

These are generally cases shared between a community mental health center and an AREA agency. The consumer or legal guardian has the ability to choose who is the primary provider. When the CMHC is not the primary provider, this is the category assigned. The services received at the CMHC are provided to treat only the mental illness and do not duplicate services provided by the AREA agency that does not have psychiatrists on staff and does not have the ability to provide specialized psychiatric services for their population. These individuals will likely experience a decompensation relative to their psychiatric issues and may require more costly inpatient services or become involved with the legal system should behavioral issues escalate.

(2) Meets criteria for SPMI or SMI but has refused recommended services and for whom the CMHP is providing outreach.

We are often a lifeline for difficult to engage individuals and families allowing people to engage in services when they are ready to do so, but also being aware of when an individual may be decompensating to a degree that requires intervention.

The significant reduction in Medicaid individuals served at the Community Mental Health Centers resulting from this and other budget cuts will eliminate 400 – 500 direct service jobs.

FACT:
Services for mentally ill individuals who are eligible for Medicaid, but who are able to access the CMHC system, will have a $300 service limit placed on their care.

IMPACTS:
This would cover 1 intake evaluation, and 1 psychiatrist visit per year[v].

Currently Medicaid recipients who do not meet the clinical criteria for SMI, SPMI, LU, SED or SED-IA have an annual limit for CMHC services of $1,800 per year. Once an assessment is made to determine whether or not someone meets the State criteria for BBH-eligible care, a provider may determine that care is warranted and appropriate even though the person may not meet the level of impairment required for the State eligibility categories. A reduction in the benefit limit will essentially mean that you are asking clinical providers, who have codes of ethics for their profession, to determine that someone is in need of services and then not provide those services. A psychiatrist would likely be hesitant to provide any medication-related service given that they would not be able to provide ongoing follow-up care. Prescribers have a legal and ethical level of care required when they prescribe medications.

Lack of access to care beyond an intake assessment will likely lead to deterioration that could have been avoided resulting in more costly, more restrictive care. Some of these individuals will harm themselves or others and will require services in emergency departments, community hospital inpatient units and NHH, all at a cost greater than the $1,800 limit currently allowed.

FACT:
The Budget reduces projected Medicaid caseload growth (based on actual historical data) from 2.5% per year to 0% per year.

IMPACTS:
In the likely event that caseloads do grow, the State will have not adequately budgeted and additional fiscal shifts, executive orders or other agency actions will need to be taken to find dollars to account for this cost. For the first 6 to 9 months of FY2012, the system will remain a fee for service system, so if cases increase, eligible recipients will be entitled to care and the State will have an obligation to pay the general fund portion of Medicaid payments.

FACT:
Reimbursements for Community Mental Health Centers' targeted case management will be reduced by $4 million over the biennium.

IMPACTS:
The cost for this care will not be reduced, only the level of payment; as a result, the lower reimbursement level will be shifted to the non-profit community mental health centers, thus increasing unfunded liabilities to the centers. An audit conducted by the LBA in 2010 identified the issue of uncompensated

care as a leading policy and financial concern to the State. This action makes the problem worse. This rate reduction is in addition to significant rate reductions totaling approximately $7M implemented in FY2010 (July 1 for non-eligible intake and therapy; and Oct 15 for the FSS cap/ rate cuts) and FY2011 (the 2011 FSS rate cut was effective in August).

FACT:
A waiting list system will be created for those who are eligible for care, but for whom the community-based system does not have resources to provide care.

IMPACTS:
The burden for care will shift to family members to provide supports until the individual is able to access services at the CMHC, primary care practices, and school systems for children and local hospitals. In addition, these individuals will be at risk for harming themselves or others in the community without services, will require frequent hospitalizations, will also have increased contact with law enforcement and hospital emergency departments, and the costs for serving this group of individuals will be completely cost shifted to: family members, special education and local school budgets, hospital emergency departments, hospital inpatient including NHH which will lose all capacity, and law enforcement. Services for Medicaid recipients will be end up being more restrictive and costly due to the lack of availability of appropriate community- based care.
The creation of any wait list mechanism for people needing medically necessary services will require the state to develop clinical guidelines and policies for delaying treatment. If a person with mental illness has an increasing clinical need while on the wait list and has an "incident" the state will have additional liability as a result.
A new liability risk will emerge for the CMHCs and the State in the event an individual is harmed, harms himself or others, while he is on a waiting list.

FACT:
The current community-based non-profit system will be altered by reducing the number of local administrative units by 30% and seeking bids from either for-profit or non-profit alternatives.

