


NH Bureau of Behavioral Health



Payment Reform- Board Briefing
January 20, 2010

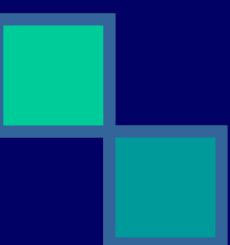



Historical Funding Approach

- In prior years, availability of funding could keep pace with growth in demand for services.
 - Growth was fairly predictable, as were utilization patterns.
 - New programs and services were funded with targeted appropriations approved by the Legislature.
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Historical Funding Approach

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- More state funds have been used to leverage Federal matching funds to support services to the Medicaid population.
 - Medicaid client growth in the community mental health system has been fairly predictable at 2.6% per year
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Current Challenges

- Due to the downturn in the economy, we are seeing unprecedented increases in the Medicaid population coming in for services
 - FY 08 to FY 09 had an increase of 10.4%
 - FY 09 to FY 10 is projected at 10.5% increase
 - Combined increase in 2 years of 21%
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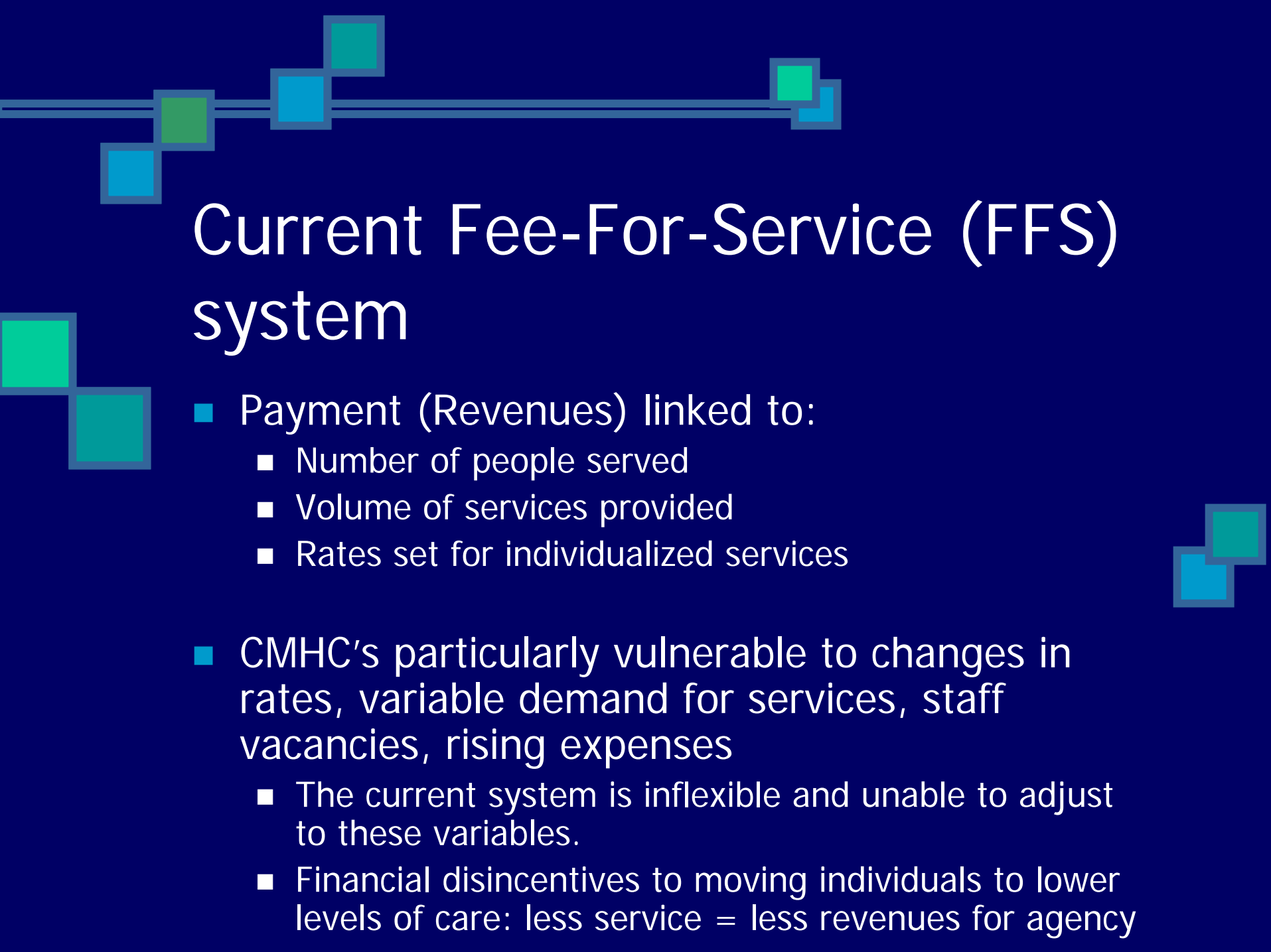
Current Challenges, continued

