STATE OF NEW HAMPSHIRE
COMMUNITY MENTAL HEALTH SYSTEM

PERFORMANCE AUDIT REPORT
JULY 2010

To The Fiscal Committee Of The General Court:

We conducted an audit of the Department of Health and Human Services, Bureau of Behavioral Health's (BBH) oversight of the community mental health system to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The purpose of the audit was to determine whether BBH oversight of community mental health centers ensured services were being delivered efficiently and effectively. The audit period includes State fiscal years 2008 and 2009.

This report is the result of our evaluation of the information noted above and is intended solely for the information of the Bureau and the Fiscal Committee of the General Court. This restriction is not intended to limit the distribution of this report, which upon acceptance by the Fiscal Committee is a matter of public record.

Office Of Legislative Budget Assistant

July 2010

THIS PAGE INTENTIONALLY LEFT BLANK

TABLE OF CONTENTS

ABBREVIATIONS

BBH	Bureau Of Behavioral Health
BEAS	Bureau Of Elderly And Adult Services
CMHC	Community Mental Health Center
DCYF	Division Of Children, Youth And Families
DHHS	Department Of Health And Human Services
DoIT	Department Of Information Technology
EBP	Evidence-Based Practice
FSS	Functional Support Services
FTE	Full-Time Equivalent
GAO	U.S. Government Accountability Office
ISP	Individual Service Plan
LBA	Office Of Legislative Budget Assistant
LPAOC	Legislative Performance Audit And Oversight Committee
LU	Severe Or Severe And Persistent Mental Illness Low-Utilizer
MIO	Medicaid In-And-Out Program
NHCBHA	New Hampshire Community Behavioral Health Association
NHH	New Hampshire Hospital
NOMs	National Outcome Measures
OAG	Office Of The Attorney General

OMBP	Office Of Medicaid Business And Policy
PSA	Peer Support Agency
PT	Part-Time
QI	Quality Improvement Unit
RSA	Revised Statutes Annotated
SAMHSA	Substance Abuse And Mental Health Services Administration
SED	Serious Emotional Disturbance
SED-IA	Serious Emotional Disturbance With Interagency Involvement
SFY	State Fiscal Year
SMI	Severe Mental Illness
SPMI	Severe And Persistent Mental Illness

THIS PAGE INTENTIONALLY LEFT BLANK

STATE OF NEW HAMPSHIRE
COMMUNITY MENTAL HEALTH SYSTEM

SUMMARY

Purpose And Scope Of Audit

This audit was performed at the direction of the Fiscal Committee of the General Court consistent with the recommendation of the joint Legislative Performance Audit and Oversight Committee. It was conducted in accordance with generally accepted government auditing standards applicable to performance audits. The purpose was to assess the Bureau of Behavioral Health's (BBH) oversight of the community mental health system to ensure efficient and effective service provision. The audit period is State fiscal years (SFY) 2008 and 2009.

Background

Mental illness is a common, sometimes debilitating, and often costly illness. Those with severe mental illness may have difficulties maintaining jobs, relationships, and caring for themselves. The severely mentally ill were originally served in institutional settings; however, starting in the 1960s, there was a significant shift towards community-based care. This shift was a result of changes in how governments funded mental health services and in treatment philosophy that sought to provide care in the least restrictive environment possible. The introduction and expansion of Medicaid allowed states to leverage federal dollars while limiting the growth in state expenditures for mental health services. Medicaid incentivizes community-based care by reimbursing services to Medicaid-eligible adults in the community, but not services provided in an institutional environment.

In New Hampshire, the Department of Health and Human Services (DHHS) is responsible for establishing, maintaining, and coordinating a comprehensive, effective, and efficient service system for those with severe mental illness. The BBH oversees community-based services by contracting with ten regional community mental health centers (CMHC). The CMHCs provide contracted services and follow BBH Administrative Rules He-M requirements. RSA 135-C:1, II contains the State's policy that the mental health services system (which includes the CMHCs and the New Hampshire Hospital) is to provide adequate and humane care to severely mentally disabled persons in the least restrictive environment, and directed toward eliminating the need for services and promoting the person's independence.

The State's ten not-for-profit CMHCs provided community mental health services to 47,207 consumers in SFY 2008 and 47,587 consumers in SFY 2009, according to the BBH. Severely mentally disabled persons comprised 17,598 consumers (37 percent) in SFY 2008 and 18,449 consumers (39 percent) in SFY 2009. This population is commonly referred to as "BBH-eligible" and receives services regardless of ability to pay. In SFY 2009, the BBH expended $93.9 million for community mental health services.[1] State funds are primarily used to reimburse

[1] This total represents both federal and State funds; approximately $1.3 million was spent on BBH administration.

the CMHCs for services to Medicaid recipients; the State no longer reimburses centers for non Medicaid BBH-eligible consumers who cannot fully pay for services they receive.

Results In Brief

We found the BBH needs to better align its operations with its current environment through planning, improved service oversight, and risk mitigation. Our audit presents 14 observations with recommendations to assist the DHHS, the BBH, and the Legislature in optimizing the efficiency and effectiveness of the community mental health system. Three observations require Legislative action.

To better assess risks facing the system, the BBH needs to determine the amount of uncompensated care being provided by CMHCs and improve data collection regarding unmet consumer needs. We also found written policies and procedures are inadequate to ensure Bureau operations function correctly.

We found a number of weaknesses in the BBH's oversight of the community mental health system. Contracting is inefficient, access to Bureau guidance needs improvement, Medicaid rates are not set properly, and some statutory requirements are not checked for CMHC compliance. BBH annual reviews of CMHCs should be improved, and reapprovals should be better scheduled. The BBH also needs to improve its oversight of community mental health providers.

We found the BBH is not consistently collecting, analyzing, or acting upon program data to provide better oversight of the system. For example, the BBH has not managed its reporting systems effectively, including its long-awaited computerized system, Phoenix. In addition, the BBH improperly paid CMHCs from other DHHS accounts.

We identified a number of weaknesses in how the BBH oversees the community mental health system and many of them contribute to the lack of program information to better plan and manage the system. Because the BBH has not established and collected outcome data, our ability to evaluate the efficiency and effectiveness of service provision by CMHCs is hampered. Without measuring consumer outcomes, it is impossible to say whether the amount and types of services were excessive or inadequate.

RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required?	Recommendation	Agency Response
1	25	No	Determine the full effect of uncompensated care on the system for the severely mentally ill.	Concur
2	29	Yes	Request amendment to RSA 135-C:5, II to remove the term "state-funded" replacing it with language specifying the right to audit and monitor the records of all BBH-eligible clients. Define the term BBH-eligible and change Administrative Rules to eliminate the term "State-funded."	Do Not Concur
3	31	No	Comply with rate setting requirements for CMHC services, and amend Administrative Rules. Use benchmarks and public input to align rates with the mission, goals, and priorities.	Concur
4	35	Yes	Seek statutory authority to require contract outcome measures, collect and review outcome data. Revise contracts with the CMHCs to: focus on services for the BBH-eligible population, limit non Medicaid general funds, link payment with outcome measures, use contract managers familiar with community mental health services, establish contracting policies and procedures, and consider two-year contracts coinciding with the biennial budget.	Concur In Part

Observation Number	Page	Legislative Action Required?	Recommendation	Agency Response
5	43	No	Improve the annual reviews by evaluating the efficiency and effectiveness of services, ensuring contractual obligations are met, publicly reporting results, and adopting Rules. In addition, penalties should be established.	Concur In Part
6	48	No	Regularly review significant cost differences per recipient to ensure State resources are efficiently and effectively provided and follow Administrative Rules regarding the required subcontracting relationship between the CMHC and any regional community mental health providers.	Concur
7	50	No	Redistribute workload by conducting two reapproval reviews each year in order to complete all ten reapproval reviews within the five-year period.	Concur
8	52	No	Verify CMHC compliance with RSA 15:5, prohibiting use of State funds for lobbying, and with RSA 7:32-g, requiring a Community Benefits Plan.	Concur
9	55	No	Develop policies and procedures for current functions and practices.	Concur
10	56	Yes	Ensure all expenditures comply with State law, transfer funds to ensure accurate financial reporting, and seek legislation delegating authority for year-end transfers.	Concur In Part
11	58	No	Use available CMHC data to analyze utilization, costs, trends, and identify key performance measures to better oversee and manage the community mental health system; develop outcome or performance measures for each center and across the system, and require reports benchmarked against those measures.	Concur

Observation Number	Page	Legislative Action Required?	Recommendation	Agency Response
12	62	No	Collect needed but unavailable consumer services as required by RSA 135-C:13 and Administrative Rules.	Concur
13	63	No	Align information technology needs with organizational goals. Coordinate with the DoIT to finish implementing Phoenix, including developing a method for uniquely identifying consumers across all CMHCs.	Concur In Part
14	67	No	Improve contract management by ensuring contracts reviewed by Governor and Council include descriptions of work scope, and link payment with deliverables and performance outcomes.	Concur

THIS PAGE INTENTIONALLY LEFT BLANK

OVERVIEW

In December 2009, the Fiscal Committee of the General Court approved the joint Legislative Performance Audit and Oversight Committee's (LPAOC) recommendation for a performance audit of community mental health services overseen by the Department of Health and Human Services (DHHS). The purpose of the audit was to determine whether Bureau of Behavioral Health (BBH) oversight of community mental health centers (CMHC)[2] ensured services were delivered efficiently and effectively. The LPAOC approved the audit scope in January 2010.

SCOPE, OBJECTIVES, AND METHODOLOGY

Scope And Objectives

Our audit sought to answer the following question – **Are the mental health services provided by the Bureau of Behavioral Health, through the community mental health system, efficient and effective?** To address this question, audit efforts examined BBH oversight of CMHC services, contracts, expenditures, quality of care, and outcomes during State fiscal years (SFY) 2008 and 2009. Our efforts focused on determining how the BBH ensures:

- a statewide comprehensive system of community mental health services is available for eligible consumers;
- the community mental health system complies with federal and State laws and Rules;
- the efficient and effective use of State resources; and
- the Bureau is organized and functions to provide oversight, leadership, and planning.

Methodology

In conducting our audit work, we employed the following methods to address our audit objectives. To gain a general understanding of mental illness, its treatment in community-based settings, and the role of both state and federal governments, we:

- Reviewed national reports on mental illness, community mental health services, New Hampshire's mental health system, and similar reports about other states.
- Reviewed national outcome measures for mental health services across the country.

To better understand the roles and responsibilities of the BBH, the CMHCs, and other stakeholders, such as the New Hampshire Hospital (NHH) and peer support agencies (PSA), we:

- Reviewed pertinent State laws, Administrative Rules, BBH policies and procedures, and management controls.
- Interviewed BBH and DHHS personnel, CMHC officials from all ten centers, and

[2] In State law and Administrative Rules, community mental health centers are referred to as community mental health programs.

external stakeholders of the State's community mental health system about BBH operations and management, strengths and weaknesses, and each party's role in the system.

- Reviewed each CMHC's most recent five-year reapproval and annual review to determine consistencies in the statewide community mental health system.
- Reviewed CMHC annual reports, CMHCs' Internal Revenue Service Form 990s, Community Benefits Reporting, and regional demographics of each CMHC; while also reviewing websites and promotional information from CMHCs, PSAs, and other stakeholders.

To identify strengths, weaknesses, and risks in the State's community mental health system, we:

- Reviewed BBH operations for compliance with Administrative Rules and laws, oversight of costs, quality of care, and outcomes.
- Reviewed CMHCs' SFY 2008 and 2009 contracts for performance and efficiency measures, terms of enforceability, and levels of management.
- Reviewed 2008 and 2009 annual customer satisfaction surveys sponsored by the BBH.
- Analyzed or reviewed SFY 2008 and 2009 program and financial data collected by the BHH for its oversight of CMHCs.
- Collected and analyzed SFY 2009 data from each of the CMHCs to examine revenues by eligibility type, payer source, number of recipients, Medicaid spend down, and unmet needs. In addition, we analyzed SFY 2009 DHHS revenues and expenditures from the State's financial system, Medicaid data, and CMHC self-reported expenditures and quarterly reports.

BACKGROUND

Mental Illness

The term mental illness encapsulates varying degrees of psychiatric disorders. New Hampshire law RSA 135-C:2 X defines mental illness as:

> a substantial impairment of emotional processes, or of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to reason, when the impairment is manifested by instances of extremely abnormal behavior or extremely faulty perceptions.

Administrative Rule He-M 401.02 (s) further defines mental illness as psychiatric disorders classified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* including schizophrenia and other psychotic disorders; mood disorders; borderline personality disorder; post traumatic stress disorder; obsessive compulsive disorder; eating disorders; panic disorder; and dementia with a co-morbid symptom such as anxiety, depression, delusions, hallucinations, or paranoia.

In 2000, a U.S. Government Accountability Office (GAO) report entitled *Community-Based Mental Health* noted in any given year nearly 20 percent of the population is affected by mental illness. Additionally, the GAO cited statistics showing nationwide annual mental health costs in

the billions of dollars during the 1990s (e.g., $78.6 billion in lost productivity in 1990 and $73 billion in mental health service provision in 1997). Beyond these societal costs, mental illness can have a profound effect on the quality of life for people with mental illness.

The most severe forms of mental illness can substantially limit a person's ability to function in many areas of life such as employment, self-care, and interpersonal relationships. One study found the life span for someone suffering from serious mental illness is 25 years shorter than the general population. According to a 2003 report by *The President's New Freedom Commission on Mental Health*, five to seven percent of the adult population and five to nine percent of the child population suffer from serious mental illness or a severe emotional disturbance in any given year, respectively. The report contends mental illness ranks first in illnesses causing a disability in the United States.

RSA 135-C:13 states every severely mentally disabled person is eligible to receive services in the community mental health system. RSA 135-C:2, XV defines severely mentally disabled as having a mental illness which is either so acute or of such duration as to cause a substantial impairment of a person's ability to care for himself or to function normally in society. According to the Bureau's 2010 uniform block grant application, 5.4 percent of adults in the State had severe mental illness and 5.5 percent of children had severe emotional disturbance in SFY 2008. We estimate 1.4 percent of New Hampshire's population was determined to be severely mentally ill and engaged in the community mental health system in SFYs 2008 and 2009.

The History Of Community Mental Health Services

Mental health services have changed significantly since Virginia opened the first hospital for the mentally ill in 1773. By 1840, there were eight "asylums for the insane" in the United States. By 1900, the "mental hygiene" movement began after the release of a book detailing graphic accounts of hospital conditions entitled *The Mind That Found Itself*.

Starting in the middle of the twentieth century, treatment for the majority of people with severe mental illness transitioned from institutional to community settings, according to a 2002 University of Southern Maine, Maine Rural Health Research Center, study entitled *The Role of Community Mental Health Centers as Safety Net Providers*. *The National Mental Health Act of 1946* established the National Institute of Mental Health and tasked the organization with assisting states in developing mental health programs to limit institutionalization, training for mental health professionals, and mental health research. The Act administered block grants allowing the number of clinics serving those with mental illness to double between 1947 and 1964. Between 1950 and 1960, state spending on community-based mental health care began to increase, in part as a "response to mounting concerns about the growth of the inpatient population in state hospitals and a recognized need to shift to more humane community-based models of care."

According to the 2002 University of Southern Maine study, in 1960, the Joint Commission on Mental Illness and Health released a report entitled *Action for Mental Health*. Soon after, in 1963, President Kennedy called for a 50 percent reduction in state hospital populations around the country and the *1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act* funded construction and staffing of community mental health centers and required providing outpatient, inpatient, consultation/education, partial hospitalization, and

emergency/crisis intervention services. The Act stipulated the mental health authority in each state divide its jurisdiction into catchment areas of 75,000 to 200,000 people, each of which was intended to be served by a community mental health center. The Act, paired with the national movement towards deinstitutionalization, led to the community-focused setting found today. In the first 15 years after the Act, "the census of state and county mental hospitals declined by about two-thirds, while federal funds supported the establishment of more than 500 community mental health centers." The concept of federally-mandated catchment areas was later abandoned when the federal government switched to a block grant funding mechanism.

Funding For Community Mental Health Services

Introducing Medicaid as a substantial funding source for community mental health services affected state mental health service delivery systems. In 1965, the Medicaid program was established through *Title XIX of the Social Security Act* as a medical assistance program serving certain individuals and families. The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services administers the Medicaid program. Each state establishes Medicaid eligibility standards, determination types, amount, duration, scope of services, and payment rates within broad federal guidelines established by federal statutes, regulations, and policies. The Medicaid program's funding of community mental health services was a factor in shifting treatment from state-run institutions like the NHH, to community settings. Medicaid prohibited mental health service payments for institutionalized individuals between the ages of 22 and 64, although they could receive Medicaid support for outpatient care (i.e., community mental health services). In 1984, new disability evaluation criteria increased availability of Medicaid for mental health services.

