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The Center for Public Policy and the Social Sciences

Policy Research Shop

New Hampshire State Mental Health Services

Assessing the Consequences of a Decade of Funding Cuts

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EXECUTIVE SUMMARY

This report analyzes data obtained through research of past literature, consumer satisfaction survey analysis, and original interviews with mental health providers. The objective is to provide relevant information about past and present mental health services in New Hampshire, the impact of recent budget cuts on the system, and the broader implications of reduced services.

New Hampshire has only one state-run public hospital that provides mental health services, the New Hampshire Hospital (NHH). In addition to the NHH, the state contracts out to ten mental health centers in the state for community services.¹ These ten centers are private, non-profit organizations. Over the past decade, the demand for mental health services in New Hampshire has greatly increased while the system has been affected by numerous budget cuts. This has led to reduced or closed programs, staff shortages, layoffs, and extended waiting lists. In addition to direct impacts on the mental health system, the budget cuts have also led to an increased usage in other areas such as correctional facilities, the judiciary system, and emergency rooms.

In this report, we first examine the organization and funding of New Hampshire's mental health system. We then explore how cuts in funding have impacted the mental health system's patients, staff members, and programs, as well as the impact in emergency rooms and correctional facilities. Next, we analyze the state mandates that cause mental health centers to lose the most money, such as the requirement to serve under-insured and uninsured patients and provide emergency services 24 hours a day. We conclude by comparing New Hampshire's mental health system to those of nearby states, and by providing several possible policy options.



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1. INTRODUCTION

In the 1980s, New Hampshire boasted a model mental health care system. The Wheelock-Nardi Commission, established in 1982, developed a long-term plan to transition the state's mental health care facilities from mental institutions to community mental health care facilities (referred to from this point forward as CMHCs). The commission created ten community centers serving different geographic regions. The CMHC facilities serve a broad range of functions including case management services, emergency services, and some residential programs.² Today, the ten CMHCs serve roughly 47,000 patients annually.³

However, the system was quickly overwhelmed. In a fifteen-year time frame, the number of patients admitted to the New Hampshire facilities increased by fifty percent and demands were being placed on facilities that were already functioning near or at their capacity. Patients who needed access to critical care facilities found them much more difficult to access, while recent consumer surveys have also indicated a decrease in staff attention when those services were accessed.

According to a 2010 article in the Nashua Telegraph, in 2008, a \$4.6 million rate reduction across the ten centers required cutbacks in employees and services. With the recent economic downturn, mental health care in New Hampshire has been cut back even more; in August of 2010, the state government made more cuts in Medicaid payments.⁴ CMHCs have been unable to accrue financial reserves to successfully provide uninterrupted services during these funding cuts.⁵

2. THE STRUCTURE OF NEW HAMPSHIRE'S MENTAL HEALTH CARE SYSTEM

2.1 Organizational Structure

New Hampshire has a total of ten CMHC facilities located in Conway, Lebanon, Keene, Nashua, Derry, Laconia, Concord, Dover, Manchester, and Portsmouth.⁶ Each facility is a not-for-profit agency that has a contract with the New Hampshire Department of Health and Human Services (DHHS) under the Bureau of Behavioral Health (BBH). Services provided by the CMHCs include: 24-hour Emergency Services, Assessment and Evaluation, Individual and Group Therapy, Case Management, Community-Based Rehabilitation Services, Psychiatric Services, and Community Disaster Mental Health Support. All CMHCs have specialized programs for older adults, children, and families. The Community Mental Health Centers also provide services and referrals for short-term counseling and support.⁷ The centers are each governed by a volunteer Board of Directors, composed of mental health professionals and community leaders.



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In addition to contracting with CMHCs, the state also operates The New Hampshire Hospital (NHH), the only state operated facility in New Hampshire. The NHH has 230 licensed beds and is a public psychiatric inpatient facility managed in partnership with the Dartmouth Medical School. It provides both hospital-based services and services for those in transitional housing on hospital grounds, with the ultimate goal of eventually helping its clients reach the point where they can live independently in their communities. NHH divides its clients into three age categories: adults age 18 and over, teens age 14 and over, and children who are served through the Anna Philbrook Center.⁸

2.2 Funding Structure

According to the New Hampshire DHHS, the CMHCs are private, not-for-profit facilities that have been contracted out by the government. Three-quarters of the CHMCs' funding comes from Medicaid payments and the remaining portion comes from various grants that the centers find independently and charitable contributions. Such grants include federal money for providing mental health services for state correctional facilities.⁹ The state of New Hampshire provides little to no funding to the mental health system with its Medicaid money, meaning that New Hampshire's mental health system is almost entirely dependent on federal Medicaid fees. In the 2008-2009 fiscal year, the ten CMHCs received a total of \$93 million in federal Medicaid funds.¹⁰