- High proportion of revenues in the community mental health system dependent on Medicaid services and Medicaid revenues- on average 75%
 - Range: 66% to 85%
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Current Challenges, continued

- Medicaid rates: Actual cost of the service versus the current reimbursement
 - Varies by service how closely the rate approximates the actual cost
 - Do not currently have a separate funding stream for services to the uninsured
 - State mandates services based on level of impairment, not payer source by Statute.
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Current Fee-For-Service (FFS) system

- Payment (Revenues) linked to:
 - Number of people served
 - Volume of services provided
 - Rates set for individualized services
- CMHC's particularly vulnerable to changes in rates, variable demand for services, staff vacancies, rising expenses
 - The current system is inflexible and unable to adjust to these variables.
 - Financial disincentives to moving individuals to lower levels of care: less service = less revenues for agency

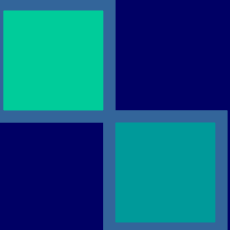



Current Budget Challenges for FY 10/11

- More people coming in for services
 - More diverse and challenging population to serve
 - Inadequate community based resources to meet the need
 - 10-year mental health plan
 - Medicaid funds for FY 10: \$90.8M
 - Actual expenditures FY 09: \$92.8M
 - Started FY 10 with projected Medicaid payments exceeding \$99M
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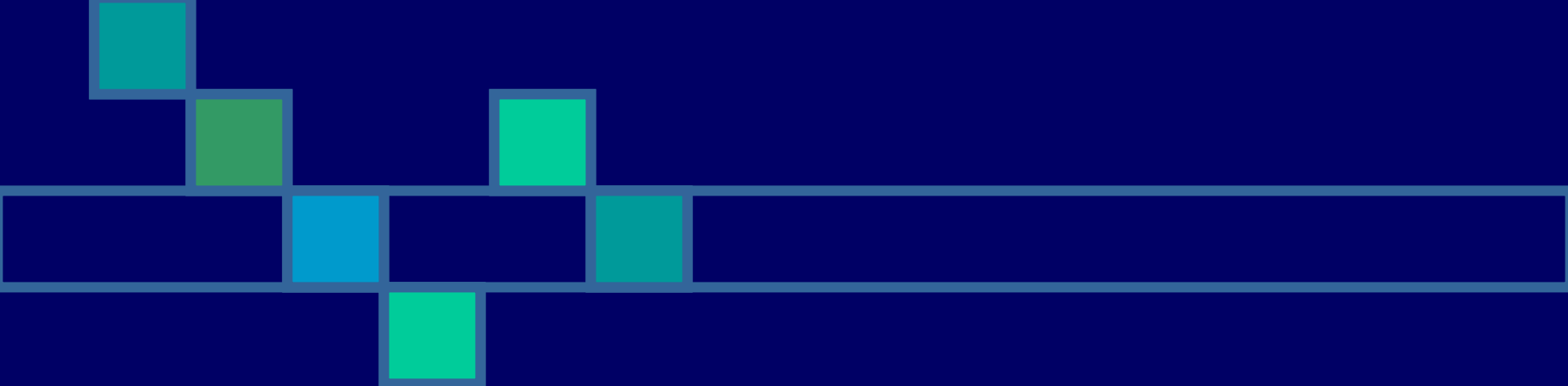
Cost Containment Measures