IMPACTS:
The current Community Mental Health system is built around local private, not-for-profit, 501(c)3 organizations managed by a local Board of Directors. Any decision to alter the number or types of contracts for service will require an administratively burdensome and time-consuming process that would require Board approval and consideration of fiduciary impacts and organizational mission, which are outside the control of the Legislature.

The current NH Medicaid system for community mental health centers does not pay separately for administrative costs. Any perceived savings associated with this change would not and cannot be directly captured in Medicaid savings.

This section of the budget is particularly confusing. The bill suggests that the bids for this care would be required for contracts beginning on July 1, 2011, one day after the budget is expected to be enacted. The budget does not assume any savings associated with this effort, nor are there any guarantees the bids would not cause costs to increase.

FACT:
The Medicaid and Business Policy section of the DHHS budget proposed by Division III of House Finance assumes a $25 million savings associated with a new federal "health home" program in which a 90% federal match will be paid for through integrated care efforts undertaken by the Community Mental Health System. These savings associated with a larger federal "source of

funds" allocation will be realized in the Bureau of Behavioral Health sections once implemented, yet the BBH budget does not reflect this. As a result, it is likely that the budget is wrong, in that the savings are being booked in the wrong section of the budget.

IMPACTS:
The result of this booking of BBH dollars in the Medicaid and Business Policy section of the budget is the need to seriously reduce the BBH budget and make the cuts outlined above. The resulting impact on thousands of lives, the loss of hundreds of jobs, downshifting of millions of dollars, exposing the State and non-profit organizations to costly litigation and putting at risk the entire community mental health system, is related to this accounting decision by the House budget writers.

FACT:
The budget imposes several new and large administrative burdens on the Community Mental Health Centers. These include changes associated with new managed care provider contract relationship; some type of required bidding for Medicaid contracts; human resource costs associated with employee terminations and unemployment taxes; as well as likely litigation costs.

IMPACTS:
The administrative budget requirements, serious reductions in Medicaid reimbursements, and increasing unfunded mandates, will clearly put a number of the non-profit Community Mental Health Centers in financial jeopardy and could cause the entire system to fail. For these non-profit organizations, HB 1 & HB 2 will have costly financial impacts.

These new State-imposed administrative costs have additional payments associated with them. Sizable lay-offs or employee reductions might trigger the WARN Act without adequate time to properly notify impacted employees as required in the federal law.

CONCLUSION
The proposed budget will reduce reimbursements to individuals with mental illnesses by $68.1 million over the biennium. This reduction in care will be achieved by changing the definitions of what constitutes a severely mentally disabled person who would be eligible for care in the community mental health system, along with several other serious changes to the system which are outlined below.

On July 1, 2011, nearly 8,000 low-income, disabled and uninsured children and adults who are today receiving care for their serious mental illness or serious emotional disorder will be removed from the system with no alternative provided for, no adequate time period, and no alternative options to allow for any appropriate clinical termination or transfer of care. The proposed House budget make a dramatic cut in mental health care, eliminating more than a third of those who now receive Medicaid covered services. In order to achieve this cut and be in compliance, the definitions of who is qualified for care at the Community Mental Health Centers will be changed. The policy change eliminating this care is not just for Medicaid recipients, but also for others who under NH law today are eligible for care.

As a result of the changes, only the most seriously mentally ill will be cared for in the system. The concept to investing in wellness, to prevent more serious and expensive care, has been abandoned.

This proposed budget suspends or abandons the Department's and the State's recognition of the fragility of and need for restoration of New Hampshire's community mental health system as outlined in the Ten Year Plan, released in the fall of 2008. Elimination of these services will cause harm, up to and including death, while at the same time NOT saving the money intended, but instead spending it in more costly and restrictive levels of care, incarceration and litigation, while at the same time resulting in unemployment for 400-500 individuals across the state.

[i] Source, March 9, 2011DHHS Briefing materials, page 63 http://www.dhhs.nh.gov/ocom/documents/options.pdf
[ii] Source, March 9, 2011DHHS Briefing materials, page 63 http://www.dhhs.nh.gov/ocom/documents/options.pdf
[iii] Source, March 9, 2011DHHS Briefing materials, page 62 http://www.dhhs.nh.gov/ocom/documents/options.pdf
[iv] Source, March 9, 2011DHHS Briefing materials, page 63 http://www.dhhs.nh.gov/ocom/documents/options.pdf
[v] Source, March 9, 2011DHHS Briefing materials, page 63 http://www.dhhs.nh.gov/ocom/documents/options.pdf