In the past two years, there have been a series of budget cuts due to the national recession. In April 2008, a \$4.6 million rate reduction required "cutbacks in staff, employee benefits, and some direct services at the ten centers."¹¹ In October 2009, there were cuts of \$3 million to the ten centers as a result of the Department of Health and Human Services' efforts to keep itself on budget. From 2004 to 2009, operating expenses increased by 26 percent, while revenue also increased by 26 percent, due to an increasing base of consumers.¹²

3. IMPACT OF FUNDING LOSSES

Funding cuts in New Hampshire have impacted the state mental health system in numerous ways. They have affected the number of patients being served, the burden on staff members, the types and number of services that the centers can provide, and the burden on other state-funded facilities such as emergency rooms and jails.

3.1 Impact On Patients

The budget cuts have forced CMHCs to reduce their numbers of inpatient beds which limits the number of patients they can serve. The New Hampshire Hospital Association cites a decline from 236 voluntary inpatient beds across the state in 1990 to 186 beds in 2008.¹³ It is important to note that a decline in beds has a "multiplier effect" in terms of the number of patients that can be served; NH Hospital's fiscal year 2011 budget reduced



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the number of hospital beds by 15, resulting in 500 fewer patients being served each year.¹⁴ Certain programs in particular have seen especially large reductions in their numbers of beds from 1990 to 2008, especially the Designated Receiving Facilities (101 to 8) and Acute Psychiatric Residential Treatment Program (52 to 16). In addition to these losses, three psychiatric units have closed entirely, and residential group homes contain only 203 beds for the 7,000 adults with chronic mental illnesses.¹⁵

These cuts come at a time when New Hampshire's population is steadily growing, with approximately 70,000 more people living in the state now than in 2005.¹⁶ The mentally ill population is growing as well, with a ten percent rise in the number of people seeking mental health services in 2008 and an eleven percent rise in 2010.¹⁷ The growing demand for mental health services combined with fewer beds is leading to longer wait times for patients. Even at CMHCs that are purely outpatient facilities, wait times for patients are increasing as more and more people compete to make use of facilities that cannot expand due to a limiting budget.¹⁸ This greater load on mental health facilities combined with a reduction in the number of patients that can be served will lead to many more people who cannot access mental health services.

At the request of the New Hampshire Department of Health and Human Services, the University of New Hampshire conducted consumer satisfaction surveys for adults, youth, and family members of children receiving services from New Hampshire's ten CMHCs in 2010. The surveys found strong support for several areas of mental health treatment, including distribution of information about patient rights, respect for information release choices, improved patient encouragement by CMHC staff, and staff sensitivity to cultural backgrounds. Further, more respondents indicated police encounters and school absences decreased as a result of mental health services. However, the concerns expressed by survey respondents reinforce those issues discussed in our interviews. Patients were concerned about the need for assistance to suicidal patients, greater focus on self-advocacy, staff actively listening more to patients, treatment wait times, follow up appointments with parents, valuing patient perspectives, valuing and respecting parents, and understanding the relationships between disabilities and treatments. Additionally, they cited problems about staff quality and availability, adequate alcohol and drug treatment services, maintaining treatment plans, transition planning for young patients, and the need for continued access despite changes in circumstances.¹⁹

3.2 Impact On Staff Members

Budget cuts have also put a burden on workers in the mental health sector. This burden comes in several different forms, the most obvious one being through layoffs. At one CMHC, the Riverbend Community Mental Health Center, ten percent of the total workforce has been laid off over the past several years. As a result of this decreased staff and an increasing mentally ill population, workers' caseloads have risen – from 32 to 35



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cases per caseworker at Riverbend, for example – which reduces the amount of time and energy a worker can devote to each case.²⁰

In addition to a larger caseload, employees who have held on to their jobs have faced other setbacks, such as a loss of paid vacation time or salary freezes; for example, Greater Nashua Mental Health Center froze its workers' salaries three years ago and has not issued any raises since the freeze.²¹

The current turnover rate of workers at NH mental health centers is twenty percent.²² It is important to the centers that this number does not go up because that would cause further setbacks in terms of maintaining qualified staff members who are experienced with the environment at the CMHC at which they work.