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- October 2009
 - Rate reductions to Functional Support Services, Targeted Case Management
 - Established daily limit on FSS for adults
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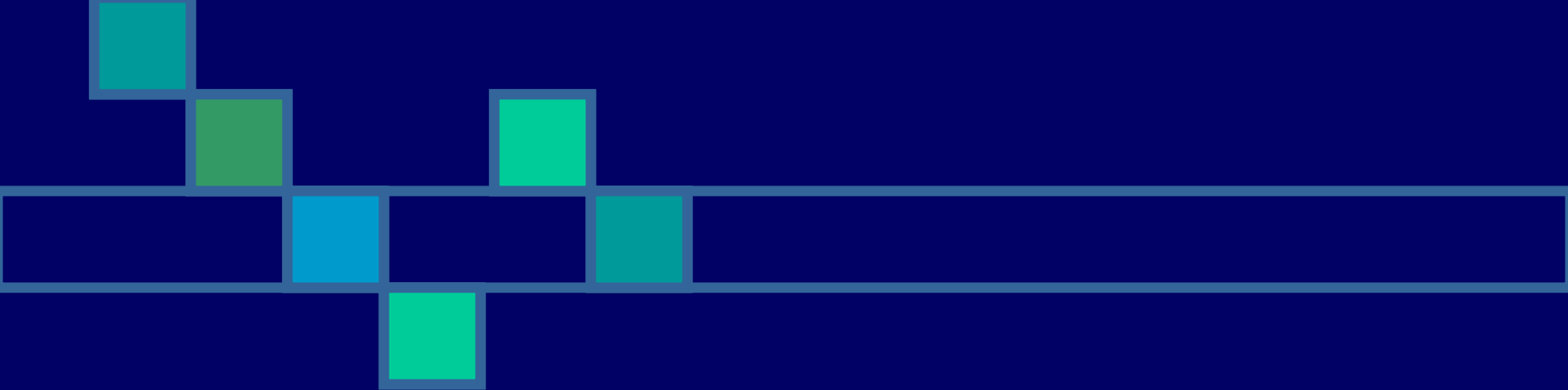
Challenges in Utilizing a Cost Containment Approach

- Cost containment measures apply to all providers, but not necessarily equally
 - CMHC's with a larger more diverse set of programs and revenue mix are able to absorb rate changes and reductions more easily than those more dependent on Medicaid
 - CMHC's who are currently below budget this year in Medicaid revenues are impacted even more significantly



Ideas for the Future






Payment and System Reform: Community Behavioral Health Services in NH



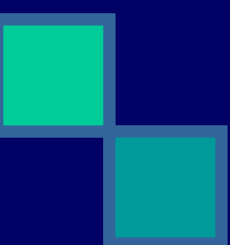



Payment and System Reform

- Move from a Fee for Service to a capitated, per member, per month payment model
 - Incorporate lessons learned from the Dartmouth Atlas Project, as well as data from our own experience specific to mental health services in NH
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Priorities

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- Enhance and maintain access to services for priority population
 - Improve quality of care and outcomes
 - Reinvest cost savings into additional service development to enhance treatment outcomes
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Program Elements

- Payments based on population within a specified geographic region(s) rather than individuals in treatment or volume of services provided.
 - Care is managed locally by the CMHC and not a third party administrator
 - Flexibility to implement new programs and services that may not be currently reimbursable under the Medicaid fee for service program
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Program Elements