With Medicaid, states could leverage federal dollars while limiting the growth in state expenditures for mental health services. According to a 2003 article in *Health Affairs*,[3] "[t]he introduction of Medicaid also dramatically altered the terms of fiscal responsibility for paying for mental health care. For the states this meant that their on-budget price for many mental health services for people eligible for Medicaid fell from 100 percent of costs to 17–50 percent of costs, depending on the federal matching rate for a state." This policy helped deinstitutionalization, in fact "cost-shifting opportunities offered by Medicaid were the factors with the largest impact on the rate of deinstitutionalization.… During 1955–1965 the populations of public mental hospitals fell by about 1.5 percent per year. Following the introduction of Medicaid, they fell at a rate of 6 percent per year."

The Medicaid program currently funds more than half of all mental health services administered by states. While Medicaid funding has reduced the need for general fund expenditures, BBH officials informed us the almost exclusive use of the Medicaid program to fund the CMHCs limits the Bureau's influence in the community mental health system. A 2009 review by the federal Substance Abuse and Mental Health Services Administration, Center for Mental Health Services noted the Bureau struggled with collecting 100 percent of necessary reporting data from CMHCs. According to reviewers, "the State could learn of ways in which to develop the appropriate balance of power" to enable the Bureau to provide the necessary oversight and administration of the community mental health system.

[3] Frank, Richard G., Goldman, Howard H., and Michael Hogan. "Medicaid And Mental Health: Be Careful What You Ask For," *Health Affairs*. Volume 22, Number 1. 2003 p 101 – 113.

Bureau Of Behavioral Health

Chapter 212:1, Laws of 1986 (codified in RSA 135-C) requires the DHHS to establish, maintain, implement, and coordinate a system of mental health services. Within the Department, the BBH is designated as the State Mental Health Authority for Medicaid. The BBH contracts with ten not-for-profit CMHCs[4] on an annual basis to provide community mental health services in ten regions. In SFY 2009, the BBH expended at least $93.9 million,[5] the majority of which ($90.8 million, or 97 percent) was Medicaid (State and federal) funds. Another $1.35 million was general funds contracted to the CMHCs for specific programs and services, and $450,000 to other vendors for community mental health-related services. In addition, the BBH expended approximately $1.3 million of State and federal funds on Bureau administration of community mental health services. To assist consumers with their recovery, the BBH also contracts with private not-for-profit PSAs in each region of the State to provide peer-to-peer support by people with mental illness.

Prior to a 2004 reorganization, Behavioral Health was its own division within the DHHS, which included the NHH and Glencliff Home for the Elderly. The BBH is now within the Division of Community Based Care Services. During the audit period, the NHH and Glencliff Home were separate from the BBH and were organized under the Division of Direct Programs and Operations, reporting to a Deputy Commissioner. As of March 2010, the NHH is also under the Division of Community Based Care Services.

Currently, the BBH organizational structure is somewhat fluid with several personnel supporting multiple areas. There are also a part-time Medical Director contracted from Dartmouth Medical School and legal counsel from the Office of Operations Support, Legal Services Unit. The BBH also contracts for other Dartmouth staff to provide training and consultation to CMHCs on certain clinical best practices. The Bureau has the following sections:

- **Quality Improvement** completes annual quality assurance audits and five-year reapproval reviews for each CMHC. Quality Improvement also reviews PSAs, and designated receiving facilities, such as hospitals approved by the DHHS Commissioner for the care, custody, and treatment of persons subject to involuntary admissions.
- **Community Mental Health Services** or the "program group" oversees PSAs, adult and forensic services, and acute and emergency services.
- **Data Management** consists of one employee responsible for data management and reporting for grants, the uniform reporting system, and the CMHCs.
- **Medicaid Rules** maintains compliance with all State and federal Medicaid regulations. Additionally, the team coordinates communication with the CMHCs on any billing or other questions.
- **Financial Management** reviews the CMHC financial indicators required per the Memo of Understanding within the CMHC contracts. Additionally, financial management determines financial allocations allotted each CMHC in the contracting process. The unit

[4] The BBH also identifies two community mental health providers, one directly under contract with the BBH as discussed in Observation No. 6.

[5] Because of fund transfers at the end of SFY 2009, these expenditure numbers are understated. See Observation No. 10.

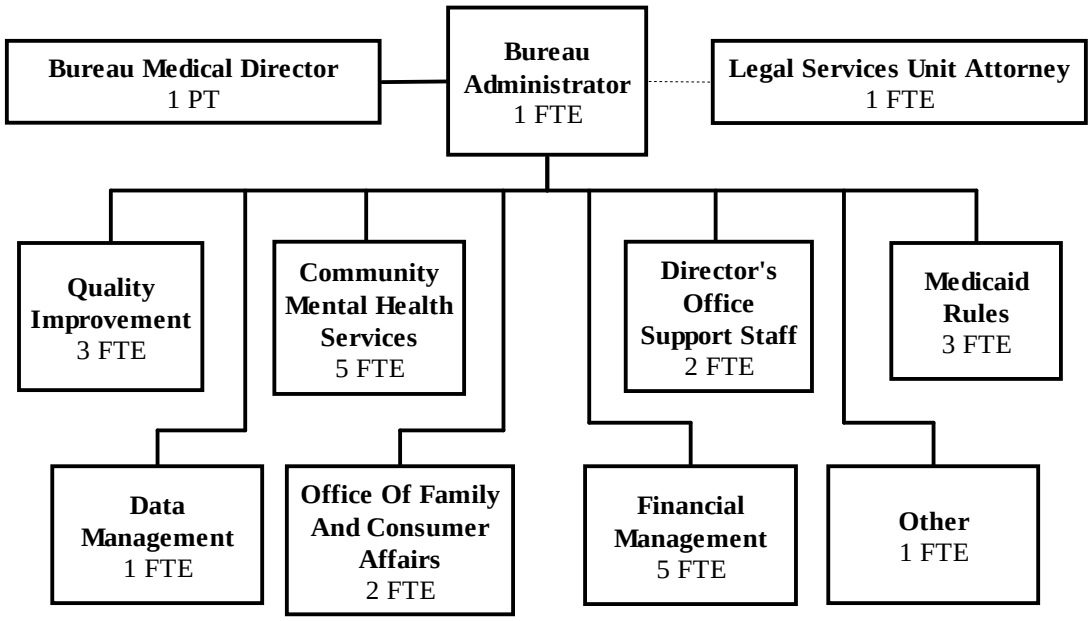
completes basic accounting requirements such as bill payment and procurement for the BBH and other bureaus within DHHS.

- **Office of Consumer and Family Affairs** provides communication, education, and advocacy for mental health services consumers. The Office holds regular trainings, produces a quarterly newsletter, maintains a resource center, and meets with stakeholders.
- **Other** is a position that splits time between the Housing Subsidy Bridge Program, the quality improvement team, and oversees the procedure waiver process outlined in Administrative Rules for consumers or a PSA.
- **Director's Office Support Staff** consists of two employees providing clerical and administrative support to all BBH personnel.

Figure 1 presents the organizational chart for the Bureau with the number of full-time equivalent (FTE) and part-time (PT) employees in each unit.

Figure 1

Bureau Of Behavioral Health Organizational Chart
(24 FTE, 1 PT)



Source: LBA analysis of interviews and BBH information.

Information Technology

During the audit period, the BBH primarily used the Phoenix system to assist with its monitoring and reporting responsibilities, but also used other Departmental information systems, including the Medicaid Management Information System, which handles Medicaid claims, and New Heights, which is used in eligibility determination.

Phoenix supports the BBH's role in monitoring the community mental health system and captures data for federal reporting. This system consists of spreadsheets compiled by staff from each CMHC based on information generated from their own database systems and sent electronically to the BBH. The BBH consolidated the spreadsheets to provide a system-wide overview of CMHC activities for each quarter for federal reporting purposes.

Concerns for data consistency and administrative burdens upon the CMHCs prompted the BBH to issue a request for proposals for Data Management Services in 2004. The BBH's intent was to develop and implement a new reporting method to ensure timely and complete reporting of essential data and production of meaningful management information reports to influence decisions at all levels. The new system, known as Phoenix, is designed to collect information directly from the CMHCs' claims processing databases to gather the most accurate and robust client-level data such as demographics (date of birth, gender, race); consumer status (insurance information, employment, diagnosis); episodes (admission date, discharge date, discharge reason); and services (date provided, service category, duration). However, as discussed in Observation No. 13, Phoenix was not yet complete as of April 2010. Although Phoenix reportedly accepts incoming data from the CMHCs, data are transferred to an Access database for federal and State reporting. Remaining tasks include developing an automated reporting process, systems operating manuals, training plans, CMHC guidance, and final testing.

BBH Oversight Of The Community Mental Health System

While the BBH leaves service delivery to each CMHC, the BBH maintains oversight of the system by conducting various types of reviews, requiring financial and performance reporting, and producing an annual consumer survey in conjunction with the University of New Hampshire. Additionally, in order to provide community mental health services, all CMHCs must have a BBH-approved program as required by State law. The centers must apply for reapproval of their program once every five years. State laws and Administrative Rules detail specific requirements for approved programs. In addition to required reviews, reporting, staff training, and Board of Directors' structure, Rules also detail what services can be provided, how clinical records are to be maintained, and other aspects of CMHC operation. Each CMHC enters into an annual contract with the BBH, which details additional reporting requirements and standards.

Mental Health Designations

The New Hampshire community mental health system overseen by the BBH targets consumers who are severely mentally ill. According to BBH officials, the CMHCs determine consumer eligibility for services. The eligibility categories include severe and persistent mental illness (SPMI), severe mental illness (SMI), severe or severe and persistent mental illness and low service utilization (LU), serious emotional disturbance (SED), and serious emotional disturbance with interagency involvement (SED-IA) as defined in Administrative Rules. The SMI, SPMI, and LU categories are used only for adults and SED and SED-IA are for children. If found eligible based on specific criteria for these categories (generally referred to as being "BBH-eligible"), the CMHCs must provide services to those residing in their geographic region independent of ability to pay. Additionally, the CMHCs can serve non BBH-eligible consumers in need of mental health services. According to BBH data, the CMHCs reported serving 18,449 BBH-eligible (39 percent) and 29,138 non BBH-eligible (61 percent) consumers, for a total of 47,587 consumers during SFY 2009 (as shown in Table 1).

Table 1

Percent Of Consumers Served Within Each Eligibility Category, SFY 2009

Eligibility Category	Unduplicated Consumers	Percent Of Total Consumers
BBH-Eligible Adults:		
Severe and Persistent Mental Illness	4,836	10%
Severe Mental Illness	3,367	7%
Low Utilizer	871	2%
BBH-Eligible Children:		
Serious Emotional Disturbance	4,586	10%
Serious Emotional Disturbance – Interagency	4,789	10%
Total BBH-Eligible Population	**18,449**	**39%**
Non BBH-Eligible Adult	25,590	54%
Non BBH-Eligible Children	3,548	7%
Total Non BBH-Eligible Population	**29,138**	**61%**
Total	**47,587**	**100%**

Source: LBA analysis of unaudited CMHC quarterly reports.

Number Of Community Mental Health Consumers By Payer Source

The determination for BBH-eligibility is not the same as the determination for Medicaid eligibility. Individuals may be designated BBH-eligible, but not qualify for Medicaid. Conversely, non BBH-eligible consumers may be Medicaid recipients and still receive services at the centers. We estimated the number of consumers by eligibility category and payer source based on a one-day count on June 30, 2009 (as shown in Table 2). We used a single point in time to avoid duplicating counts for people who may have changed eligibility category or payer source throughout the year. Similar to the BBH data in Table 1, the one-day count found 40 percent (15,752 of 38,965) of consumers at CMHCs were BBH-eligible.

As Table 2 shows, the Medicaid-only population represented 26 percent of the consumers served (10,171 of 38,965 consumers) on June 30, 2009, but as Table 3 shows, Medicaid recipients generated 79 percent of the centers' revenues ($78,461,408 of $98,833,511) over SFY 2009.[6] Based on our estimates, $84,332,931 (85 percent) of the centers' revenues were generated by BBH-eligible consumers and $14,500,580 (15 percent) was from non BBH-eligible consumers. As Table 3 shows, Medicaid was the primary payer for the BBH-eligible population, while Medicaid and commercial insurance were the predominant payers for the non BBH-eligible population.

[6] Another 14 percent of the population is both Medicaid and Medicare recipients and account for an additional 7 percent of CMHCs' revenues.

Table 2

Estimated Consumers By Payer Source And Eligibility Category On June 30, 2009

Payer Source	BBH-Eligible[1]	Non BBH-Eligible[1]	Total	Percent Of Total
Medicaid	6,910	3,261	10,171	26%
Medicare/Medicaid	2,946	2,408	5,354	14%
Commercial Insurance	2,596	8,336	10,932	28%
Self Pay	918	4,586	5,504	14%
No pay	153	842	995	3%
Other[2]	2,229	3,780	6,009	15%
Totals	**15,752**	**23,213**	**38,965**	**100%**

Notes: [1]We estimated the distribution of BBH-eligible and non BBH-eligible for all ten centers based on nine centers reported eligibility data and all ten centers reported totals.
[2] Other payers are Medicare, Medicare/commercial insurance mixed, or grants.

Source: LBA analysis of unaudited CMHC self-reported data.

Table 3

Estimated Revenues By Payer Source And Eligibility Category, SFY 2009

Payer Source	BBH-Eligible[1]	Non BBH-Eligible[1]	Total	Percent Of Total
Medicaid	$71,399,881	$7,061,527	$78,461,408	79%
Medicare/Medicaid	$6,186,127	$611,815	$6,797,942	7%
Commercial Insurance	$4,894,724	$4,894,724	$9,789,448	10%
Self Pay	$1,367,696	$1,671,628	$3,039,324	3%
No pay	$0	$0	$0	0%
Other[2]	$484,503	$260,886	$745,389	1%
Totals	**$84,332,931**	**$14,500,580**	**$98,833,511**	**100%**

Notes: [1]We estimated the distribution of BBH-eligible and non BBH-eligible for all ten centers based on eight centers reported eligibility data and all ten centers reported totals.
[2]Other payers are Medicare, Medicare/commercial insurance mixed, or grants.

Source: LBA analysis of unaudited CMHC self-reported data.

Community Mental Health Centers

The BBH contracts with ten private not-for-profit CMHCs to provide an array of community-based services to those with serious mental illness. RSA 135-C:3 authorizes the DHHS to contract with CMHCs; while Administrative Rule He-M 403.14 (a) mandates a CMHC will "relinquish its approval" as a CMHC if not entering into a contract with the DHHS. Seven of the ten CMHCs have been incorporated for over 40 years, with the most recent incorporated in 2001. The CMHCs provide services within regions defined in Administrative Rule He-M 425.03. Table 4 details the different regions throughout the State. We estimate the severely mentally ill (BBH-eligible) served at the centers represent between one percent and two percent of each regions' total population.

Table 4

Overview Of The Ten CMHC Regions

Region	Headquarters (Number of Towns)	Region Population (2008 Estimate)	Region Area (sq mi)	CMHC Consumers Served (SFY 2009)	BBH-Eligible		
					Consumers (SFY 2009)	Percent Of CMHC Consu-mers	Percent Of Region Popula-tion
1	Conway (58)	105,982	3,263	4,254	1,466	34%	1.4%
2	Lebanon (24)	79,853	955	4,386	1,266	29%	1.6%
3	Laconia (24)	86,379	903	2,230	1,685	76%	2.0%
4	Concord (30)	150,331	1,023	7,409	2,185	29%	1.5%
5	Keene (35)	107,499	1,038	4,093	1,290	32%	1.2%
6	Nashua (10)	188,973	263	5,079	2,393	47%	1.3%
7	Manchester (8)	198,915	287	9,000	3,482	39%	1.8%
8	Portsmouth (24)	143,008	437	3,394	1,765	52%	1.2%
9	Dover (13)	122,828	383	2,969	1,132	38%	0.9%
10	Derry (11)	131,234	215	4,773	1,785	37%	1.4%
	Total (237)	**1,315,002**	**8,767**	**47,587**	**18,449**	**39%**	**1.4%**

Source: LBA analysis of New Hampshire Office of Energy and Planning statistics and unaudited BBH data.

We found considerable variation in how states provide services to the mentally ill and the number of community mental health centers furnishing those services. According to a 2007 report commissioned by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 26 states directly contract with local, typically not-for-profit, community organizations to provide the bulk of mental health services. Of the states *not* using this model, 17 provide mental health services primarily by designating responsibility to county or city governments, and seven provide services primarily through state-operated facilities.

We did not identify the optimal number of CMHCs per capita to compare with New Hampshire's use of ten CMHCs for the State's approximately 1.3 million residents. However, BBH officials reported, if necessary, some CMHCs may be able to provide services in a second region in the event an existing CMHC was no longer operating or licensed by the BBH.