3.3 Impact on Programs

CMHCs have had to close or reduce many of their patient service programs in order to cope with a tighter budget. Riverbend, for example, has closed a satellite clinic, terminated a thirteen-bed, twenty-four hour-per-day residential program for its most gravely ill patients, and merged its elder-focused program into the adult program. Riverbend was also planning on making use of an Assertive Community Treatment (ACT) team starting in January 2011, but had to abandon that project due to lack of funding.²³ West Central Behavioral Health, meanwhile, closed a residential facility in Claremont and shut down its Child Respite Program, a program designed to give parents a several-hour “break” by caring for children with mental health issues.²⁴

3.4 Impact On Other Areas

3.4.1 Emergency Rooms

While there is no truly accurate way to measure the impact of reduced mental health services on emergency rooms, the consensus among the mental health experts we interviewed is that there has been an increased burden on these facilities over the past several years. Maximum wait times for beds at Concord Hospital's emergency room, the most widely used emergency room in the state, have gone from eight hours to almost a week.²⁵ Child psychiatrist Dr. Diana Weiner of Riverbend Community Mental Health Center claims that the longer a patient must wait to receive service, the more their mental health will deteriorate. In her words, “The longer a problem goes on, the more a problem tends to grow.” People with mental health problems “need that safe environment. They need to be somewhere they can be worked with, (they need) a wide variety of team members. And that is not going to happen in the Emergency Department.”²⁶ This increased burden on emergency rooms may also be partly due to reductions in services the emergency rooms themselves can provide in response budget cuts across the health



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care sector; for example, in fall of 2010, the state had to close Silbrook Children's Hospital and open a children's unit in the adult hospital.²⁷

By focusing its spending on emergency room treatment rather than on the prevention of mental health problems, the state saves money in the short run by cutting back on potentially expensive programs, but it may actually be losing money in the long run. According to Louis Josephson, CEO of the Riverbend Community Mental Health Center, creating community programs where patients can live semi-independently while still getting the treatment they need should be a top priority for the state. Josephson claims that currently, thirty out of every hundred patients in the state psychiatric hospital system are ready for a community-based system of care but not quite ready to be fully independent. As a result, either they end up in jail or are kept in the state hospital at a cost of about \$600 to over \$2,000 per day.²⁸ Discharging these patients and putting them in community-based, residential treatment programs would cost around \$200 per day, making these services a more cost-effective measure in the long run despite the short run cost of setting up these programs. According to Josephson, an increase in funding of \$10 million (bringing the total mental health care funding up to \$103 million) would go a long way toward beginning to achieve these and other important mental health care goals.²⁹

3.4.2 Correctional Facilities

Correctional facilities have also seen increased use as mental health services have been cut back. From 1999 to 2009, New Hampshire's prison population has increased by 31%. A large portion of this population comes from prisoners who are released from prison, then are re-arrested; recidivism rates have gone up quickly, from 40% for those released in 2003 to 51% for those released in 2005. In addition, spending on correctional facilities has doubled, from \$52 million (or \$67 million when adjusted for inflation) to \$104 million.³⁰

According to a report by the Council of State Governments Justice Center, police chiefs and sheriffs believe that insufficient services for mental health and substance use treatment is one factor contributing to the rising rates of both crime and recidivism.³¹ With fewer residential, community-based treatment programs or other options for care, mentally ill patients often commit crimes and end up incarcerated. The available statistics make this trend clear; 65 percent of the inmates at the State Prison are diagnosed with mental health issues,³² and 60 percent of the inmates at the Strafford county jail are being prescribed some kind of mental health medication.

Correctional facilities that take prisoners with mental health problems are often ill equipped to deal with them. According to the Bureau of Drug and Alcohol services, the state's addiction treatment system can treat only 6,000 people, or 10 percent of the people who need it. The state does not provide the Corrections Department with resources to



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contract with community-based substance use treatment providers, and the Bureau of Drug and Alcohol services only funds one program that serves clients with co-occurring mental health and substance abuse disorders.³³

To treat prisoners with mental illnesses, county- or state-run jails tend to contract out to both state-run and private mental health facilities. For example, West Central Behavioral Health serves mentally ill patients at the Sullivan County Jail with a yearly Department of Justice grant of \$250,000 per year,³⁴ and one jail has a \$6 million contract with a private psychiatry company to provide these services.³⁵

The Council of State Governments' Justice Center reports that, for an annual investment of \$350,000, the state could provide addiction, mental health, and co-occurring services to 100 high-risk parolees and felons on probation. For \$1.3 million, it could provide these services to 400 medium/high risk parolees and high-risk felons on probation, and for \$2.4 million, it could provide services for all 700 individuals in these categories.³⁶ Another strategy the state could pursue involves investing in community-based mental health and addiction treatment outside of prison to serve both recently released prisoners and people with the potential to be incarcerated if their conditions are not treated. Both of these strategies could cut down on the increasing crime and recidivism rates in New Hampshire, but at some financial cost to the state.