- Key principle is accountable care: Care is driven by outcome and not payment or volume of services
 - Local providers charged with coordinating an integrated model of care with other supports and services in the community
 - Fisher's model of "Accountable Care Organization"
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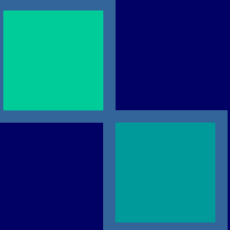



Program Elements, continued

- Model would incorporate specific access to care standards to ensure timely access to services for the population
 - Consideration to increasing consumer access to services across regional boundaries
 - Examples:
 - Alternatives to hospitalization at the Cypress Center in Manchester
 - Highly successful Evidence Based Supported Employment at another CMHC
 - An innovative and promising program at another CMHC outside the individuals region
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Program Elements, continued

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- Providers would need to utilize existing resources to ensure that access is maintained, clients ready to move on are transferred to a lower level of care or discharged, and Evidence Based Practices are emphasized in order to ensure the best client outcomes
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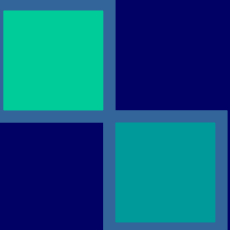



Program Elements, continued

- Inclusive of Hospital Payments?
 - Some states have utilized new payment structures to leverage payments for inpatient care in new and innovative ways
 - Pay for all or a portion of hospital stays through a risk agreement with the state
 - Utilize the funds to develop alternative programs in the community that will decrease hospitalization rates
 - Contract with local hospitals to provide the service
 - Leverage for Medicaid services
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Program Elements, continued

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- Future payments tied to a fixed medical inflation rate and other actuarial factors for the duration of the contract and the Medicaid penetration of the population
 - Need to address the uninsured population?
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Program Elements, continued

- Least Desirable to have a third party administrator- Managed Care Organization
 - More Desirable to have care managed locally, by the CMHC or consortium of CMHC's
 - Accountable Care Organizations- "ACO's"
 - System design that won't require complex MIS implementation locally or additional resources at BBH
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Program Elements, continued

- Shared risk agreement where the State and contracted providers share risk in both enrollment growth and decline on a regional level.
 - Establish risk thresholds/risk corridors
 - Enrollment
 - Max/minimum revenue over expense and vice versa
 - Outcome measures
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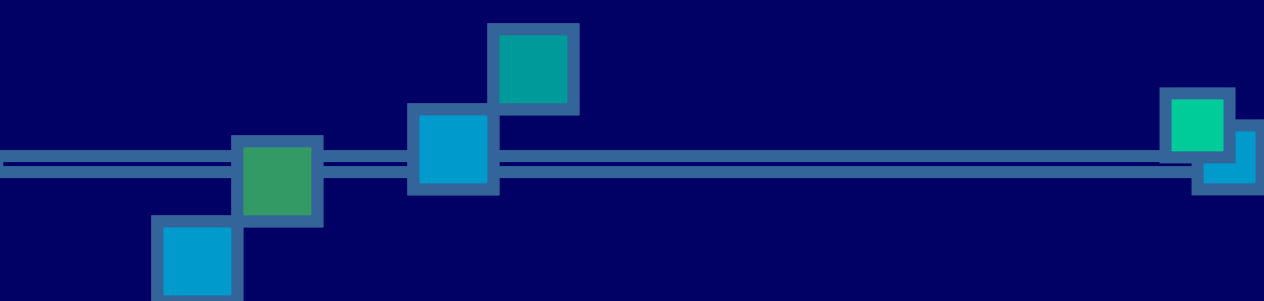
Future Modifications?