Two experts we interviewed stated the ideal number of centers in each state is often determined by geographic considerations, with more CMHCs typically found in larger, more geographically dispersed states. The average population covered per CMHC in New Hampshire (approximately 131,000) is at neither the high end nor the low end among states using the contracted local service provider model, based on data found in the 2007 report from 23 of the 26 states utilizing this model. We found the average population per center in these 23 states was 106,000.[7] Where variation exists, it is likely attributable to such factors as geographic area, the balance of hospitalization versus community treatment within the state (states with greater reliance on hospitalization typically require fewer community providers), and the size or specialization of individual providers (states in which individual providers are smaller or more specialized may have a greater number of providers overall).

Community Mental Health Services

The CMHCs provide services as required by Administrative Rules He-M 400 including: medication related services, psychotherapeutic services, emergency services, evaluation and testing, partial hospitalization, certain evidence-based practices, and case management. Additionally, the CMHCs are responsible for ongoing eligibility determination, developing and monitoring individual service plans, and maintaining clinical records.

Evidence-based practices (EBP) are mental health interventions which systematic empirical research has demonstrated are effective treatments for specific problems. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) requires states annually submit plans for implementing EBPs. Of the EBPs in use nationwide, five have been approved by SAMHSA and all ten CMHCs reported providing the two required by the State: supported employment and illness management and recovery. Additionally, nine of ten CMHCs reported providing at least one other EBP not required by the BBH.

In total, nine of the ten CMHCs reported 4,146[8] consumers received EBP services in SFY 2009. The BBH estimates 25 percent of BBH-eligible recipients receive EBPs. Of the nine centers reporting, 54 percent of consumers receiving EBPs received illness management and recovery, and 24 percent received supported employment. Additional EBPs used throughout the State include:

- Integrated Dual Disorder Treatment,
- Trauma Focused Cognitive Behavioral Therapy,
- Dialectical Behavioral Therapy,
- Assertive Community Treatment,
- Parent-Child Psychotherapy, and
- Helping the Non-Compliant Child.

[7] The average population covered per center ranged from a low of 9,854 in Alaska to a high of 300,434 in Kentucky, with a median of 85,000.

[8] This number may include duplicated counts for those receiving more than one EBP. Additionally, one CMHC identified the EBPs used, but not the number of recipients served.

In interviews, three CMHCs indicated they view EBPs as a positive development for the mental health system overall, and four indicated EBPs are clinically positive but the costs and paperwork of administering EBPs present substantial burden on centers. Two CMHCs stated EBPs were a negative development, and one stated whether they are positive or negative depends upon the EBP being implemented. Seven CMHCs suggested the BBH could lessen the burden on centers by enhancing reimbursement rates to compensate for the cost of implementing EBPs. However, a 2007 State Health Authority Yardstick report stated the reimbursement rate used appeared sufficient to cover the costs of providing illness management and recovery services. Further, five CMHCs suggested the BBH allow centers greater flexibility in administering EBPs, and two suggested the BBH place increased emphasis on measuring outcomes.

The Bureau contracts with Dartmouth Medical School to evaluate implementation at the CMHCs for fidelity to the model practices of the two required EBPs, and to provide EBP-related technical assistance and training to CMHC staff. Four of the ten CMHCs identified Dartmouth participation as a strength of the community mental health system.

Mental Health Performance Measures

Performance measurement in mental health is a mature field. Many of the performance measures available are appropriate and useful for measuring treatment outcomes for the severely mentally ill population, who are the focus of the New Hampshire community mental health system. In 2004, the federal Substance Abuse and Mental Health Administration introduced several performance measures called National Outcome Measures (NOMs) for mental health and substance abuse including: employment/education, stability in housing, social connectedness, access/capacity, retention, perception of care, and use of evidence-based practice. All 50 states are actively reporting one or more NOMs. We note New Hampshire's outcome measurements include *all* consumers served by CMHCs, not just those who are BBH-eligible.

It is difficult to compare New Hampshire with other states' performance measures as services and data collection may differ. However, according to the 2008 New Hampshire NOMs, 61 percent of adults felt positive about their mental health outcomes compared to 72 percent across the United States. Fifty-five percent of children and families felt positive about outcomes compared to 64 percent across the country. Thirty-six percent of adults with mental illness were employed (with employment data available) in New Hampshire compared to 21 percent nationwide. Readmission rates to State hospitals were generally higher in New Hampshire than across the country, but New Hampshire generally had shorter institutional stays and a lower level of co-occurring mental health and substance abuse consumers compared to the rest of the nation.

Many states, including New Hampshire, produce a consumer satisfaction survey measuring the consumer's perception of domains such as access, participation in treatment, quality, respect, outcomes, social connectedness, recovery, functioning, and overall satisfaction. The 2009 New Hampshire Public Mental Health Consumer Survey Project, completed by the University of New Hampshire Institute on Disability in collaboration with the Bureau, reported strengths and weaknesses of the mental health system from the consumer's perspective. Strengths identified included responsive individual CMHC staff, effective supports, and improved outcomes. Weaknesses included questions regarding staff quality and availability, limited transition planning for youth, insufficiently providing information to consumers on treatment and medications, need for additional services, and better coordination of care needed between the

CMHC and the community. As with the NOMs, the survey includes *all* CMHC consumers, not just the BBH-eligible population.

Logic Model

Measuring a government program's performance is difficult as many factors influence its outcomes. Determining the absolute extent government entities contribute to particular outcomes is not usually possible. Instead, performance measurement aims to acquire insight and provide some evidence the community mental health system is actually having an impact. A key tool for determining attribution is a logic model, which illustrates intended relationships.

Logic models are presented as flow charts describing programs in a way that facilitates developing relevant measures by portraying intended causal relationships between activities, outputs, and outcomes. The flow chart illustrates how a program intends to solve identified problems. Individual program activities, outputs, and outcomes are arranged in rows. Relationships between the various activities, outputs, and outcomes are arranged vertically on the page according to the sequential flow of program logic. The arrows linking the program elements signify the intended flow of the program.

Figure 2 presents the two components of the community mental health program: BBH oversight of the community mental health system and CMHC delivery of community mental health services. We created this logic model to aid in understanding the management of these functions; it is not intended to describe all activities carried out by the Bureau or the CMHCs.

Significant Achievements

Performance auditing by its nature is a critical process, designed to identify weaknesses in past and existing practices and procedures. Noteworthy achievements provided by management related to the scope of the audit are included here to provide balance to the report. Significant achievements are considered practices, programs, or procedures evidence indicates are performing above and beyond normal expectations.

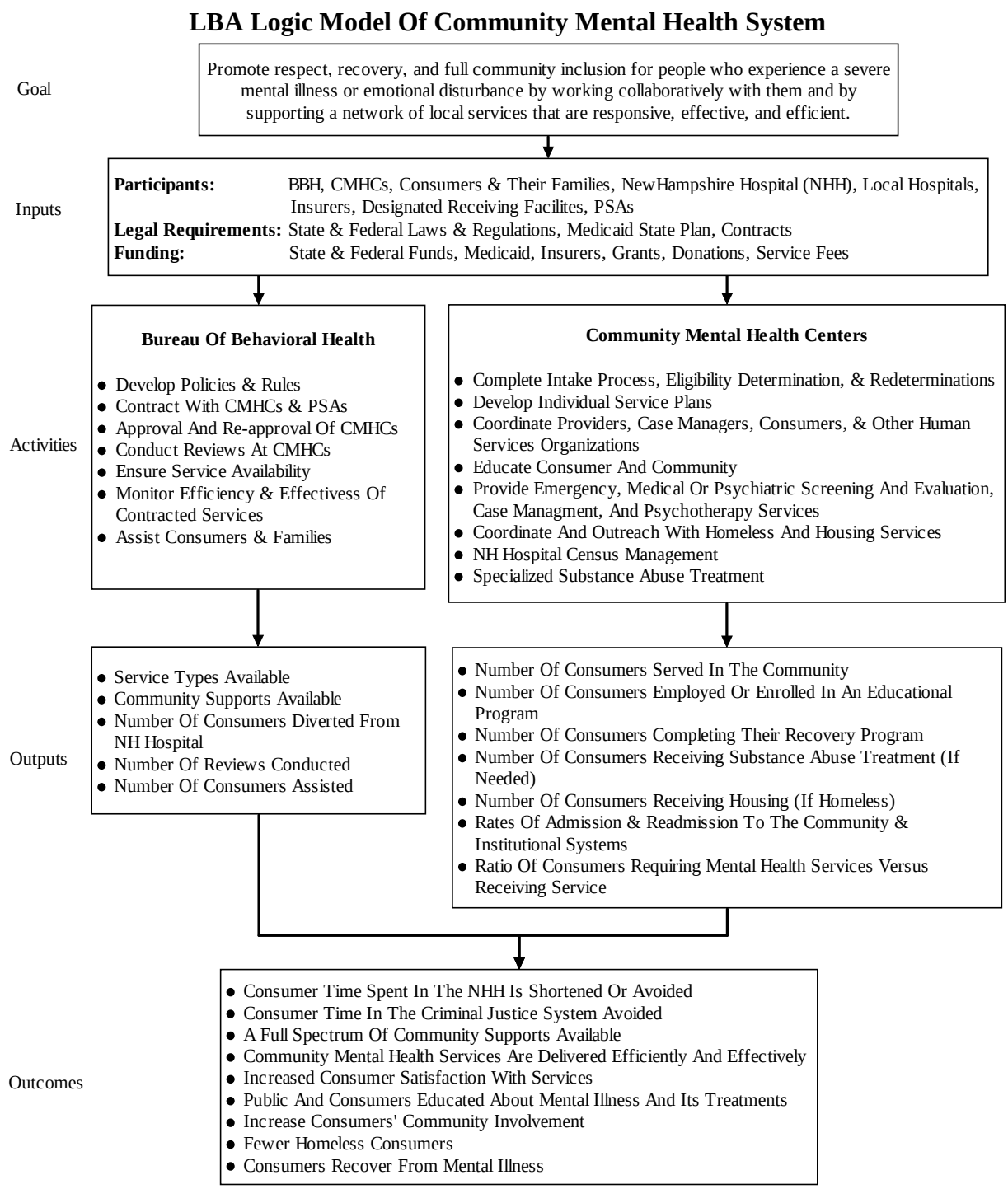
Video Conferencing

Video conferencing was implemented in the community mental health system as an alternative service delivery model, communication system, and tool for increased efficiency. The BBH notes "Video Conferencing provides an opportunity to leverage technology to improve access to services as well as deliver services in a more cost effective and efficient manner. In the North Country, video conferencing is now used to provide access for the first time to specialty child psychiatry services to families…" One CMHC reported tele-psychiatry is used in all five of their locations with 40 to 50 sessions per year and an expectation the annual caseload utilizing video conferencing technology will reach 200 in the coming years. In the North Country, where there was previously a wait of six to eight months to see a doctor two to three hours away, tele-psychiatry has allowed faster response to child psychiatry needs.

The BBH and the CMHCs worked to develop video conferencing capacity by obtaining equipment, making necessary policy changes such as allowing services to be provided and billed

to Medicaid, requiring third-party payers to accept the service, and conducting trainings and technical assistance.

Figure 2



Source: LBA analysis of BBH information.

Video conferencing provides an opportunity to leverage technology to improve access to services as well as develop more cost-effective and efficient service delivery methods. The BBH is expanding the technology across the State. Potential expansion includes: 1) using video conferencing in hospital emergency departments where necessary specialists are not on staff, 2) video conferencing with the NHH to allow clinicians and other witnesses to testify at involuntary emergency admissions hearings remotely and conduct discharge planning, 3) testifying at mental health courts, and 4) attending meetings in Concord. Further implementation of this technology will eliminate the need for travel to Concord, therefore reducing costs such as mileage reimbursement and lost hours for direct service provision by clinicians. Additionally, video conferencing may allow more efficient and regular contact with community mental health players.

THIS PAGE INTENTIONALLY LEFT BLANK

MEDICAID FUNDING OF COMMUNITY MENTAL HEALTH SERVICES

The State's funding for community mental health centers (CMHC) has become almost exclusively Medicaid. However, State law requires all Bureau of Behavior Health (BBH)-eligible consumers to receive services regardless of ability to pay, and not all of these consumers are Medicaid recipients. As a result, the CMHCs often do not receive State reimbursement for services to non Medicaid BBH-eligible consumers unable to fully pay for those services. We found State law and Rules have not been changed to clearly reflect this reimbursement practice. In addition, we found the Department of Health and Human Services (DHHS) has not established Medicaid rates correctly.

Medicaid Recipients And Their Costs

Medicaid is a substantial revenue source for the CMHCs. In the past, CMHCs received a more even mix of Medicaid (State and federal funds) and non-Medicaid State general funds. However, over ten years from State fiscal year (SFY) 1998 to 2008, the portion of non-Medicaid general fund expenditures to CMHCs fell from 27 percent of State funding to five percent. BBH officials informed us the use of the Medicaid program to fund the CMHCs, as opposed to State general funds, limits the Bureau's influence in the community mental health system. Under the fee-for-service model as used by the BBH, services are paid regardless of the treatment outcome.

According to CMHCs' self-reported data, Medicaid recipients accounted for 79 percent of the centers' service revenues ($78,461,408 of $98,833,511) during SFY 2009 (Table 3). Medicaid recipients represent a mix of BBH-eligible and non BBH-eligible consumers. BBH-eligible consumers have severe and persistent mental illness (SPMI), severe mental illness (SMI), severe or severe and persistent mental illness and low service utilization (LU), serious emotional disturbance (SED), or serious emotional disturbance with interagency involvement (SED-IA). Based on CMHC data, we estimate 68 percent of all Medicaid recipients are BBH-eligible at any one time. According to a BBH official this is understandable; the most severely mental ill consumers are less likely to be able to work and therefore will likely qualify for Medicaid.

We were able to analyze SFY 2009 Medicaid claims for community mental health services from DHHS Medicaid data. In total, 18,680 unique Medicaid recipients were served by the community mental health system in SFY 2009. The total amount reimbursed for Medicaid services rendered during SFY 2009 was approximately $91.7 million with $88.1 million (96 percent) applied to the BBH-eligible population and $3.6 million to the non BBH-eligible population.[9] The total Medicaid reimbursement per CMHC ranged from approximately $6 million to $15.7 million in SFY 2009. Average Medicaid cost per recipient varied depending on eligibility category and the region in which the consumer received services. In general, SPMI consumers had the highest per recipient cost while non BBH-eligible populations had the lowest. Table 5 provides an overview of per recipient cost by region and eligibility category.

[9] These totals will not equal the $90.8 million of Medicaid expenditures made in SFY 2009, as we analyzed the Medicaid data based on the date of service and not date of payment.

SPMI per recipient costs were highest of all eligibility categories, as well as having the greatest range in costs, with a regional low of $4,563 per recipient to a high of $18,451.[10] SED-IA had the next highest range in costs, $3,595 to $7,366; however, neither it nor any other eligibility category has the level of variation found in SPMI. Table 5 also demonstrates the difference in per recipient cost for BBH-eligible versus non BBH-eligible populations.

Table 5

Per Recipient Medicaid Cost By CMHC And Eligibility Category, SFY 2009

CMHC Headquarters	SPMI	SMI	LU[1]	SED	SED-IA	BBH-Eligible[2]	Non BBH-Eligible[3]
Conway	$18,451	$3,624	$1,732	$3,083	$4,736	$9,093	$446
Derry	14,330	3,035	2,135	2,770	5,291	7,274	557
Manchester	12,133	4,839	2,336	3,346	4,728	6,043	528
Concord	11,323	4,120	1,215	3,920	7,366	8,572	483
Dover	10,315	3,692	1,456	3,763	4,980	5,937	440
Lebanon	9,844	4,294	1,348	4,003	6,074	6,809	434
Keene	7,040	3,735	1,931	3,214	6,503	5,980	393
Laconia	6,781	3,043	1,272	4,100	4,817	5,093	372
Portsmouth	6,652	3,221	1,822	2,800	5,723	4,863	487
Nashua[4]	4,563	2,555	1,142	2,306	3,595	3,926	457
Average	**$9,650**	**$3,922**	**$1,777**	**$3,340**	**$5,405**	**$6,249**	**$462**

Note: [1] LU recipients have an annual spending cap of $4,000 per recipient according to the Medicaid State Plan.
[2] BBH-eligible column contains the average payment for all eligibility categories (SPMI, SMI, LU, SED, & SED-IA).
[3] Non BBH-eligible recipients have an annual spending cap of $1,800 per recipient according to the Medicaid State Plan.
[4] The CMHC in Nashua averages do not include costs for services to SPMI consumers provided by a community mental health provider.

Source: LBA analysis of unaudited Medicaid claims data.

Service Provision

Medicaid reimbursement is based on procedure codes for specific mental health services. Among all CMHCs, 67 different procedure codes were identified. However, for Medicaid BBH-eligible populations, two services, "Therapeutic Behavioral service per 15 minutes" and "Case Management" represented the majority of units and costs across all centers. Statewide, these two services represent 65 percent of the units of service provided to BBH-eligible Medicaid recipients and 68 percent of the Medicaid costs.

[10] While not included in Table 5, we calculated the median SPMI per recipient Medicaid cost for each CMHC and found similar variances between the centers. The CMHC headquartered in Conway had the highest median cost at $9,900 and Nashua's center had the lowest at $3,275.