3.4.3. Homeless Shelters

A lack of strong mental health support services may also be exacerbating New Hampshire's homelessness problem. When mentally ill people who cannot take care of themselves are unable to access the support services they need, they often end up homeless. National studies say that approximately one-third of homeless people throughout the country are seriously mentally ill,³⁷ while many more may have varying degrees of mental illness. In Massachusetts, 27 percent of people discharged from a state psychiatric hospital became homeless within six months, while in Ohio, that number was 36 percent.³⁸ In addition, studies have found a direct correlation between a shortage of psychiatric beds and higher rates of homelessness.³⁹ The statistics in New Hampshire paint an equally bleak picture; currently, 50 percent of people in New Hampshire homeless shelters have one or more mental health issues.⁴⁰

The state of New Hampshire has little direct financial stake in homeless shelters with the exception of several grants in the hundreds of thousands of dollars.⁴¹ However, the statistics show that there is a high human cost of leaving the mental health care system as is, in terms of people who need treatment but end up homeless instead. Repairing New Hampshire's mental health system would be a major step toward getting New Hampshire's homeless the care that many of them need and getting them off the streets.



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4. WHERE MONEY IS BEING LOST

Despite cuts in funding, the use of mental health services in New Hampshire has increased, due both to an increase in population and an increase in services utilized by patients. In 2008, mental health centers recorded a ten percent increase in the number of mentally ill patients seeking services, while in 2010 there was an eleven percent increase.⁴² Under these circumstances, the CMHCs will not be able to meet the increasing demand for their services; they will have to choose where to spend money and where to cut.

4.1 Serving Uninsured And Underinsured Patients

As a result of the cuts in Medicaid and Medicare, the community mental health centers (CMHCs) are currently losing money in many program areas. The budget cuts have created an operational deficit for the fiscal year of 2010. According to Suellen Griffin, CEO of West Central Behavioral Health (WCBH) located in Lebanon, the main area where the CMHCs are losing money is in serving uninsured (those who qualify for Medicaid but opted out) and underinsured (those who do not qualify for Medicaid) patients. The network of ten CMHCs has a contract with the state that requires them to serve these patients. However, because the centers receive no funding from the state, serving these patients must be funded solely by the centers themselves. The patients are charged on a sliding scale fee, so that uninsured patients essentially do not need to pay the CMHCs any money to receive services. In the last fiscal year, the ten CMHCs lost over \$1 million due to serving uninsured and underinsured clients.⁴³ According to Suellen Griffin, “there should be an obligation for the state to cover some of these patients, but currently there is none.”

4.2 Mandate To Be Open 24-Hours A Day

According to Jay Couture, executive director of the Seacoast Mental Health Center located in Portsmouth, the biggest problem for their center is, “the requirement to be open for 24-hour service.” The state requires all the CMHCs to be open 24-hours a day as part of their contract. Because the number of people in need of emergency mental health services is rising beyond the point that hospital emergency rooms can handle, the CMHCs have become something of a “safety net” for people who would otherwise go to emergency rooms.⁴⁴ However, because Seacoast Mental Health Center and several other centers have never had beds in their facilities, these facilities are becoming inadequate for the types of services they are performing. There is currently no funding for beds, but as more patients utilize CMHCs for 24-hour service, it will become critical for beds to be available.



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The 24-hour service requirement also creates the necessity to have workers with certain credentials available. With such a high number of shifts to be filled and a relatively low number of qualified employees to fill them, it becomes difficult to schedule time slots for employees to work. This may cause a shortage of employees during certain shifts, which makes patient wait-times longer and ultimately leads to more hospitalizations when patients cannot get the care they need at CMHCs. If CMHCs were not required to be open 24-hours, they could save money both in terms of employee salaries and facility operating costs; however, this would also mean that the CMHCs would not be available to give care at all hours, which might cause a bigger load on already-strapped hospital emergency rooms and deny patients the care that they need.

4.3 Proposal To Amend Legislation

To combat the negative impacts of the past year's series of Medicaid cuts, representatives from the CMHCs have collaborated on writing legislation to amend the state policies regarding the CMHCs. The directors of the ten centers and the Bureau of Behavioral Health are crafting a bill that will limit the percentage of underinsured and uninsured patients these centers must pay to care for. Currently, 18 percent of CMHCs' patients are uninsured or underinsured; the directors would prefer to limit this percentage to around 8. Under the terms of the bill, the CMHCs will cover the patients that they can afford to cover, while the New Hampshire State Finance Committee would fund the rest. The directors of the CMHCs feel that this bill will allow them to provide care to those who cannot afford it while keeping their costs to a manageable level. The CMHCs currently have two legislators in support of the bill.⁴⁵

5. HOW NEW HAMPSHIRE COMPARES TO OTHER STATES

5.1 State Rankings

The National Alliance on Mental Illness (NAMI) is a mental health advocacy organization that rated each state's mental health system in 2006 and again in 2009. The ratings were based on scores NAMI gave each mental health system in the areas of Health Promotion and Measurement, Financing and Core Treatment/Recovery Services, Consumer and Family Empowerment, and Community Integration and Social Inclusion. The overall average grade rating for the U.S. was a "D" with six states making a B, eighteen with a C, twenty-one states earning a D, and six states receiving an F.