- Add additional program elements based on the funding available for those programs and services
 - Substance abuse services
 - Community Health Services- Integrated Care Pilot
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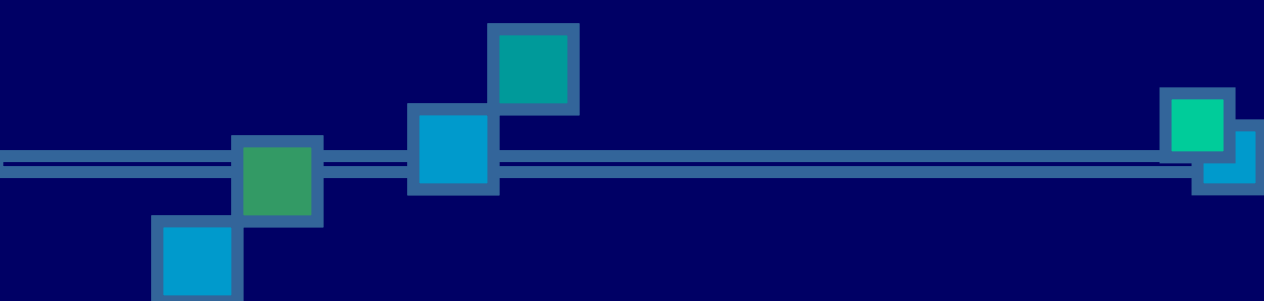
Peer Support

- How do we bring peer support services in to support a continuum of care for individuals in the community mental health system?
 - What role can the PSA's take on to develop programs that will help fill existing and future gaps?
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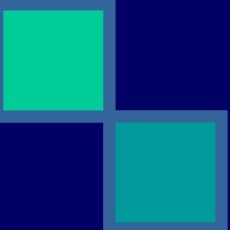


Any states that have a similar model?

- Under consideration- application to CMS for a 1915(b) Waiver, similar to what other states have implemented
 - Kansas
 - Utah
 - Arizona
 - BBH is working with a consultant from the State of Arizona funded by a technical assistance grant from NASMHPD
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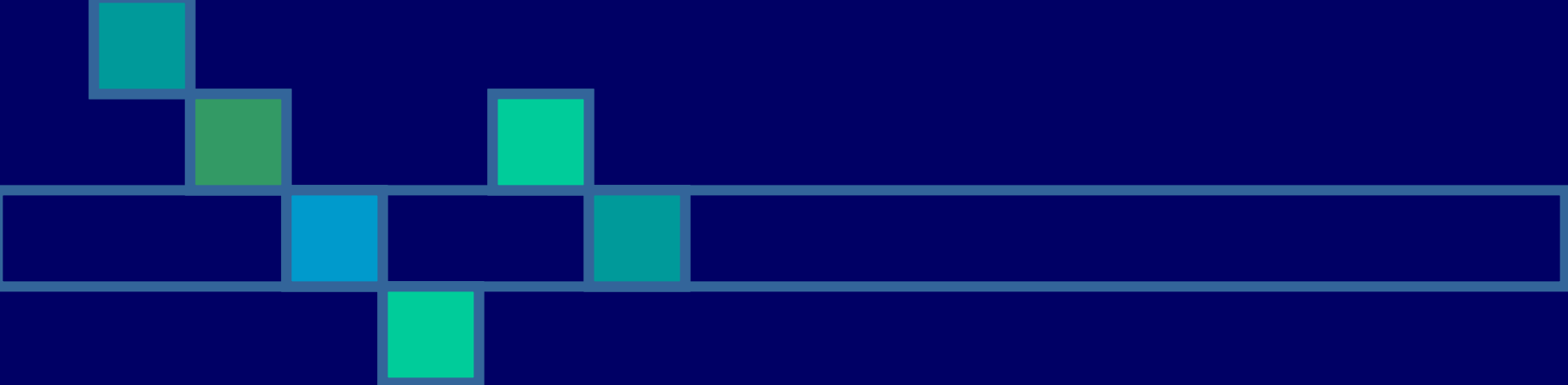
What other principles should we consider in the design?





Next Steps?





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