In SFY 2009, annual cost per Medicaid recipient ranged from $0.21 to $252,588. Table 6 summarizes annual Medicaid recipient costs. In addition, 450 Medicaid recipients received services from two separate CMHCs throughout the year, 20 received services from three separate CMHCs, 18,206 were seen by a single CMHC, and the remaining four were seen by a community mental health provider.

Table 6

Distribution Of Annual Per Recipient Medicaid Cost, SFY 2009

Total Cost Per Recipient[1]	Number Of Recipients	Percent Of Recipients	Percent Of Total Cost
Over $100,000	16	3%	28%
75,000 - 99,999	23		
50,000 - 74,999	114		
25,000 - 49,999	405		
10,000 - 24,999	1,686	9%	27%
0 - 9,999	16,436	88%	45%
Total	**18,680**	**100%**	**100%**

Note: [1] This table includes Medicaid cost data for ten CMHCs and one community mental health provider.

Source: LBA analysis of unaudited Medicaid claims data.

Observation No. 1

Evaluate The Impact Of Uncompensated Care On The Community Mental Health System

The CMHCs absorb the cost of uncompensated care generated from:

- serving Medicaid-eligible consumers subject to the Medicaid In-and-Out (MIO) program;
- serving the non Medicaid, BBH-eligible consumers who are unable to fully pay; and
- providing emergency services.

The BBH does not know the full cost of uncompensated services. During our interviews, officials from all ten of the CMHCs identified uncompensated care as a weakness in the system. State law (RSA 135-C:13) requires services be provided to persons who are severely mentally disabled regardless of ability to pay when such services are available. Historically, some CMHCs have continued to provide services even when the State does not reimburse for those services. BBH and CMHC officials report, based on this statute and the contract between the BBH and the CMHCs, the centers are required to provide unreimbursed services to BBH-eligible consumers.

The Cost Of Uncompensated Care Is Unclear

There is no clear measure of uncompensated care in the community mental health system. Eight of ten CMHCs self-reported uncompensated care for all consumers (not only BBH-eligible)

ranged from $700,000 to $3.7 million, for a total of approximately $19 million uncompensated of $102 million billed during SFY 2009; however, the BBH does not track uncompensated care provided for BBH-eligible consumers and could not verify this amount, nor could we audit this number. BBH management has stated some services to consumers are initially uncompensated but will be paid retroactively if those consumers are later determined eligible for Medicaid. Nonetheless, CMHCs may provide some uncompensated care each year because some consumers are not yet Medicaid recipients when services are rendered.

Self-pay consumers and consumers in the MIO program accounted for 58 percent of uncompensated care based on our analysis of self-reported CMHC data. However, the CMHCs could not allocate these losses between BBH-eligible and non BBH-eligible populations served. RSA 7:32-e requires all health care charitable trusts, such as CMHCs, submit an annual *Community Benefits Report*, including unreimbursed costs, to the Office of the Attorney General. Only four CMHCs submitted this report for SFY 2009; however, these four CMHCs identified unreimbursed community benefits expenses ranging from over $500,000 to just under $3 million.[11]

The BBH-Eligible Population

The BBH estimates 25 to 30 percent of the approximately 18,000 BBH-eligible individuals served in SFY 2008 were not Medicaid eligible. The CMHCs self-reported 37 percent of BBH-eligible recipients were commercial insurance, self-pay, no pay, or other as of June 30, 2009, with the remaining 63 percent being Medicaid recipients or both Medicaid and Medicare recipients. Consumers who are self-pay or no pay (7 percent) may pay sliding scale fees based on ability to pay or may be required to make no payment. [12]

Medicaid In-And-Out

For services to the BBH-eligible population on the MIO program, the ten CMHCs' self-reported uncompensated care was just over $5 million for SFY 2009. MIO is a Medicaid program for those with monthly incomes too high for Medicaid, but who meet all other requirements for assets and functional disability. MIO participants must pay a certain amount of their medical bills each month, a spend-down, before becoming eligible for Medicaid benefits. According to the BBH and CMHCs, many consumers cannot afford to pay the spend-down amounts. The CMHCs still serve these consumers without payment and must write-off the receivables for the services provided during the spend-down period. The BBH was unable to estimate what percentage of the BBH-eligible population was on MIO or the cost to the CMHCs. The CMHCs self-reported 2,128 consumers (approximately 5.5 percent the total population served) were in the MIO program on June 30, 2009.

According to the CMHCs, the MIO program results in uncompensated costs in a variety of ways. While there was a direct loss of $5 million in uncollected billings for SFY 2009, there also were uncalculated administrative costs for monitoring and managing the MIO recipients' eligibility.

[11] *Community Benefits Reports* may include unreimbursed care such as community building activities or health professional education and not only unreimbursed direct service provision.

[12] These percentages are based on nine of the ten CMHCs who were able to report on their BBH-eligible populations.

Six of ten CMHCs reported MIO is especially burdensome for CMHCs because some CMHCs do not refuse services to BBH-eligible consumers, while other medical providers may deny consumers services until the spend-down requirements have been met. Medical providers will send recipients to the CMHCs to meet the spend-down requirements with services provided by the CMHCs (which are non-reimbursable by Medicaid) causing the CMHCs to absorb costs for the entire health system.

Emergency Services

CMHCs are required to provide emergency psychiatric services to all clients in need, per He-M 403.06 (a) (6) and He-M 426.09. These services must be available 7 days per week, 24 hours per day. Four of ten CMHCs specifically identified emergency services as a drain on the system, reporting uncompensated emergency services up to $500,000 per year at one center. CMHC officials reported the demand continues to increase.

BBH personnel also reported emergency or crisis response often goes uncompensated, as 40 percent of consumers have no insurance and this is one of the most costly services. The BBH budget change request for the SFY 2010-2011 biennium included approximately one million additional general fund dollars for emergency services at one designated receiving facility. These funds were not appropriated.

Risks To The Community Mental Health System

The BBH is responsible for maintaining the State community mental health system for the severely mentally ill, and should identify risks facing the system and take appropriate actions to mitigate those risks. Risk assessment and establishing objectives are necessary internal controls. Risk assessment requires identifying the resources necessary to meet objectives. If resources are insufficient, a plan should be developed for acquiring them or the objectives need to be modified to align with available resources.

Uncompensated care puts a strain on the system, affecting the CMHCs' ability to meet consumers' needs. A 2010 Endowment for Health report entitled *Community Mental Health Centers in New Hampshire: Financial Performance and Condition* reviewed operating margins at the ten CMHCs from 2004 through 2009. Three of ten CMHCs reached operating margins of two percent in two of the years, three others achieved a maximum operating margin of one percent in two of the years, and the remaining four had negative margins every year. Negative operating margins cannot sustain the infrastructure of the system or individual CMHCs for the long term. The report concluded the likely outcome of Medicaid cuts will be a reduction in service levels when the demand for mental health services may well be rising.

Additionally, uncompensated care may lead to overusing compensated services to shift dollars from these services to those not compensated. One CMHC official noted Medicaid is not intended to cover indigent and unfunded care, but it is likely happening. According to federal code 42 CFR 447.57, payments cannot be increased in a way to offset uncollectable costs, yet there is a risk the current system may encourage leveraging federal dollars in this way. CMHC officials we interviewed indicated resource shortages will continue, leading to cuts in services and staffing at the CMHCs, resulting in diminished ability to meet the needs of the severely mentally ill as intended by law.

Recommendation:

We recommend the BBH, in collaboration with the CMHCs, formally determine the full effect of uncompensated care on the system for the severely mentally ill, including identifying any risks these costs pose to the system's infrastructure. The BBH should report its findings to the Legislature and, if warranted, seek to amend statute or change Rules to mitigate potential risks to the State's community mental health system.

Auditee Response:

We concur.

While the Bureau concurs with the recommendation, we have some additional important comments for consideration. A proposal to establish a separate uncompensated care commission to examine this issue specific to the Community Mental Health system was presented and rejected by the Legislature in State fiscal year 2010. The Department of Health and Human Services has already established a commission to study this issue across all Divisions as part of a comprehensive look at uncompensated care for NH citizens. The Health and Human Services oversight committee determined that this issue needed to be examined as a broad policy issue across all service areas, and not just one.

BBH is working toward payment reform, and moving to an alternative payment methodology. We will be incorporating this issue into the scope of services the capitation firm examines as part of the design of a new payment structure for community mental health services. In addition, we will explore other options to serve this population. This will become a key policy issue for the Legislature. The current intent of RSA 135-C is to require CMHC's to serve any individual meeting the definition of having a Severe Mental Illness or Serious Emotional Disturbance without regard to ability to pay. As noted elsewhere in the report, the decline in available state funds to support services to this population has almost diminished to zero. If this mandate is to continue, BBH will either require specific funds to support services to this population, or alternatively need to consider modifying the statute to change the existing requirements. These and other options will be presented to the Health and Human Services Oversight Committee for consideration once the analysis is complete.

With regard to the provision of Emergency Services to local hospitals, we do not believe that this is the sole responsibility of either the Bureau of Behavioral Health or the Community Mental Health System. There are a number of examples across the state where local hospitals and the CMHC's have established contractual relationships to share in the responsibility (both fiscally and programmatically) which have benefited not only the organizations themselves, but has enhanced access to crisis care in the community for those individuals needing it the most. We encourage the development of alternative proposed solutions other than the Bureau of Behavioral Health and/or the CMHC's taking sole responsibility for the costs of providing this service.

There are several observations regarding the Medicaid In and Out program detailed in the report. BBH would like to emphasize that despite its shortcomings, the alternative would be to deny any coverage to this population group. For all program recipients, there is tremendous benefit to the individual. Although this is an observation attributed to an area under BBH's authority in the report, this issue is not one where BBH has any control or ability to make any changes.

Observation No. 2

Change "State-Funded" Language In Statute And Rules

Due to changes in the funding mix for community mental health services over time, the term "State-funded" as used in State law and the BBH Administrative Rules has become obsolete. State-funded no longer applies to the entire population required to be served by the community mental health system. The system is intended to serve the most severely mentally ill and emotionally disturbed individuals. BBH officials now refer to these consumers who qualify for community mental health services based on diagnosis and functional impairment as being "BBH-eligible." However, the term BBH-eligible is not currently defined in law or rule.

In the past, State general funds were used to pay for services to treat the most severely mentally ill and emotionally disturbed consumers. The majority of State general funds are now primarily used to match federal payments for services to Medicaid-eligible consumers and general funds no longer directly cover the cost of the non Medicaid BBH-eligible population. Nonetheless, the BBH-eligible population is referred to as "State-funded" multiple times in the Rules; for example, He-M 401.01 identifies the purpose of the Administrative Rule to "establish the requirements and procedures for determining eligibility for *state-funded* community mental health services" and He-M 408.01 identifies clinical record requirements "for persons eligible to receive *state-funded* services" (emphasis added). A similar discrepancy arises in Administrative Rule He-M 1002.02 (f)(4), where community residences are defined as those serving individuals "funded by the department" which, according to the Bureau Administrator, is meant to refer to the BBH-eligible population not the State-funded population.

As shown in Table 7, there are four population categories in the State's community mental health system; A) BBH-eligible, Medicaid-funded; B) BBH-eligible, non Medicaid-funded; C) non BBH-eligible, Medicaid-funded; and D) non BBH-eligible, non Medicaid-funded. Within this table the State directly funds populations A and C through the Medicaid Program. However, the Bureau's interpretation implies wherever Administrative Rules refer to the State-funded population (A and C), they should be interpreted as "BBH-eligible" populations (A and B), even though in practice the CMHCs receive no direct State funds to pay for services for non Medicaid BBH-eligible consumers (B).

Table 7

Overview Of Community Mental Health Population By Eligibility And Funding

Eligibility Status Of Consumers	State Matching Funds For Services Paid Through The Medicaid Program	Self Pay, No Pay, And Third Party Payer
BBH-Eligible (SPMI, SMI, LU, SED, SEDI)[1]	A	B
Non Eligible (not severely mentally ill)	C	D

Note: [1]Severe and persistent mental illness (SPMI), severe mental illness (SMI), severe or severe and persistent mental illness and low service utilization (LU), severe emotional disturbance (SED), and severe emotional disturbance with interagency involvement (SEDI).

Source: LBA analysis of the population served by the community mental health system.

This definitional difference is important because if a literal interpretation of Administrative Rules as currently written were applied, community mental health providers would not be required to maintain the same clinical records, eligibility requirements, or services for the non State-funded, BBH-eligible population (B in Table 7) as for the State-funded eligible population (A and C in Table 7). Additionally, RSA 135-C:5, II authorizes the DHHS to conduct site visits and otherwise audit and monitor all aspects of the administration, fiscal operations, and services of the program providing the service to determine compliance with the Rules; however, the statute limits review to records of state-funded clients. In practice, the BBH reviews a sample of BBH-eligible consumer files, not just State-funded consumers.

Recommendations:

We recommend the BBH request an amendment to RSA 135-C:5, II to remove the term "State-funded" and replace it with language specifying the right to audit and monitor the records of all BBH-eligible clients and Medicaid recipients.

We further recommend the BBH define the term BBH-eligible and change the language in Administrative Rules to eliminate the term State-funded.

Auditee Response:

We do not concur.

Eligibility for services and the terminology governing eligibility are defined in He-M 401. An individual determined eligible for services is an adult who has been assessed to have a severe or severe and persistent mental illness (SMI, SPMI), or a child who has been determined to have a serious emotional disturbance (SED). The eligibility determination process is independent of the payer source, and the intent of RSA 135-C is to ensure that any individual who has been determined "eligible" for community mental health services receives those services from the designated community mental health program.

The term "state funded" was not intended to be synonymous with "BBH eligible", as state funding refers to a payment mechanism- whether those be state general funds to support the provision of services, or Medicaid payments to the provider from the State of NH.

BBH already has the authority, through administrative rule, He-M 408.03 (c) (3), statute (RSA 135-C:10, III and RSA 126-A:4, IV) and federal regulations, to audit and monitor the records of any individual determined "eligible" for services, or any individual who is a Medicaid recipient, even if they have not been determined "eligible" for community mental health services. The recommendation to amend RSA 135-C:5 to replace "state funded" with language providing a right to audit and monitor the records of "eligible" clients would be redundant as BBH already has that authority, and the proposed language restricting BBH's authority to eligible clients only would restrict our ability to monitor and audit records for other Medicaid recipients receiving services.

LBA Rejoinder:

The Auditee response states the BBH has the authority to audit and monitor the records of any individual determined eligible for services *or* any individual who is a Medicaid

recipient. However, RSA 135-C:5 only grants the DHHS authority to audit and monitor "individual records of *state-funded clients*" (emphasis added). Only Medicaid recipients are State funded, therefore, the Bureau currently only has authority to audit individual records of Medicaid enrollees. The Auditee response further states record-keeping requirements defined in Administrative Rule He-M 408 apply to persons eligible to receive "state-funded services" pursuant to RSA 135-C:13 and He-M 401. As RSA 135-C:13 and He-M 401 define BBH-eligibility, not Medicaid-eligibility, the language in Administrative Rules He-M 408 should be changed.

Observation No. 3

Establish Medicaid Rates Compliant With Statutes And Rules

The DHHS is not complying with rate setting laws to ensure the Medicaid rates for community mental health services are appropriate to meet the needs of service recipients while being fiscally responsible. RSA 126-A:18-b requires the DHHS to review Medicaid reimbursement rates every two years, benchmarking them to Medicare rates, Medicaid rates in other New England states, private pay rates, and actual provider costs. To meet these requirements, the Department's Office of Medicaid Business and Policy (OMBP) prepared the *Medicaid Provider Reimbursement Rate Benchmarks for Key Services*, report dated October 2008. The OMBP originally intended to benchmark rates for community mental health services (identified as the third highest expenditure by category of service in SFY 2007). However, due to DHHS resource constraints, the review was limited to eight service categories, which did not include community mental health services.

The BBH also does not follow rate-setting methodology described in Administrative Rule. He-M 426.22 (b) states community mental health services are paid based on units of services provided by all community mental health providers divided by the sum of costs for client transportation, staff, and staff-related costs. Instead, rates for new services are reportedly based on existing rates for "like" services. BBH personnel stated Medicaid rates for community mental health services have not been comprehensively analyzed and set since 1991, and recent rate changes have only occurred in response to State budget constraints (shifting rates downward) or Legislative mandate through the State Operating Budget (shifting rates upward).

Rates Do Not Reflect Service Cost

While rates are not compared to individual service costs, the BBH analyzes costs to ensure Medicaid payments do not exceed "allowable cost" in aggregate. The BBH periodically reviews the CMHC audited annual financial statements and Medicaid data to ensure the percentage of Medicaid revenues to total revenues is close to the percentage of Medicaid service units provided to total services provided. This methodology is not identified in the State plan, statute, or Administrative Rules.