New Hampshire, which received a "D" when it was previously graded in 2006, earned a "C" in the 2009 grading. While this was an improvement, NAMI suggested that New Hampshire was in danger of falling backwards if it did not receive more state funding. Among NAMI's suggestions was an emphasis on cost-effective and proven methods, particularly the supported-employment program developed at Dartmouth College.⁴⁶ The



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most urgent needs identified by NAMI are inpatient beds, housing, increasing the mental health workforce, and jail diversion programs.

5.2 New York

New York was one of the six states that received a “B” grade, the highest grade given in the NAMI report. In 2006, New York chose not to participate in the NAMI survey. The fundamental difference between New York and New Hampshire is the amount of state funding given to mental services in addition to Medicaid and Medicare. While New Hampshire receives no state funding for its mental health services, making it completely reliant on federal Medicaid dollars and private grants, New York’s mental health system receives state funding in addition to Medicaid and Medicare. This gives New York more flexibility than New Hampshire in terms of what kinds of programs it can pursue.

New York is a national model in terms of its innovative “Housing First” project, which helps homeless and mentally ill people obtain housing immediately rather than return to the streets or a shelter. Through this program, New York pledged 9,000 new housing units over a ten-year time span. This program only costs the state \$62 per person per day, making it more cost-effective than hospital care (\$479 per person per day), treatment in correctional facilities (\$233 per person per day) or treatment in homeless shelters (\$74 per person per day).⁴⁷

Given New York’s position as a leader in the mental health sector, New Hampshire should include New York as a possible source of tested and proven efficient ideas that New Hampshire could implement. For example, a program similar to Housing First may ultimately save the state money that it is currently spending on emergency rooms and correctional facilities. In addition, New Hampshire could consider providing state funding to the mental health system so that the mental health sector can afford to accommodate the state’s growing mentally ill population.

5.3 Massachusetts

Massachusetts, also rated a “B” state, has long been at the forefront of mental health care. The commonwealth established the United States’ first asylum, Worcester State Hospital, in 1833. Since 1966, Massachusetts has been decentralizing mental health care facilities and focusing on community-based systems of care. It is divided into six regions for community care. Funding for Massachusetts’ mental health services comes from a mix of state allocations and federal grants, and its mental health centers are both state and contracted facilities. Massachusetts’s state expenditures on mental health services totaled \$432,694,125 in fiscal year 2008.⁴⁸

The Commonwealth saw a 6 percent cut in state funding from FY 2009 to FY 2010, which was the result of a series of funding cutbacks through FY 2009.⁴⁹ Despite budget



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cuts, Massachusetts continues to have an ambitious commitment toward universal health care and is rebuilding Worcester Hospital on its original grounds with the hopes of completion by 2012.

One of Massachusetts' newest initiatives is the Community Based Flexible Support program. This program allows discharged mental health patients, along with their families, to be trained in independent living and self-management skills so they can be fully integrated into the community. This program replaces residential and community rehabilitation programs and was implemented as a more cost-effective way to provide the same services in the face of budget cuts. The program was implemented in July of 2009, so it is still very new and its effectiveness remains to be seen. However, if successful, New Hampshire could consider implementing a program such as this to save money while still providing essential services to mental health patients.⁵⁰

Massachusetts certainly is not without its share of problems. For example, it has to address both a large inmate population and a "crisis-level" inmate-suicide rate. Despite these problems, Massachusetts has been able to make significant improvements while facing budget cuts, moving up a full letter grade from a "C" to a "B" between 2006 and 2009. While using Massachusetts as a model is difficult for New Hampshire because of the differences in resources and tax revenue, Massachusetts is a useful state to examine due to its historical preeminence in mental health care and its ability to make improvements in its mental health care system despite budget cuts.

5.4 Vermont

Vermont also received a rating of "C" in the NAMI's 2009 state ratings and saw no change since the previous evaluation 2006. Like New Hampshire, Vermont is in danger of falling behind in terms of quality of care and ability to provide services due almost entirely to budget cuts at the state level. Vermont also has a similar community mental health care system in place as New Hampshire, and a state hospital in Waterbury, which did not receive federal certification. Vermont did receive praise, however, for its efforts to improve and update the VT State Hospital and its mental health insurance parity law. Vermont and New Hampshire are in fairly similar predicaments in terms of the needs of the mental health facilities and further research may suggest the value of working in conjunction with Vermont to achieve their goals.

