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.

Historical Funding Approach

- 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

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%

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%

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.

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

Cost Containment Measures

- October 2009
  - Rate reductions to Functional Support Services, Targeted Case Management
  - Established daily limit on FSS for adults

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

Priorities

- 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

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

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”

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

Program Elements, continued

- 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

Program Elements, continued

- Inclusive of Hospital Payments?
  - Some states have utilized new payment structures to leverage payments for inpatient care in new an 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

Program Elements, continued

- 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?

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

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 vise versa
  - Outcome measures

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

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?

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

What other principles should we consider in the design?

Next Steps?

<END>