Federal regulations for state plans for medical assistance require plans include methods relating to utilization and payment for services to safeguard against unnecessary utilization; and ensure payments are consistent with efficiency, economy, and quality of care. However, BBH personnel

reported the Medicaid fee-for-service payment structure may lead centers to provide more services than necessary to shift funds received from Medicaid recipients to the clients receiving uncompensated services.

Eight of the ten CMHCs stated rates do not necessarily reflect costs of services. Some rates are reportedly set higher than costs to incentivize certain services, particularly rates for community-based services and psychiatric diagnostic visits which are reimbursed above cost. According to one CMHC official, some services are volume-driven (i.e., when a service is delivered in high volume, then the rates may generate revenue from Medicaid). One CMHC official noted Medicaid is not intended to cover indigent and unfunded care, but it is likely happening. An official at another CMHC reported because Medicaid revenues are diminishing, it is less helpful in supporting the indigent BBH-eligible population than in the past, while an official at a third CMHC stated decisions are based on billable hours instead of need. According to the Community Benefits Report filed with the Office of the Attorney General, two of the four CMHCs that filed reports identified net Medicaid revenue of between $1 and $4 million for reimbursements over costs.

BBH management and the CMHCs also reported current rates for residential services are paid below cost, thereby dis-incentivizing providing these services. The per diem reimbursement rate was increased to $120 at the beginning of SFY 2010, but costs are estimated to be $160 per day by the Bureau and $180 per day by the CMHCs. The BBH prioritized the expansion of residential bed facilities in its ten-year plan, *Addressing the Critical Mental Health Needs of NH's Citizens*. However, since the release of the plan in 2007, two residential facilities with a total of 28 beds have closed and no new beds have been established. According to the BBH Administrator, the Bureau cannot raise the rates enough to satisfy the financial needs of the centers, as estimates show it will cost around $1 million in State funds to increase the rate sufficient to encourage CMHCs to keep beds open (requiring a corresponding reduction in other services). The BBH and CMHC management noted once residential facilities are closed, individuals receive services in the community at a much higher per-hour cost, rather than the residential per-day cost.

Future Benchmarking

According to the BBH Administrator, the Bureau is required to use an actuarial firm approved by the federal Centers for Medicare and Medicaid Services to establish a per-member per-month rate. The Bureau plans to hire an actuary in 2010, therefore, it is unlikely community mental health rates will be included in the biennial rate-setting report due October 1, 2010. Nonetheless, during the audit period, there was no analysis of community mental health service rates as required by statute. Without regular and thorough analyses, the BBH cannot ensure rates do not incentivize some services while ensuring other rates are sufficient to maintain adequate community mental health services. Currently, rates for newly created services are only reviewed retrospectively to ensure they do not exceed allowable costs.

Recommendations:

We recommend the DHHS comply with all State and federal rate setting requirements for CMHC services, and amend Administrative Rules consistent with rate-setting policy and practice, including:

- **establishing methodologies in the State Plan,**
- **conducting regular assessments,**
- **considering stakeholder and public input, and**
- **reporting this information.**

We also recommend the BBH use benchmarks and public input to align rates with the mission, goals, and priorities established for the community mental health system.

Auditee Response:

We concur.

BBH is already in the process of addressing the issue of rates, and most importantly the inherent problems that have persisted with maintaining a payment system that is based on fee-for-service rates. Our current fee-for-service payment methodology creates disincentives for ensuring timely access to care, matching the level of services to need, incentivizing movement towards recovery and out of the system, and basing payments on achieving positive outcomes rather than the volume of services provided. BBH is in the process of completing a waiver application to CMS (implementation date of July 1, 2011) to revise our current payment system moving from fee-for-service to a capitated, pay for performance model. The following highlights the objectives and deliverables from BBH's payment reform, recently highlighted in a publication distributed by BBH:

BBH will establish a payment model that…

- *Reimburses community mental health services for New Hampshire's Medicaid primary population based on the approved cost of providing services*
- *Is flexible and allows for funding to preserve the infrastructure to respond appropriately to changes in enrollment over time*
- *Creates incentives for care that promotes individual recovery goals utilizing performance based outcomes*
- *Facilitates timely access to treatment on a statewide basis and promotes efficient and effective service delivery*
- *Facilitates improvement in the quality of care and outcomes for the population served with an emphasis on providing care that is Evidence Based or through new promising practices that are recovery oriented*
- *Provides an opportunity to reinvest potential savings into additional services and program development on a statewide and regional basis to improve treatment outcomes*
- *Has care managed locally and not by a third party administrator*
- *Leverages other supports in the community, including Peer Support, Family Support, Primary Care, and other service providers in the community*

- *Shares risk between the State and provider community for the provision of services*

- *Provides for the transparent dissemination of reports on outcomes and quality indicator data to the public and other stakeholder groups*

BBH has been working with a consultant funded through a technical assistance grant from the National Association of State Mental Health Program Directors (NASMHPD) for the past 12-months. In January, DHHS hosted a stakeholder forum to review the initial concepts for a waiver application to CMS with the CMHC Boards of Directors, Executive Directors, Peer Support Boards of Directors and Executive Directors, Advocacy Organizations, Legislators, and individuals receiving services. A copy of this presentation is on BBH's webpage: http://www.dhhs.state.nh.us/DHHS/BBH/default.htm.

We are currently completing a concept paper for submission to CMS following a meeting this past spring with representatives from CMS to outline our project plan and timetable. CMS has assigned staff to work with BBH on this project and provide technical assistance. Based on an additional grant for technical assistance submitted this month, we anticipate hiring a project manager this summer, and will be completing the project plan for the waiver submission, a detailed communications plan, and retention of a capitation firm by the end of August. As is always our practice, we will continue with active stakeholder involvement throughout this project, and a separate communication plan will be developed detailing multiple strategies for engaging stakeholders in providing input, and communicating progress and identifying key decision points as they arise.

The capitation firm will be establishing a rate that is based on the actual cost of providing services. This will be reviewed annually through a modified financial reporting system, and adjustments will be made to ensure that the rates do not exceed the allowable costs established in the waiver- Section D, 1915(b) Waiver Preprint Package.

COMMUNITY MENTAL HEALTH CENTER OVERSIGHT

The Bureau of Behavioral Health (BBH) has historically chosen to contract primarily with private, not-for-profit community mental health centers (CMHC) to provide services. We found the BBH oversight of the CMHCs has a number of weaknesses. The BBH annual contracting process is inefficient and does not contribute to effective management of the CMHCs. Further, the BBH annual reviews of CMHC consumer files do not establish whether services provided are efficient and effective, have not ensured review findings lead to corrective actions improving services, nor does the BBH share results with the public. Neither the annual nor the five-year reviews by the BBH examines CMHC compliance with State laws: 1) prohibiting lobbying with State funds and 2) requiring development and submission of a Community Benefits Plan to the Office of the Attorney General. We also found the BBH does not sufficiently provide formal, organized guidance to CMHCs regarding shared responsibilities in the community mental health system and interpreting new federal or State laws, Rules, or procedures. Finally, we found at least one community mental health provider may not be receiving proper oversight of its service provision, and reimbursements to the provider are not in accord with Administrative Rules.

Observation No. 4

Contracting Process Needs Improvement

The BBH contracting process with the CMHCs is inefficient and could do more to ensure services provided to BBH-eligible consumers are effective. RSA 135-C:3 gives the Department of Health and Human Services (DHHS) Commissioner discretion to operate programs for services to the mentally ill directly or to enter into contracts for providing those services. However, the description of services and budgetary information CMHCs must include in the contract are not limited to the BBH-eligible population, nor do they correspond directly with the Medicaid or general fund services actually reimbursed by the BBH. In addition, we found contract requirements are not based on measurable performance outcomes, are not monitored in the annual or five-year reviews, and contracts do not include penalties for failure to meet requirements.

Use Of Non-Medicaid General Funds

State general funds are primarily used to reimburse the CMHCs through the Medicaid Program for Medicaid recipients only. The BBH also has a comparatively small amount of discretionary general funds it distributes through the CMHC contracts. However, the contracts do not require these discretionary funds be used for indigent BBH-eligible consumers (those severely mentally ill not on Medicaid or other insurance, but unable to pay for services), even though this is the population the BBH is required to serve per RSA 135-C:13, and the population the centers are contractually required to serve. In State fiscal year (SFY) 2009, seven of the ten centers had contracts for approximately $1.4 million in general funds (non-Medicaid) to provide a variety of services including a nursing facilities coordinator, substance abuse treatment program for older adults, and services to the Deaf. According to a Bureau official, the CMHCs prefer to use

discretionary general funds for programs which are not reimbursable through Medicaid and which serve consumers who may or may not be severely mentally ill.

Required Contract Information Extends Beyond BBH-Eligible Consumers

While CMHCs report only 39 percent of consumers were BBH-eligible in SFY 2009, and 26 percent were Medicaid recipients,[13] the "Statistics" section of each contract contains the estimated units of services to be provided to all consumers. This section describes services in program areas extending beyond those required in Bureau Rules for the BBH-eligible population, and which do not correspond with the Bureau's budgeted class lines for the Medicaid-eligible population. As a result, the contracts contain multiple tables of expected outputs (units of service) for all CMHC consumers, not all reimbursed by the BBH. One contract provision specifically requires CMHCs provide services to all BBH-eligible consumers, but the Bureau does not reimburse for all services to this population.

According to a Bureau official, six pages of required detailed budget information remain from the 1980s when the centers primarily received general funds. These pages include all revenues and expenditures in all program areas and for all consumers served by the CMHCs.

Contract Proposals Not Fully Analyzed By The BBH

During contracting, BBH contracting personnel reported data regarding how each CMHC plans to serve similar populations are not compared. Rather, BBH personnel check whether the "basic math" is correct and the numbers are reasonably close to the numbers from the previous year. According to the Bureau Administrator, some of the types and numbers of services provided would relate to the centers' treatment philosophy and certain types of services cannot be compared across centers.

Projected estimates of units of service required in the contract's Statistics section are delineated by program area (e.g., vocational services, emergency services, or intensive partial hospitalization). Bureau personnel reported using this information to track services provided to the entire consumer population for budgeting and potential grants. However, over the audit period, CMHCs reportedly interpreted titles of program areas differently, so services were not identified in the correct areas. Additionally, "unit" may describe various quantities of service, but in the contract, units of service are reported in aggregate. For example, two centers may project providing 1,000 units of a service, but one center anticipates each unit to be a 15-minute session while the other anticipates 45-minute units. One Bureau employee said confusion over program area definitions would not have occurred if regional managers were still part of the contracting process. Without regional manager positions, contracting is currently conducted exclusively by BBH financial personnel. In contrast, the Bureau of Developmental Services regional liaisons serve as contract managers with their service providers, known as area agencies.

Each contract contains a Memorandum of Understanding outlining financial ratios such as cash-on-hand, which centers are required to report monthly, enabling the Bureau to monitor their general financial health. One BBH official reported the Memorandum requirements have superseded previous mandatory financial reporting. However, the BBH still requires CMHCs to

[13] Another 14 percent of the population is both Medicaid and Medicare recipients.

submit budgets detailing all revenue sources (beyond revenue from the BBH) and for all expenditures (beyond programs for BBH-eligible consumers or Medicaid recipients). BBH contracting personnel reportedly do not check whether budgeted amounts are reasonable for the number of services provided, have no criteria to measure whether amounts are reasonable, and have no way of checking budget estimates for non-BBH revenues, such as private insurance or self-pay consumers. Rather, two BBH personnel reported only checking the submitted materials against other submitted materials from the same CMHC for consistency. According to written contracting procedures, these reviews take 75 to 80 percent of one contract employee's time from mid-January to June.

More Outcome Measurements Needed

CMHC contracts include many output measures but few outcome measures. Outputs are the results of a process (for example, units of services provided) while outcomes describe performance expectations (for example, a highly-functioning consumer) and are considered a better measure of whether contracts are achieving objectives. To the extent possible, contract administration should begin with the development of clear performance-based work.

There are no outcome measures for services paid with State general funds. The Bureau Administrator stated the BBH does not use performance measures to allocate the non-Medicaid State dollars because the general fund portion of the contract has diminished over the last decade. We noted in our 1990 audit of the Community Mental Health System, "outcome-oriented measures of program effectiveness need to be developed that tie the delivery of mental health services to resulting improvement… in client conditions and behavior." Bureau management stated the BBH has since included the provision of evidence-based practices (EBP) in Administrative Rule; however, adherence to proper implementation of EBPs is monitored, but not outcomes. The federal Substance Abuse and Mental Health Services Administration states outcome measures such as fewer hospitalizations and more consistent use of medications should be collected to capture program results. As the CMHCs and the BBH estimate only 22 to 25 percent of the BBH-eligible population took part in EBPs in SFY 2009, outcome measures should be established for other BBH-eligible consumers as well.

Inadequate Contract Management

BBH follow-up review at the CMHCs to ensure services are provided as contracted is minimal. Of the outputs and outcomes identified in the contracts, only substance abuse screening is included in annual reviews. During the audit period, only one of the 11 contracted services paid for with State general funds (non-Medicaid) was reviewed to determine whether the dollar amount charged was appropriate. Although DHHS auditors found the contracted amount was approximately $150,000 higher than necessary, the amount was not changed in the subsequent contract cycle.

According to the Office of Federal Procurement Policy's *Best Practices for Contract Administration*, a contract administration plan should include how to measure the contractor's performance and link performance with payment. However, there are no penalties in CMHC contracts for failure to meet projected outputs, Administrative Rules, reporting, or outcome requirements. One BBH official noted contracts cannot be enforced until the CMHCs are nearly in crisis.

The BBH provided us with a document titled *Contract Procedures Manual* which indicates if CMHC budgets' projected Medicaid revenue is more than the BBH-allocated amount, the figures will be adjusted to match the BBH Medicaid allocation. However, Government Accountability Office internal control standards stipulate agencies should not submit inappropriate or inaccurate reports in order to meet targets. One CMHC Executive Director pointed out the centers know in advance they may not meet budgetary projections and five of ten CMHCs report the required budget does not necessarily reflect reality. Further, we were unable to find any Administrative Rules outlining the contracting process and in subsequent conversations, BBH officials reported the contract manual is a set of notes, not a formal document.

Finally, although CMHCs and budget personnel have described the contracting process as time- and resource-intensive, the process is repeated annually rather than biennially in conjunction with the BBH budget. Seven of the ten CMHCs reported the contracting process is highly time-consuming and cumbersome and is not used to identify needs or to plan, assess, or support the system.

Recommendations:

We recommend the BBH seek statutory authority to require outcome measures in contracts with CMHCs to ensure the BBH-eligible population are being effectively treated. We also recommend the BBH revise its contracts with the CMHCs to focus on services for the BBH-eligible population and limit non-Medicaid general funds to directly support the BBH-eligible population only.

Additionally, the BBH should improve its contract management by:

- **adopting Administrative Rules for collecting consumer-specific outcome data,**
- **regularly collecting and reviewing required outcomes measures,**
- **enforcing contracts by linking payment with outcomes measures,**
- **using a BBH official knowledgeable of community mental health services as contract manager,**
- **establish formal written contracting procedures and outline contracting policies in Administrative Rules, and**
- **considering two-year contracts to coincide with the biennial budget.**

Auditee Response:

We concur in part.

The present contracting process with the CMHC's has been in place for over two decades. In FY 2012, as part of BBH's payment reform initiative, and in conjunction with a waiver from the Centers for Medicare and Medicaid Services, BBH plans to change the way community mental health services are reimbursed in the state – from a fee-for-service system to a capitated per member per month model. As part of this process, the present contracting system, will, by necessity, be dramatically altered. Several of the recommendations made by the LBA relating to improvements in contract management have already been planned for. Future contracts will incorporate a significant emphasis on a pay for performance model, enhancing the quality of

services, ensuring timely access to treatment and the importance of demonstrating positive performance on established outcomes measures.

Concerning the LBA recommendations to focus on the BBH-eligible population and limit non-Medicaid general funds to the BBH-eligible population, BBH respectfully disagrees that these funds are restricted to the eligible population. The use of these general funds have been instrumental in promoting the implementation of Evidence Based Practices, for example, by covering the costs of attending training and supervision, and providing funding for non-Medicaid services to recipients in EBP programs. They have also been used to fund services to the deaf, inpatient care services for the uninsured, supporting clinical staff positions in the community and providing funding to community outreach programs for seniors who are not yet clients of the community mental health center. Finally, these funds are used to provide funding for indigent care. These are policy decisions made based on input from providers and stakeholders, and a careful prioritization of the limited funds available for the best outcomes for our consumers. The use of these specific funds is detailed at the time of each budget submission with the Legislature, and a detailed accounting of each initiative is provided and reviewed.

The LBA makes the observation that one program was paid $150,000 "higher than necessary" which is taken out of context specific to the scope of the review done, and implies that these funds should have been retained by the Bureau. This is in reference to funds supporting an inpatient program in Manchester. Part of an audit conducted by BBH was to determine whether these funds were adequate to cover admissions to the program for individuals without insurance. While the BBH audit did find that the amount was over what was needed for uninsured admissions, the purpose of these funds was to ensure the overall operations of the program were covered with state funds for non-Medicaid reimbursable expenses due to losses ($700K annually) in the program threatening its closure in the year prior. Data submitted to the state to oversee the use of these funds was changed, and subsequently reviewed, and in FY 10 the amount allocated was $140K less than actual cost. This program is a critical resource in the state, and handles over 900 admissions for individuals who would ordinarily go to New Hampshire Hospital.