5.5 Connecticut

Connecticut received a "B" rating both in 2006 and in 2009, but according to the NAMI report concludes that it too has many issues that demand urgent attention, particularly the lack of appropriate care facilities based on severity of mental illness. Connecticut does have a very forward-thinking vision for its state mental health facilities and practices, but with the economic downturn the state has had trouble progressing from its overuse of



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nursing homes and correctional facilities (referred to as “warehousing” patients). Its shortcomings are largely a result of inadequate and inappropriate community environments for those being treated with mental illnesses. Connecticut could be used as a model for New Hampshire in terms of its theorized ideas about collaboration with correctional facilities and electronic monitoring systems for recovery of patients.

5.6 Summary of Comparisons

Examining how other states have dealt with mental health budget cuts and the recent economic crisis provides some valuable insight on how New Hampshire can address these problems. New York’s relatively strong system provides some intriguing policy options, including innovative, cost-effective programs such as Housing First and a system supported by state Medicaid dollars. Massachusetts provides another example of some strong options for New Hampshire to examine, particularly its movement toward decentralized, community-based care that both cuts costs and empowers individuals with mental illnesses. Vermont, as a state facing issues parallel to New Hampshire’s, could be a potential ally and partner to New Hampshire in developing strategies for dealing with these issues. Finally, Connecticut can be a source of several forward-thinking strategies for New Hampshire to consider, such as collaboration between CMHCs and correctional facilities and electronic monitoring systems for recovery of patients.

6. POLICY OPTIONS

6.1 Maintain the Status Quo

The state could do nothing and keep the mental health system the way it is. While this may be the simplest solution in the short-run, it is not likely to be the best long-term solution. First of all, a growing demand for mental health services in New Hampshire combined with reduced services caused by budget cuts may overwhelm the system if nothing is done to reverse this trend. In addition, this growing demand will place an increased burden on hospitals and correctional facilities that are state-funded, costing the state more money on patients who cannot find appropriate care outside of these facilities.

6.2 Begin Putting State Medicaid Funding into the Mental Health System

Currently, the state of New Hampshire does not put any of its own Medicaid dollars into the mental health system; only federal Medicaid money is used. Most CMHC leaders cite this as a major constraint on their budgets. States with very highly regarded mental health care systems, such as New York and Massachusetts, tend to put state funding into these systems in addition to federal dollars. Providing state funding in addition to federal money gives mental health care providers more flexibility in terms of pursuing new, innovative programs, treating large numbers of mental health patients, and providing preventative care that can ultimately save money that would otherwise be spent in



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emergency care. The state must determine how much money it can afford to spend on mental health care, and whether or not there are other places in its budget there is waste or unnecessary expenditures that could be redistributed to the mental health care system.

6.3 Institute Community-Based, Transitional Housing Programs

Rather than merely pumping more money into existing services, the state of New Hampshire could consider funding more community-based, transitional housing services for mentally ill patients who are functional enough to leave the hospital but not yet ready for full community integration. Louis Josephson, the CEO of Riverbend Community Mental Health Center, recommends this as a cheaper alternative to emergency room care, claiming such a program costs \$600 less per patient per day than emergency room care. Empirical evidence seems to support the claim that community-based care is a cost-effective strategy: New York's Housing First program only costs \$62 per patient per day vs. \$479 for hospital care or \$233 for care in correctional facilities, and Massachusetts' community-based flexible support program was instituted as a way to save money in the face of budget cuts. Since the state does spend money on both the New Hampshire Hospital and correctional facilities, spending money on community-based treatment programs similar to those in New York and Massachusetts may actually save the state money by giving people ways to avoid these facilities. The state could work with the directors of the ten CMHCs, as well as mental health representatives from states with successful programs such as New York and Massachusetts, to craft a program that incorporates elements from other states' programs while conforming to New Hampshire's unique population, budget, and needs.

6.4 Eliminate the 24-hour Service Mandate

One major challenge for the CMHCs is the state mandate that they must remain open 24-hours per day. At a time when the CMHCs' budgets are particularly tight, it is difficult for them to maintain enough properly trained and experienced staff members to fill shifts at all hours of the day and night. The state could take several courses of action with this problem; eliminating the mandate altogether, keeping the mandate and letting the CMHCs determine how to deal with it themselves, or eliminating the mandate and providing incentives, such as subsidies or tax credits, for CMHCs that remain open longer than the required amount of hours. Eliminating the mandate without some sort of incentive would likely result in most CMHCs opting not to remain open 24 hours; incentivizing these centers to provide care for 24 hours per day through subsidies or tax credits would ease the strain on their budgets while still encouraging them to provide the round-the-clock preventative care that will keep patients from going to emergency rooms, which cost the state more money and can quickly become overwhelmed by a large number of patients.



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6.5 Pay for the Care of Uninsured and Underinsured Patients that the CMHC's Cannot Afford to Cover

As mentioned previously, the CMHCs are required by law to serve patients that are uninsured or underinsured, despite the patients' inability to pay for their own treatment. When the patient's insurance does not cover the cost of their care and the patient cannot pay for the treatment, the CMHC must pay the bill. Thus, this requirement cost the CMHCs a combined \$1 million in the last fiscal year.⁵¹ To remedy this problem, the state could pursue several courses of action. First of all, the state could eliminate this mandate and let the CMHCs themselves decide whether or not to treat uninsured and underinsured patients. While this seems like a lucrative, cost-cutting solution from the CMHCs' perspective, it will likely lead to many patients who cannot afford treatment being denied the care that they need, and may inadvertently lead to increased costs for the state when these patients end up in emergency rooms or correctional facilities. Alternatively, the state could adopt a policy similar to the bill that the CMHC leaders are crafting, in which the CMHCs would cover a portion of the cost of treating these patients and the state would cover the rest.

7. CONCLUSION

The ten community mental health centers (CMHCs) and the New Hampshire Hospital receive over seventy-five percent of their funding from Medicaid. In the past few years, the centers have seen huge rate cuts in Medicaid funding, making it difficult for the centers to operate. Maintaining services and programs is the most important goal of all the CMHCs. To accomplish this while still managing their budget deficits, the centers have reduced beds, frozen salaries, laid off staff and increased the case loads of those who remain. While this solution has worked to some extent in the short-term, it is not sustainable in the long run; overworked staff members may quit or become unable to give the proper amount of attention to each patient, and a mental health care system that cannot expand due to budget cuts will be unable to cope with the growing mentally ill population in New Hampshire.

In addition, the state provides little to no funding to the centers, but has issued several mandates for services that the state believes each center should provide. These mandates include providing emergency services 24 hours a day and accepting all patients regardless of their insurance status. While both mandates are important in ensuring that patients receive the care they need, without state funding, both place a large burden on the operational costs of the facilities. Accepting underinsured and uninsured patients costs the CMHCs over one million dollars in just one year.

Based on our current research, the costs that have been cut from the mental health system have been instead shifted to other areas. The emergency rooms have seen an increase in



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usage and wait times—sometimes up to one week for a bed. Also, local law enforcement has seen a rise in criminal activity.

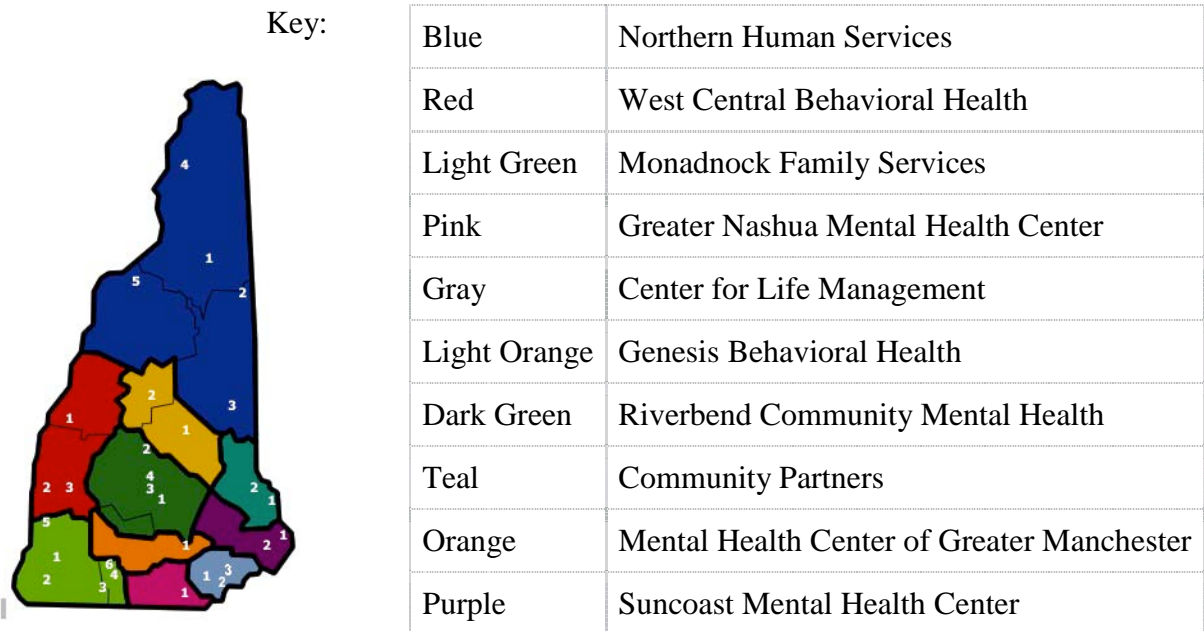
In considering future actions, New Hampshire lawmakers may find it useful to examine what other states have done to deal with budget deficits in their mental health systems. While the New Hampshire mental health system has been able to cope with budget cuts in the short run, its current cost-saving methods are not sustainable in the face of a growing mentally ill population.