In terms of required contract information, BBH respectfully disagrees that the current required information goes beyond what should be required of only the eligible population served. The Community Mental Health Centers receive the majority of their funding (75% to 85%) from the State of NH, either through Medicaid or state general funds. The Bureau has a critical interest in ensuring that services are available to our priority population and requires information that goes beyond a single group to include other Medicaid recipients, as well as data to ensure that services provided to the Medicaid population are paid in accordance with the aggregate allowable costs which requires reference points to the organization's overall budget and services provided for comparison and monitoring.

With respect to outcomes measures, as noted in previous responses, BBH intends to integrate more outcomes measures as part of future contracts, a pay for performance model, and a new payment methodology. While we agree the current contracts do not require outcome measures, we do not agree with statements implying that our system is not outcomes driven. The following is a summary of current outcomes collected and analyzed on an annual basis which drive the Bureau's strategic planning process:

National Outcomes Measures (reported on by all states):

Accountability in the delivery of quality mental health services is a guiding principle of New Hampshire's planning process, to support recovery for adults with serious mental illness (SMI) and children with severe emotional disturbance (SED), through an effective community-based system. Per the Mental Health Block Grant to the States, CMHS has established that one level of accountability will be measured by the collection of standardized data from States using uniform national outcome measures (NOMS) and other State-identified measures that reflect the priorities and needs of individual States. The Community Mental Health Services Block Grant Application Guidance is based on the existing authority of the Public Health Service Act (PHS Act)[14] and provides detailed instructions for articulating and reporting the State Plan. The NOMS are derived from data tables in the Uniform Reporting System (URS), as reported by the States.

National Outcome Measures (NOMS) and Related Performance Indicators

Outcome	***Mental Health Indicator***	***Relevant Criterion***	***DIG/URS Tables***
1. Increased Access to Services (Service Capacity)	*Number of Persons Served by Age, Gender, and Race/Ethnicity*	*Criteria 2 and 3*	*Tables 2A and 2B*
2. Reduced Utilization of Psychiatric Inpatient Beds	*Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 30 days and 180 days*	*Criteria 1 and 3*	*Table 20A*
3. Use of Evidence-Based Practices	*Percent of SMI and SED Clients Receiving EBPs*	*Criteria 1 and 3*	*Tables 16 and 17*
	Number of EBPs Offered	*Criteria 1 and 3*	*Tables 16 and 17*
4. Client Perception of Care	*Percent of Clients Reporting Positively About Outcomes*	*Criteria 1 and 3*	*Table 11*
5. Increased/Retained Employment or Return to/Stay in School	*Percent of Adult Clients Who are Competitively Employed*	*Criterion 1*	*Table 4*
	Percent of Parents Reporting an Improvement in Child's School Attendance	*Criteria 1 and 3*	*Table 19B*

[14] Sections 1911-1920 of the PHS Act (42 USC 300x-1through 300x-9) and Sections 1941-1956 of the PHS Act (42 USC 300x-51 through 300x-66). A complete copy of the PHS Act may be found at http://energycommerce.house.gov/108/pubs/109_health.pdf.

6. Decreased Criminal Justice Involvement	*Percent of Clients Arrested in Year 1 Who Were Not Re-Arrested in Year 2*	*Criteria 1 and 3*	*Table 19A*
7. Increased Stability in Housing	*Percent of Clients Who Are Homeless or in Shelters*	*Criteria 1 and 3*	*Table 15*
8. Increased Social Supports/Social Connectedness	*Percent of Clients Reporting Positively About Social Connectedness*	*Criteria 1 and 3*	*Table 9*
9. Improved Level of Functioning	*Percent of Clients Reporting Positively About Functioning*	*Criteria 1, 3, and 4*	*Table 9*

The data is reported in the State Plan on forms titled Goals, Targets, and Action Plans (GTAPS). The purpose of the performance indicator tables in the GTAPS is to show progress made over time as measured by the NOMS and any State-selected performance indicators. These forms must identify one or more of five statutory criteria that must be addressed in the State Plan. In total, New Hampshire currently reports on 36 measures; 25 for adults and 11 for children.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

- *Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders.*
- *Describes available services and resources within a comprehensive system of care, provided with Federal, State, and other public and private resources, in order to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. These shall include:*
  a. *Health, mental health, and rehabilitation services;*
  b. *Employment services;*
  c. *Housing services;*
  d. *Educational services;*
  e. *Substance abuse services;*
  f. *Medical and dental services;*
  g. *Support services;*
  h. *Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA);*
  i. *Case management services;*
  j. *Services for persons with co-occurring (substance abuse/mental health) disorders; and*
  k. *Other activities leading to reduction of hospitalization.*

Criterion 2: Mental Health System Data Epidemiology

- *Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and*

- *Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.*

Criterion 3: Children's Services

- *Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include:*
  - *Social services;*
  - *Educational services, including services provided under IDEA;*
  - *Juvenile justice services;*
  - *Substance abuse services; and*
  - *Health and mental health services.*
- *Establishes defined geographic area for the provision of the services of such system.*

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

- *Describes the State's outreach to and services for individuals who are homeless;*
- *Describes how community-based services will be provided to individuals in rural areas; and*
- *Describes how community-based services are provided to older adults.*

Criterion 5: Management Systems

- *Describes financial resources, staffing, and training for mental health services providers necessary for the plan; Provides for training of providers of emergency health services regarding mental health; and describes how the State intends to expend the MH block grant for the fiscal years involved.*

New Hampshire Specific Outcomes Measures:

In addition to the National Outcome Measures (NOMS) required by the Center for Mental Health Services, the State of New Hampshire has developed a number of State-specific performance measures, in order to collect data for policy and planning purposes. These measures are current for SFY10 and will be continued in SFY11 and beyond.

Health Promotion-All Six Physical Health Measures

Health Promotion 1-Primary Care Provider

Health Promotion 2-Communication with PCP

Health Promotion 3-Monitoring Weight

Health Promotion 4-Weight and Anti-Psychotic Medication

Health Promotion 5-Labwork

Health Promotion 6-In Shape

Mental Health and Aging Advisory Project

Peer Support Agencies Utilization

Peer Support Agency Member Survey

PATH Homeless Outreach

Increased Private Residence Status

Financial Ratios from monthly financial reports from CMHC's (11)

Annual Consumer Satisfaction Surveys (Adults, Children/Families)

Annual Fidelity Reviews with established benchmarks for improved performance: Illness Management and Recovery, Evidence Based Supported Employment

New Hampshire Hospital Admission Rates by Region

New Hampshire Hospital Readmission Rates

Regarding a contract manual, BBH will establish one when it implements a new payment methodology which will also be tied to performance outcomes. BBH has not developed a specific contracting manual as this is currently a significant initiative within the Department of Health and Human Services, which is developing a more standardized process to be used across the Department, and also a restructuring of the contracting process.

LBA Rejoinder:

The auditee response indicates because the BBH collects data and annually reports on the NOMs, the system is therefore outcomes-driven. However, reporting on the NOMs is not a contract requirement nor are contract payments linked to these outcome measures. A Bureau official indicated the NOMs are not included in the current contracts because there are better outcome measures which could be used. In fact, the auditee response to Observation No. 5 indicates the BBH hopes to implement individual-level outcome measures in contracts under a new payment system.

Observation No. 5

Improve Annual Reviews And Focus On Efficiency, Effectiveness, And Measuring Outcomes

Annual reviews of CMHC consumer files do not establish whether services provided are efficient and effective or ensure review findings result in corrective actions to improve services. Results of the reviews are not shared with the public. The Quality Improvement Unit (QI) within the BBH conducts the reviews in all ten CMHCs.

Efficiency And Effectiveness

RSA 135-C:13 charges the BBH with ensuring eligible consumers receive services which are "necessary and appropriate" to bring about an improvement in consumers' conditions. However, the annual review process does not examine service utilization to ensure services are appropriate or to ensure centers do not try to increase Medicaid revenue by providing more Medicaid services than medically necessary.

He-M 400 Administrative Rules require CMHCs work with consumers to develop Individual Service Plans (ISP) which focus on recovery, identified as developing personal and social skills that minimize susceptibility to symptoms and dependence on professional supports, and require clinical records document the consumer's response to and effectiveness of services. However, the annual review process does not assess whether consumers have progressed towards recovery. QI annual review reports typically include comments on the robustness of consumer goals and objectives identified in the ISP; but the file review checklist does not record whether individual consumers meet goals and objectives or reduce dependency on professional supports, nor is information on the success of individual consumers compiled in the report.

In the past, the Bureau had a full-time Medical Director who reviewed files the QI team had identified as questionable for appropriateness, quantity, or quality of services, and clinical records requirements. The current part-time BBH Medical Director, charged with monitoring, assuring, and improving the quality of services provided within the BBH, does not review individual consumer files. Some QI team members reported they do not have the clinical expertise to determine whether consumers receive appropriate levels of services. Administrative Rules He-M 408 require the clinical record reflect the medical necessity of prescribed services, where medical necessity is defined as: 1) consistent with generally accepted clinical practice for diagnosis and treatment of the symptoms of mental illness or severe emotional disturbance; 2) the most efficient and economical that can be safely provided as prescribed by a physician; or 3) not solely for the convenience of the consumer or the providers. The QI team checks for a physician's signature on the ISPs and quarterly reviews, but does not examine whether ordered services meet the definition of medical necessity. We found other states perform medical necessity reviews of community mental health services for Medicaid enrollees, either directly or through a contracted service. Providers are required to submit clinical information to show their decision-making process which is reviewed by clinicians such as physicians, nurses, or social workers. Based on these reviews, states may deny or recoup payment if services are not found to meet medical necessity criteria.

Additionally, reviews do not examine files of consumers found *ineligible* for services. BBH personnel reported the Bureau has no authority to review these files, and does not consider the possibility CMHCs may deny services a risk. However, because CMHCs are required to provide services to BBH-eligible consumers regardless of their ability to pay, a financial incentive exists to minimize services to non Medicaid-eligible consumers who are unable to pay. As noted in Observation No. 2, RSA 135-C:5, II authorizes the BBH to review the files of all State-funded CMHC consumers, including non BBH-eligible consumers funded by Medicaid. Finally, annual reviews do not examine service utilization to ensure services are provided as reported by the centers in quarterly reports to the BBH or to ensure centers are meeting all contractual obligations between the State and the CMHCs described in the Memorandum of Understanding section (e.g., 20 percent of adult consumers are employed).

Annual Review Follow-Up And CMHC Corrective Actions

The BBH requires centers submit a corrective action plan if less than 75 percent of files reviewed meet Administrative Rules requirements. However, the BBH takes no actions against CMHCs not in compliance with Administrative Rules, or not resolving deficiencies found in previous annual reviews. Five centers did not meet the 75 percent minimum at least two years in a row for requirements such as noting consumer strengths on the ISP, consumer signature on the ISP, annual ISP updates, annual client rights notification, or evidence of family involvement on the ISP for children. Administrative Rule He-M 403.12 (b) states the BBH can suspend or revoke approval for non-compliance; however, in practice the BBH is unable to meet the immediate needs of consumers in the region if the CMHC no longer provided services. There are no other penalties for non-compliance established by Administrative Rules or the contracts.

Annual review reports include comments directing the CMHCs to improve goals, objectives, and consumer strengths recorded in consumer files. During the audit period, the BBH did not provide examples of well-written goals, objectives, or consumer strengths or other recommendations to the centers. The BBH has now designated a staff person to follow up on report findings and provide the centers technical assistance on these criteria.

Annual Review Findings Are Not Transparent

The BBH keeps annual review reports confidential, sharing them only with CMHC management and boards. Reports are not available to the public or posted on the Internet. One entity representing CMHC consumers reported CMHC performance and outcome indicators are kept from the public. According to the Government Accountability Office, management should ensure adequate communication with external stakeholders who may have a significant impact on the agency achieving its goals.

There appear to be differences of opinion within the BBH regarding whether reports should be confidential. One BBH employee reported CMHCs appreciate the review as it is currently structured and making the reports public would change the nature of the review, potentially leading to a less cooperative process. However, another employee reported there is no other accreditation requirement for the centers and consumers should be able to see how their health care provider is performing.

Current Administrative Rules Not Applicable

RSA 541-A:16 requires agencies to adopt Rules setting forth the nature and requirement of all formal and informal procedures. However, BBH Administrative Rules do not describe any specific requirements of the annual review process, such as timelines for centers to provide files or respond to the report. The annual reports cite Administrative Rule He-M 426.04 (a) (3) (d) as providing the authority to conduct the annual reviews. However, this rule is aimed at community mental health *providers*, requiring them to allow the department to conduct announced or unannounced quality assurance reviews. The CMHCs are community mental health *programs* not community mental health *providers*. The QI Compliance Director stated the BBH does not conduct QI reviews of the two community mental health providers in the State independent of their reviews of the CMHCs.

Recommendations:

We recommend the BBH use annual reviews to evaluate the efficiency and effectiveness of CMHC services by:

- **aligning reviews with priorities established in Administrative Rules, such as progress toward recovery;**
- **ensuring CMHCs are meeting contractual obligations;**
- **ensuring appropriate services are prescribed in medically necessary quantities;**
- **encouraging compliance through penalties established in Administrative Rule or contracts; and**
- **publicly reporting results.**

We also recommend the BBH adopt Administrative Rules describing general requirements of the annual review process for community mental health programs.

Auditee Response:

We concur in part.

Aligning reviews with priorities established in Administrative Rules, such as progress toward recovery.

As part of the implementation of additional individual level outcomes measures, BBH will utilize new tools currently under consideration to measure and track individuals outcomes and progress towards recovery for both adults and children. The two instruments currently being considered are the CANS (for children and adolescents) or continued use of the CAFAS (for children and adolescents) and the ANSA (for adults). BBH is currently consulting with the developer of these instruments (currently used in 25 states) to assist with finalizing a decision.

The annual reviews are in compliance with these requirements.

Ensuring CMHC's are meeting contractual obligations

Full implementation of the Phoenix project will permit BBH to generate regular contract and management reports for each of the CMHC's. These reports will ensure that contractual obligations are being met and corrective actions taken on a timely basis. Currently, BBH is running parallel systems – Quarterly Service Reporting and Phoenix data reporting – to ensure that contract data reporting is consistent among all ten CMHC's.

Ensuring appropriate services are prescribed in medically necessary quantities

*The Institute of Medicine (IOM) includes **Appropriateness** as one Dimension of Quality. The IOM further defines **Appropriateness** as "The degree to which care and treatment is compatible with the illness or outcome".*

BBH Administrative Rules require that the physician sign and date each ISP and Quarterly Review indicating the medical necessity of services to be provided, which includes the frequency and duration of each service. He-M 408.01(q) defines "Medical necessity" as services that are:

1. *Consistent with generally accepted clinical practice for diagnosis and treatment of the symptoms of mental illness or severe emotional disturbance;*
2. *The most efficient and economical that can be safely provided, as prescribed by a physician; and*
3. *Not solely for the convenience of the consumer or the providers.*

Unlike other states which have implemented a managed care model, with third party administrators contracted to review and determine the medical necessity of services, and assume the risk for the provision of services, in New Hampshire, CMHC physicians are responsible for determining medical necessity of services at the CMHC's. BBH does not support the recommendation to override the decision of a local physician who complies with the requirements outlined in Administrative Rule documenting the necessity of the service.

Annual reviews are in compliance with these requirements.

Encouraging compliance through penalties established in Administrative Rules or contracts

BBH requires corrective action plans from each CMHC when performance falls below a pre-determined level of compliance with Administrative Rule or Memorandum of Understanding requirements attached to CMHC contracts. BBH provides each CMHC with a five-year compliance history to track improvement, or lack thereof, on an annual basis. BBH will further strengthen this process through performance contracting mechanisms, which will be incorporated into future contracts beginning in FY 12, the first year BBH anticipates being able to implement its payment reform initiative. We have provided the LBA with a sample contract to illustrate what future contracts will look like for community mental health services in NH. Although previous attempts to implement a performance based contract tied to fee for service payments have not been supported by either the CMHCs or the Legislature, a new payment methodology based on capitated payments will support the implementation of performance measures that has proven successful in other states.

Publicly reporting results

BBH will work closely with legal counsel to identify those reports that can be reported publicly in compliance with RSA 126-A; 4 IV. This statute defines the reports generated as part of a Department quality assurance program as confidential and privileged and protected from direct or indirect discovery. BBH will exercise due diligence in defining the content of publicly reported monitoring and evaluation activities. BBH already provides copies of CMHC reapproval reports, annual satisfaction surveys, and EBP Fidelity Reviews to the public and advocacy organizations. Beginning August 1, with the implementation of a new DHHS website, BBH will be publishing these reports on its webpage.