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Appendix

Figure 1: New Hampshire Community Mental Health Centers



Source: "Locations & Contacts." NH Community Behavioral Health Association. Web. 4 Nov 2010. <<http://nhcbha.org/locations.aspx>>.



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Figure 2: CMHCs Financial Information

Table 1. Aggregate Income Statement for 10 New Hampshire CMHCs (\$000s).

	2004	2005	2006	2007	2008	2009	Change 2004– 2009	Average Annual Change
OPERATING REVENUE								
Net Patient Service Revenue	105,417	106,766	111,398	123,667	130,692	140,356	33%	
Other Operating Revenue:								
Grants	9,594	9,675	10,124	10,553	9,235	8,904	-7%	
Assets Released From Restricts– Operations	163	178	182	181	340	258	58%	
Other	7,882	7,165	6,885	5,940	6,329	5,464	-31%	
Total Other Operating Revenues	17,782	17,161	17,334	16,817	16,108	14,626	-18%	
Total Operating Revenue	123,184	123,926	128,732	140,484	146,800	154,982	26%	4.67%
OPERATING EXPENSES								
Salaries, Payroll Taxes, Fringes	88,998	90,858	94,334	101,639	108,043	110,574	24%	
Depreciation	1,952	1,981	1,969	1,969	2,234	2,331	19%	
Interest	520	473	696	689	904	806	55%	
Other operating expenses	30,528	32,365	30,593	35,986	38,049	39,808	30%	
Total operating expenses	121,998	125,677	127,592	140,283	149,230	153,519	26%	3.29%
Net Operating Income	1,186	-1,751	1,140	201	-2,430	1,463	23%	
Interest and Dividends	68	152	242	454	353	265	290%	
Realized Gains (Losses)	190	120	628	1,392	2	-358	-288%	
Other Income (Expense)	865	1,114	837	838	978	1,009	17%	
Total non-operating revenue	972	1,243	1,564	2,541	1,129	916	-6%	
Excess of revenue over expenses	2,166	-508	2,704	2,742	-1,301	2,379	10%	
Extraordinary Gains (Losses)	0	0	2	641	0	0	0%	
Total Surplus/Deficit	2,166	-508	2,706	3,386	-1,300	2,378	9%	
Aggregate Operating Margin	0.96%	-1.41%	0.89%	0.14%	-1.66%	0.94%		
Aggregate Total Margin	1.75%	-0.41%	2.08%	2.37%	-0.88%	1.53%		

Note: All details not disclosed so only major categories will tally.

Table 2. Aggregate CMHC Cash Flows, 2005 – 2009 (\$000s)²

Sources	\$	%	Uses	\$	%
Total Surplus/Deficit	6,621	17%	Investments in securities	-6,331	17%
Non-cash expenses (revenues)	8,539	22%	Other noncurrent assets	-1,280	3%
Working capital	3,323	9%	PP&E	-17,960	47%
Sale of Fixed Assets	3,660	10%	Repay LTD	-5,540	14%
Issue LTD	13,122	35%	Other Noncurrent Liabilities	-3,87	1%
Transfers from other Entities	2,721	7%	Increase Cash ³	-6,715	18%
Other	227	1%			
Total	37,986		Total	-38,213	



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Table 3. Estimated Impact of FY10 Medicaid cuts as of December, 2009 on CMHC Surplus and Net Worth.⁶

Center	Surplus FY09 (\$5000s)	Surplus FY10 (est.) (\$5000s)	Estimated Medicaid cuts FY10	Pro Forma Surplus (Loss) with cuts	Loss as a % of 2009 Net Worth
A	363	363	1,655	(1,292)	30%
B	186	0	490	(490)	24%
C	595	100	814	(714)	15%
D	426	426	1,173	(747)	8%
E	41	268	854	(586)	49%
F	103	103	564	(461)	16%
G	549	0	800	(800)	24%
H	109	84	568	(484)	22%
I	-23	-373	372	(745)	118%
J	50	-7	396	(403)	34%
Total	\$2,399	\$964	\$7,686	\$(6,722)	20%

Source: Kane, Nancy. Community Mental Health Centers in New Hampshire: Financial Performance and Condition. Tech. 2010.



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