We also recommend the BBH adopt Administrative Rules describing general requirements of the annual review process for community mental health programs

BBH can work to articulate general guidance/requirements for an annual review process in Administrative Rule. Good quality improvement practice requires that there be continuous quality improvement processes to review the relational, environmental and technical aspects of care that will improve health status and outcomes of care.

Observation No. 6

Strengthen Oversight Of Community Mental Health Providers

A community mental health provider in one region may not be receiving proper oversight of its community mental health services, and its reimbursements are not in accord with Administrative Rules. Community mental health providers are distinct from CMHCs. In SFY 2009, this community mental health provider had the highest per recipient cost for severe and persistent mentally ill (SPMI) consumers at $21,025;[15] compared to the statewide average of $9,650 for the ten CMHCs. We also found this provider's reimbursements for Medicaid services do not comply with BBH Administrative Rules for community mental health providers.

Oversight Of Community Mental Health Providers

According to BBH personnel, the regional CMHC is responsible for provider oversight by approving services on individual service plans, reviewing service notes of services provided, and ensuring the provider is meeting all requirements. Additionally, the interagency agreement between the provider and the regional CMHC states the CMHC shall, "assure that services provided are medically necessary, that the consumer has an ongoing need for services, that the services are provided at an appropriate level, and that progress is being made toward achievement of goals." This agreement also requires the provider to make records available upon the CMHC's request. However, the CMHC reported it does not see the day-to-day service notes nor does it have the authority to oversee the community mental health provider.

The BBH does not specifically review the community mental health provider's services, although it has authority under Administrative Rule He-M 426.04 (a)(3)(d). The BBH reimbursed over $3.8 million in Medicaid funds directly to the community mental health provider in SFY 2009, and the interagency agreement states the Bureau shall conduct annual quality assurance reviews of the community mental health provider's services. The BBH reported the community mental health provider is reviewed through the BBH review of the regional CMHC. However, we found the BBH annual review of the regional CMHC does not include specific reference to the community mental health provider.

According to the BBH, community mental health providers were originally established in regions lacking adequate community residence beds and for people being discharged to transitional housing from New Hampshire Hospital (NHH). The community mental health provider does supply community residence beds, serving 23 consumers in SFY 2009. The community mental health provider also delivers per unit functional support services, illness management and recovery, and supported employment, to consumers in their supported housing program[16] who are regional CMHC consumers. In SFY 2009, 145 consumers met this criterion at an average per recipient cost of $25,648 (this excludes those served in the residential facility). Other consumers in this region, served exclusively by the CMHC though falling into the same eligibility category (SPMI), had a per recipient cost of $4,563. The BBH Administrator noted the

[15] This average per recipient cost represents just the provider's Medicaid reimbursement. If the additional services provided by the CMHC are factored into total costs, then the per recipient cost is $25,648.

[16] Supported housing is not reimbursable through the Medicaid program.

provider's population are higher acuity than other SPMI consumers in the region, but the regional CMHC could not confirm this. The community mental health provider noted their clients are higher acuity and are unique in that they are all SPMI, struggling with housing issues, and often have co-occurring substance abuse problems.

Medicaid Reimbursement To Community Mental Health Providers

The BBH is not consistently applying the Administrative Rules for community mental health providers, because a provider must be a subcontractor to, and receive payment from, the regional CMHC. Under Administrative Rule He-M 426.02 (g), a community mental health provider is "a [M]edicaid provider of community mental health services that has been previously approved by the [DHHS] commissioner to provide specific mental health services pursuant to He-M 426." The community mental health provider discussed here, one of two in the State, is not being reimbursed for Medicaid services according to the following BHH Rules.

- He-M 426.04 (b) states "Only [CMHCs] or their subcontractors shall be authorized to provide the [M]edicaid funded community mental health services described in these rules"
- He-M 426.02 (ah) defines a subcontractor as "an individual or organization that enters into an agreement with a [CMHC] to receive payments from the [CMHC] for the delivery of [M]edicaid funded mental health services described in an [individual service plan]."

The community mental health provider has an interagency agreement with the regional CMHC but the provider is not a subcontractor of the regional CMHC, as required by He-M 426.04. In addition, Medicaid payments come directly from the DHHS, not the CMHC. We note the provider does have a contract with the BBH creating the current payment arrangement, which conflicts with BBH Rules.

Recommendations:

We recommend the BBH:

- **review the significant difference in per recipient costs for the community mental health provider contracted with the BBH, ensuring State resources are being efficiently and effectively applied to this population, and**
- **follow or change the Administrative Rules regarding the required subcontracting relationship between the CMHC and any regional community mental health providers.**

Auditee Response:

We concur.

The intent of the rule is not to require a community mental health provider, who has a contract with the State of NH directly, also be a subcontractor to the local community mental health program. We will amend He-M 426.04 to clarify that community mental health providers need not have a subcontract with a community mental health program. BBH will continue the

requirement that community mental health providers maintain an interagency agreement with the local community mental health program.

BBH will conduct separate quality improvement and compliance reviews for the region 6 community mental health provider beginning this fall. In addition, BBH will closely examine the specific cost drivers, both from a financial and clinical perspective for the region 6 community mental health provider to determine whether or not additional action steps are required, including an alternative payment methodology or contractual relationship for this provider.

Observation No. 7

Consider Changes To The CMHC Reapproval Process

The BBH reapproval schedule for CMHCs compresses the review process required once every five years into a three-year cycle, resulting in an uneven workflow within the BBH throughout the five year period. RSA 135-C:10 requires the DHHS Commissioner to adopt Administrative Rules establishing a reapproval process and requiring CMHCs be reapproved every five years. Interim Administrative Rule He-M 403.13 established an approval schedule in which three CMHCs were scheduled for reapproval in 1998, four were scheduled in 1999, and the final three were scheduled in 2000. Although a new rule became effective September 1, 2009 eliminating the schedule, the BBH continues to conduct the reapproval reviews as if the rule still existed resulting in a concentration of labor-intensive reapprovals in the first three years and none in the last two years of the five year cycle.

The five-year reapproval review process is intended to ensure the CMHCs are providing consumers with an adequate array of necessary services, either directly or through contractual relationships. Four CMHCs reported the five-year reapproval process was burdensome and required a lot of time and energy. CMHCs must submit the following items as part of their reapproval application:

- a comprehensive self-assessment of the CMHC's current abilities and past performance,
- a written proposal including a line item budget and description of all programs and services to be provided,
- a comprehensive listing of critical unmet service needs within the region,
- assurances of compliance with applicable federal and State laws and Rules, and
- a copy of the mission statement of the organization.

To ensure compliance with Administrative Rule He-M 403 which outlines the reapproval process, the BBH must review the requested documentation and consider the following:

- comments of consumers and family members of consumers to determine responsiveness and overall quality of services;
- written comments and other documentary evidence solicited from area citizens, CMHC subcontractors, and community groups demonstrating the CMHC's ability to offer satisfactory services and provide leadership in addressing the needs of its consumers;
- complaints filed by or on behalf of consumers regarding service provision and their resolution by the CMHC; and

- other available documents demonstrating compliance with all contract requirements, including adherence to the annual budget; compliance with federal and State Rules; corrective actions taken in response to the BBH's annual quality assurance reviews, if any; evidence of the CMHC's internal quality assurance activities; and the CMHC's ability to articulate its legal mandates, including setting annual goals and agency priorities.

In addition to the five-year reapproval reviews, the BBH also conducts annual quality improvement reviews of CMHCs. Table 8 illustrates the distribution of BBH reviews in each year of the five-year reapproval cycle.

As a result of front-loading the five-year reapproval reviews into the first three years of the five-year cycle, the voluminous documentation requested from the CMHCs, and the work required for the annual quality improvement reviews, the BBH appears to have difficulty providing adequate oversight. Although the CMHCs reported the reviews are helpful, they noted the BBH's findings were not provided to them timely.

Table 8

CMHC Five-Year Review Schedule

	Year 1	Year 2	Year 3	Year 4	Year 5
Five Year Review	Regions I, II, III	Regions IV, V, VI, VII	Regions VIII, IX, X	None	None
Annual Review	All ten Regions	All ten Regions	All ten Regions	All ten Regions	All ten Regions

Source: LBA analysis of RSA 135-C:10 and Administrative Rule He-M 403.13.

Because the reapproval schedule was once established in Administrative Rules, BBH staff reported they cannot now redistribute the workload more evenly over the five-year time period because statute requires reapproval every five years. However, the BBH could change the reapproval schedule, and still remain compliant with RSA 135-C:10. This would help the Bureau better manage its workflow, utilizing time and resources available to complete more timely reviews, while also allowing BBH personnel to attend to other oversight activities during the year.

Recommendation:

We recommend the BBH redistribute its workload by conducting two reapproval reviews each year in order to complete all ten reapproval reviews within the five-year period.

Auditee Response:

We concur.

BBH will work with the CMHC's to develop a reapproval review schedule that more evenly distributes the workload over a five-year period. BBH proposes the following schedule:

SFY '10	*SFY '11*	*SFY '12*	*SFY '13*	*SFY'14*	*SFY '15*	*SFY '16*
Regions VIII and X	*Regions IX and I*	*Region VI, Harbor Homes and Region V*	*Regions II and III*	*Regions IV and VII*	*Regions VIII and X*	*Regions IX and II*

This schedule would achieve the following:

- *No change to Regions IV, VII, VIII, IX and X– all CMHC's would remain on the five-year cycle*
- *Region I, V and VI would have a site visit three years from their most recent reapproval visit*
- *Regions II and III would have a site visit four years from their most recent reapproval visit*

Observation No. 8

Ensure Reviews Examine Compliance With Anti-Lobbying And Community Benefits Plan Reporting Requirements

The BBH does not examine CMHC compliance with RSA 15:5, prohibiting lobbying with State funds; nor compliance with RSAs 7:32-e and 7-32-g, requiring development and submission of a Community Benefits Plan to the Office of the Attorney General (OAG) during its annual and five-year reviews of the CMHCs.

Lobbying

The CMHCs pay dues to the New Hampshire Community Behavioral Health Association (NHCBHA), which advocates for the mental health system. The NHCBHA also retains a professional lobbyist to advocate on its behalf with the Legislature. RSA 15:5 generally prohibits recipients of State grants or appropriations from using State funds to lobby or attempt to influence legislation. The exception to this statute appears to allow lobbying by recipients of State funds if the State funds are segregated physically and financially from any non-State funds used for lobbying purposes. Mere bookkeeping separation from non-State funds is not sufficient. The CMHCs received at least $86 million in State funds during the audit period.

According to an NHCBHA representative, the CMHCs are aware of the statute and separate funds in compliance with this statute. However, the BBH does not scrutinize whether State funds and non-State funds are physically and financially segregated when it conducts its annual quality assurance reviews and five-year reapproval reviews of CMHCs.

Community Benefit Reporting

Only four of the 10 CMHCs filed a required community benefits plan with the OAG for SFY 2009. RSAs 7:32-e and 7:32-g require all health care charitable trusts to develop and file a community benefits plan annually with the OAG. A community benefits plan identifies health care needs in the area served by the trust and describes the activities the trust has undertaken and will undertake to address the identified needs. We found the BBH does not check to see if this plan has been filed with the OAG during its annual and five-year reviews.

Prior to 2009, CMHCs could submit their annual DHHS regional plan to fulfill the community benefits reporting requirement. As of January 1, 2009, the OAG requested all CMHCs submit the information on a new form. According to an OAG representative, the CMHCs are working to ensure they will not have to submit the current reporting form, noting several have refused to submit the new form.

Recommendation:

We recommend the BBH verify, through its regular annual and five-year review processes, CMHCs are complying with RSA 15:5, prohibiting use of State funds for lobbying, and with RSA 7:32-g, requiring the filing of a Community Benefits Plan.

Auditee Response:

We concur.

BBH will utilize audit staff to verify that state funds are segregated into a restricted account for non-lobbying purposes, and will review expenditures associated with these restricted accounts to ensure compliance with contractual and statutory requirements prohibiting lobbying with state funds. This will commence with the next set of reviews in the fall.

BBH will seek a report from the Attorney General's Charitable Trusts Division to verify that the annual community benefits plan has been submitted. If it has not, these findings will be noted in the annual review and the matter referred back to the AG's office for further action if indicated.

THIS PAGE INTENTIONALLY LEFT BLANK

MANAGEMENT AND ORGANIZATIONAL STRUCTURE

The Bureau of Behavioral Health's (BBH) effective oversight of the community mental health system requires strengthened management controls related to policies and procedures, data management, and financial reporting. We found the BBH used funds from other Department of Health and Human Services (DHHS) Medicaid appropriations to reimburse services provided by community mental health centers (CMHC) without first seeking proper approval. In addition, the BBH is not consistently analyzing and acting upon available data to ensure the CMHC system is efficiently and effectively providing services; the Bureau does not adhere to statute and Administrative Rules requiring collection and utilization of unmet needs data; and the BBH's new electronic reporting system needs improvement, as it lacks reporting capability and continues to have data error issues. Finally, we found the New Hampshire Hospital's (NHH) contract with Dartmouth Medical School provides no assurance the BBH will receive the services for which it pays.

Observation No. 9

Develop Policies And Procedures For Internal Bureau Activities

The BBH has few written policies or procedures documenting its current functions and practices. The BBH is responsible for developing detailed policies and procedures to ensure consistency, efficiency, and effectiveness in the delivery of community mental health services. Internal controls, such as policies and procedures, are critical tools to help an agency meet its objectives and are necessary to minimize operational problems.

Lack of written policies and procedures creates a risk current employees may not perform as intended. This risk becomes greater with staffing changes. The BBH has had a number of staffing and responsibility changes, as well as a reorganization in the recent past. The roles and responsibilities of the BBH personnel have changed accordingly. Without policies and procedures, any personnel turnover, retirements, or vacancies may result in loss of knowledge regarding processes and responsibilities, potentially leading to inconsistent Bureau operations and oversight of the community mental health system.

Because the BBH maintains a flat organizational structure, one employee may be responsible for entire cross sections of activities with limited cross training or back up. For example, one employee is responsible for the BBH database management and one employee is responsible for producing an important monthly report. Over the audit period, there were no formal, written policies for either of these functions. The potential risk to continuity of operations may appear in the near future with the anticipated retirement of both employees within the next six months. The BBH has identified this risk and is in the process of developing policies and procedures, reportedly for only one of these positions.

In addition to limited policies and procedures, others are outdated. For example, the Bureau's *Contracting Procedures* document describes certain procedures no longer in operation and includes references to outdated operating budget class lines. BBH officials later stated this is not a procedures manual, but an informal set of notes. One Bureau employee reported spending approximately 75 to 85 percent of time, during five months each year, on CMHC contracting. Despite the heavy time commitment of this position, there is only one three-page draft document describing this process specific to CMHCs.

Finally, the Quality Improvement Unit has developed checklists to identify required information for CMHC annual reviews and five-year reapproval process; however, there are no formal, written policies identifying the intent of these reviews, whether the reviews and reports are confidential, or how the Quality Improvement team will determine which compliance points are the focus of the annual review. While there are procedures outlining the five-year reapproval process and annual review process, they are not easily accessible or distributed to team members**,** and as the annual review has significantly changed over the audit period, the procedures do not match current Bureau practice.

Recommendation:

We recommend the BBH develop policies and procedures for current functions and practices such as data reporting, communication, functions required by Rules and law, and BBH activities performed by only one employee.

Auditee Response:

We concur.

During State Fiscal Year 2010, the Bureau of Behavioral Health revised all of the supplemental job descriptions for all staff to ensure that job descriptions and responsibilities for each staff position were clarified. The Bureau will prioritize the development of policies and procedures for CMHC quality improvement reviews and reapproval reviews. The Department of Health and Human Services will be developing a centralized policy and procedure manual for the contracting process across DHHS programs and Divisions and we will therefore wait until that process is complete in order to add any procedures specific to BBH to that process. BBH will establish a workgroup to identify other areas requiring updated policies and procedures and will develop a timeline and list of responsible staff to develop these in accordance with these recommendations.

Observation No. 10

Transfer Funds In Accordance With State Law

At the end of State fiscal year (SFY) 2009 the BBH's Community Mental Health Services accounting unit[17] did not have sufficient funds to reimburse all Medicaid services provided by

[17] Accounting units are used to designate funds for a particular office or program area in the State budget.

CMHCs. In order to make payments, the BBH used $1.25 million in funds from other DHHS Medicaid appropriations, including the Bureau of Developmental Services and the NHH accounting units. According to BBH financial officials, these funds were not transferred to the Community Mental Health Services accounting unit, but were paid directly from the other accounting units.

Chapter 263:28, Laws of 2007 required the DHHS Commissioner request approval from the Legislative Fiscal Committee and Governor and Council prior to transferring funds within or among DHHS accounting units for the biennium ending June 30, 2009. Additionally, RSA 9:19 prohibits controlling officials from using any part of appropriated funds for any purpose other than that for which they were appropriated, or expending any money in excess of the amount voted by the Legislature.

According to Bureau officials, there is insufficient time to make a transfer request before the last payment is made prior to the fiscal year-end closing. However, without the funds first being transferred, these expenditures to CMHCs are not reflected in the BBH end-of-year Statement of Appropriation. The SFY 2009 Statement of Appropriation reports $90.8 million in Medicaid funds paid to CMHCs without reporting the additional $1.25 million (1.4 percent) expended from these other accounting units. As a result, State law was circumvented and the reported cost of the community mental health system was understated by 1.4 percent during SFY 2009. According to the Government Accountability Office's (GAO) *Standards for Internal Control*, management should ensure reliability of financial reporting including reports on budget execution and financial statements.

Recommendations:

We recommend the BBH seek proper approval to ensure all expenditures comply with State law and transfer funds to ensure financial reporting of program expenditures is accurate.

We also recommend the BBH and DHHS seek legislation delegating authority for year-end transfers as necessary.

Auditee Response:

We concur in part.

The Bureau of Behavioral Health is aware that this observation has been made on other DHHS Bureaus and Divisions by the LBA. From a solely technical perspective, the observation is correct. However, from an operations perspective, the Bureau is unable to implement this process as recommended because existing state process limitations do not allow the necessary remedial actions to go forward. As is the case with other Divisions making payments to providers, the Bureau makes projections on spending for the state fiscal year and transfers funds into the necessary account(s), to pay all invoices in a timely manner. The Bureau and Department have suggested numerous times in past years to allow a month thirteen accounting transfer with Fiscal Committee and Governor and Council approvals to make the account

sufficient to pay all invoices received and payable prior to June 30 each year. These suggestions have been rejected. This process would reconcile expenditures with appropriations.

The Bureau and Department are not in favor of suspending claims for payment when sufficient funds are available in other accounts within the Department, especially due to an administrative timing issue. The Legislature has expressed concern about suspending payments, which delays payments to providers of services. The Bureau and the Department have been subject to criticism in the past when claims have been suspended, and not paid by June 30. In addition, under the enhanced federal financial participation through the American Recovery and Reinvestment Act of 2009, 90% of valid claims need to be paid within 30 days and 99% of valid claims paid within 90 days. The federal Centers for Medicare and Medicaid Services (CMS) monitors claims processing on a daily basis. If claims on a given day do not adhere to the CMS timeline, then the enhanced federal matching assistance percentage is lost for all claims processed on that particular day.

Presently, the federal matching assistance percentage is 11.59%, which on an average daily claims volume could result in the loss of $300K of enhanced federal funds. Our provider network is fragile and delays in payment result in unnecessary and unreimburseable expenses for the provider community. The resolution to an issue that pertains to not only DHHS but other Departments as well goes beyond the purview of BBH.

Observation No. 11

Effectively Use Data To Manage The Community Mental Health System

The BBH is not consistently analyzing and acting upon available data to ensure the community mental health system is efficiently and effectively providing services. According to the GAO Internal Control Management and Evaluation Tool, proper internal controls require an agency have reliable, relevant information, which allows the organization to analyze trends, measure results against targets, and produce performance reports. By not consistently: 1) utilizing the available data, 2) following up on discrepancies, 3) analyzing service usage, and 4) establishing performance measures and standards, the BBH cannot ensure the system is operating efficiently and effectively.

Use Of Available Data

The BBH does not currently maximize use of available data. According to best practice, data should be used to ensure the organization is meeting strategic plans and goals. The BBH collects, reports on, or has access to a variety of data for all ten community mental health regions including demographics, units of service, per recipient costs, budget information, Medicaid claims, financial ratios, and New Hampshire Hospital statistics. The BBH uses these data for budgeting, to ensure CMHCs are remaining within their contracted budget and service utilization targets, and to compare a CMHC's activity this year to last. However, the BBH does not systematically use the data to:

- perform comparative analyses of CMHC performance,
- identify variations in service usage between CMHCs,
- develop or set benchmarks, or
- produce overall system-wide reporting for strategic planning and decision-making.

Following Up On Discrepancies – Data Integrity

BBH personnel have expressed concern over the integrity of data submitted by the CMHCs. We also found inaccuracies in the BBH's internal reporting. For internal controls to be functioning appropriately, management must follow up on operational information ensuring inaccuracies are addressed. Reports submitted by the CMHCs have data integrity issues and are not updated with corrections. Additionally, the BBH lacks confidence in other data submitted by the centers. For example:

- five centers reported Medicaid billable hours exceeding 100 percent of their total billable hours in the fourth quarter of SFY 2009;
- the number of BBH-eligible consumers reported in quarterly reporting for SFY 2007 was between 15 percent less and 28 percent more than the BBH-eligible populations reported for the annual review process; and
- requested wait list information required for the contracting process is not used, as the BBH notes the definition of "wait list" and reporting method of each CMHC varies, creating inconsistent data.

Analyzing Service Usage

The BBH is not consistently addressing potential risks identified by the data. Data should be used to ensure accountability of resources and to determine when further analysis or oversight is necessary. Our analysis of BBH's Medicaid claims database found significant variances in per recipient costs for the most severely and persistently mentally ill (SPMI) among certain CMHCs, as well as a significantly higher per recipient cost by one community mental health provider. The BBH does not regularly identify, report on, or follow up on these variances. Upon further review, we found the CMHC with one of the highest SPMI per recipient costs also has an employee policy where incentives are paid for increasing the number of billable hours per day, potentially creating an incentive for over-use of the fee-for-service model.[18] The Bureau Administrator reported being unaware of this CMHC's policy and speculated the anomalies were due to variations in the types of services available and varying populations across the State.

When BBH personnel recently analyzed the use of functional support services (FSS) for children across all centers, it identified two centers using substantially more services than others. A Bureau official expressed concern FSS may be excessive in some cases. According to the

[18] The fee-for-service model is used in the New Hampshire community mental health system where CMHCs are paid for each unit of service. This model creates an opportunity for CMHCs to over-provide services to maximize revenue. However, without outcome measures and benchmarks to compare centers, the Bureau can not easily determine a reasonable amount of services needed to produce a desired result for the consumer.

DHHS's September 2009 letter to the Fiscal Committee, during a federal review the BBH learned New Hampshire was the only state these reviewers knew of without service limits in place to manage utilization. The Bureau has subsequently obtained Fiscal Committee approval to limit the number of hours of FSS children may receive per day in order to reduce Medicaid expenditures. However, this plan was not implemented.

Statewide Performance Measures And Standards

The BBH does not maintain individual center or system-wide performance indicators, yet six of ten CMHCs identified the need for outcome measures, as well as two community mental health stakeholders. Performance measures and indicators should be established and compared against anticipated results. Lack of benchmarks, system-wide targets, and performance measures limits the BBH's and the system's ability to assess efficiency and effectiveness, identify strengths and weaknesses, and ensure alignment with the mission and goals of the system.

Recommendations:

We recommend the BBH consistently:

- **use available CMHC data to analyze utilization, costs, trends, and identify key performance measures to better oversee and manage the community mental health system;**
- **use data to make decisions about the system and activities of individual CMHCs;**
- **follow up on reporting weaknesses and potential risks identified in the reporting with clear action plans;**
- **develop outcome or performance measures for each center and across the system, and require reports against those measures; and**
- **document what reports are prepared, how reports are prepared, and how they will be used for BBH oversight.**

Auditee Response:

We concur.

While we concur with the recommendations, each of which ties directly into BBH's payment reform planning process, we do not concur with several of the observations or rationale noted in the report.

"BBH is not consistently analyzing and acting upon available data to ensure the community mental health system is efficiently and effectively providing services." "By not consistently utilizing the available data, following up on discrepancies, analyzing service usage, and establishing performance measures and standards the BBH cannot ensure the system is operating efficiently and effectively."

As noted elsewhere in our response, BBH has long acknowledged the need to leverage additional information from the provider system, including client level outcomes data to more effectively

manage the system. The payment reform process already underway addresses these specific needs as part of our overall planning. We respectfully disagree that we are not maximizing the use of available data. Despite the limitations of what is available, BBH fully leverages this data for monitoring and oversight of the community mental health system. BBH does utilize this data for comparative analyses of performance, analysis of service utilization, benchmarks for system and agency level performance and most importantly for strategic planning. This data is both driven by national and state outcomes measures, programmatic and financial data, as well as Quality Improvement and fidelity data as an integral part of our operations.

"Following up on discrepancies – Data Integrity"

"BBH personnel have expressed concern over the integrity of the data submitted by the CMHC's. We also found inaccuracies in the BBH's internal reporting. Reports submitted by the CMHC's have data integrity issues and are not updated with corrections."

The Phoenix system has been established to address these issues. While we agree that manual reporting and transcription of data is subject to errors (both on the provider end and with BBH), we have moved to an automated process to improve the quality of data used for decision making from the provider network. When errors are identified, the source of the error is investigated and future year to date trending reports, for example, are corrected. Current data submitted through the automated Phoenix system is analyzed carefully to identify areas of concern which may impact the accuracy of the data, those issues are promptly brought to the attention of the CMHC and a corrective action plan is implemented to address the issue. The CMHC's have been very responsive to any issues requiring attention.

"Analyzing service usage"

BBH does monitor and follow-up on service utilization data by CMHC. Every year our annual QI reviews include a focused review of both high and low cost cases at each CMHC which are determined through trending reports on service utilization patterns. As we have discussed, there are a number of factors influencing the cost per client data by region- including the acuity level of the population served, the number and density of the population served, the types of services available to recipients locally vs. having to receive in other areas (for example inpatient or residential care), and the statistical methodology used to compare differences.

It is not accurate to imply that BBH does not follow-up on noted anomalies. We specifically target high and low utilizers of services for focused reviews and have not found a single case where the services provided were not determined medically necessary by the provider. We work with all of the providers to determine the effects of different cost drivers on a regional basis and utilize our internal reporting structure and focused reviews to determine if further action is required, for example administrative rule change, contract language change, provider education, or a referral to the SURS unit for additional review.

With respect to observations noted regarding Functional Support Services for children, BBH did propose a daily limit on functional support services for children, but this was ultimately withdrawn due to opposition from the Legislature, advocacy community and provider system.

Due to a mandated reduction in funding for FY 11, originally tied to this limit being established, BBH was required to implement a rate reduction as an alternative.

While we agree that there are risks inherent in any fee for service system, particularly in the field of health care, BBH has addressed these risks with the tools currently available, and is in the process of improving the payment structure for community mental health services to an alternative model that does not have these inherent issues. We also agree on the importance of establishing benchmarks and outcomes measures- this is reflected in our current contract and MOU, administrative rules, and our work in implementing Evidence Based Practices with annual Fidelity Reviews. We plan to continue this momentum through performance based contracting as articulated in our payment reform plan.

LBA Rejoinder:

It is true the Department's annual QI reviews include high cost cases. Our point is the BBH needs to be aware of and assure itself CMHC treatment of SPMI consumers is reasonable and not due to varying treatment philosophies.

Our analysis found notable variations in per recipient cost at the centers, particularly for SPMI consumers, regardless of whether we looked at the mean or median costs. While there may be valid reasons for SPMI cost variances among the CMHCs, interviews with the Bureau Administrator indicate the BBH has not accessed available data to comprehensively examine causes for the variances.

The current contract and MOU do not have adequate benchmarks and outcomes to measure the efficiency and effectiveness of community mental health services (see Observation 4). The MOU has *financial* benchmarks establishing acceptable financial ratios for the CMHCs regularly reported to the BBH. Aside from one MOU requirement that 25 percent of adult consumers be competitively employed, there are no benchmarks regarding acceptable level of treatment or treatment outcomes. The fidelity reviews evaluate CMHC performance for two types of EBPs, but less than 25 percent of the BBH-eligible population is reported to receive EBP-based treatment.

Observation No. 12

Improve Collection And Usage Of Unmet Needs Data

The BBH and CMHCs are not adhering to statute and Administrative Rules requiring collection and utilization of unmet needs data. Interviews with CMHC officials, corroborated by BBH officials, indicate some do not record or annually report all necessary, but unavailable, services.

RSA 135-C:13 requires CMHCs document needed unavailable services in consumers' individual service plans (ISP), and Administrative Rule He-M 401.10 (r) requires CMHCs submit an annual report by July 15 notifying the DHHS of the need for these services. Both statute and Rule require the DHHS to use the information for budgetary planning purposes. However, five centers reported they do not record needed unavailable services in ISPs, and two centers stated such a

practice unfairly misleads consumers. Only three centers indicated they provide an annual report of needed unavailable consumer services.

The BBH reportedly tracks unmet needs in other ways. Interviews with BBH personnel indicate they often discuss issues of unmet needs with each center. Centers are required by the BBH to submit lists of unmet needs every five years as part of the application for reapproval, but we found descriptions of unmet needs in only three of ten CMHCs' most recent five-year reapproval reviews. Also, all ten centers submitted waiting lists of critical services in their SFY 2009 annual contract proposals. However, BBH staff reported the waiting lists are unreliable because centers can interpret common terms differently and the waiting lists only represent a moment in time instead of a cumulative annual count of delayed services.

By not adequately quantifying unmet needs, the BBH lacks data to appropriately allot resources and form a strategic plan for the State mental health system. In addition, by not quantifying unmet needs for budgetary planning purposes, unmet needs are at least partially deprived of support and validity when used for Legislative budget requests.

Recommendations:

We recommend the BBH collect needed, unavailable consumer services data as required by RSA 135-C:13 and Administrative Rules. If the BBH determines other methods of collecting and using unmet needs data are more efficient or effective, it should request an amendment to statute.

Auditee Response:

We concur.

BBH has determined that this methodology is not currently, nor has it been historically an efficient way to collect unmet needs data, and creates an administrative burden on providers which from a cost benefit analysis is not an efficient use of staff time for the intended purpose outlined in statute. As a result, BBH has employed alternative and more effective approaches to gathering and reporting on unmet needs in the community. BBH will be proposing an alternative methodology such as an annual checklist by categories of service for the CMHC's to complete and submit to BBH as part of the annual contract submission. The new Targeted Case Management regulations currently reflect requirements to complete a comprehensive assessment of the clients service needs, including those services outside the CMHC, which will dovetail with the implementation of an alternative reporting methodology. The Administrative Rules and/or Statute will be modified accordingly.

Observation No. 13

Information Technology Requires Attention

BBH efforts to improve data collection using information technology have moved slowly over the last several years. A management reporting system development project begun in 2004 is yet

to be completed. In addition, we found the BBH has no current plans to use this technology initiative to inform its future technology needs or to standardize and streamline practices among CMHCs.

System Development Setbacks

The BBH, through the Department of Administrative Services, Bureau of Purchase and Property, issued a Request For Proposals in April 2004 soliciting potential vendors to provide data management services. The purpose of the project was to ensure an effective and efficient information system supporting BBH's oversight of community mental health services provided by the ten CMHCs. The project primarily sought software to extract and process data from each CMHC's unique computer system, create management reports, establish and maintain a secure web site, and provide data management consultation services and other technical assistance to the BBH and each CMHC.

The BBH selected the original vendor in September 2004 but terminated the contract in June 2005 due to poor performance. Department of Information Technology (DoIT) staff then took over the project, but it progressed slowly, reportedly due to extraordinary staff turnover within the DoIT.

Current Status

The information technology project remains incomplete. According to BBH staff, the project known as Phoenix, became operational April 2010, but is approximately 80 percent done and needs another year to complete. Remaining tasks include developing and implementing management reports. The Phoenix system reportedly accepts incoming data from the CMHCs, but as a workaround for incomplete reporting capabilities, data are transferred to the old system to generate reports. Additionally, systems operating manuals, training plans, CMHC guidance, and final testing are still needed.

Data Consistency

Phoenix was developed to accommodate different information systems used by each CMHC. Personnel within the BBH and the CMHCs reported concerns with data accuracy because each CMHC defines how it will measure a particular event. For example, CMHCs may treat admissions differently. Some CMHCs enter the admission date into their computer system as the date of first contact with the consumer. Other CMHCs only enter an admission date after an assessment is completed and the consumer is accepted as a client and enters the date of acceptance as the admission date. Therefore, the admission date may not mean the same thing between CMHCs and the data measurement would be different. BBH staff report rarely using the admission date event because of this situation. In addition, centers are required to track service duration either as start and stop times or as start time and duration. However, not all CMHCs capture service duration this way. Some CMHCs capture service duration in hours and minutes while others use the number of 15 minute units, or in decimal hours.

Unique Client Identification

The Phoenix system may not fully serve the needs of the BBH. Information systems typically use unique client numbers for each individual to track client-level data. When individual clients can be separated from the records of another client using a number that applies only to that particular individual, managers can easily track service utilization across multiple service providers throughout the course of treatment, identify multiple episodes of care and the individual's progress or outcomes, produce an unduplicated count of clients, and if available, can identify costs associated with an individual. Most other states use unique client identification information such as Social Security Number, a number derived from the client's personally-identifiable information, or assign a unique number unrelated to any personally-identifiable information. New Hampshire is one of only two states which reported not using unique client identification information to identify clients across the public mental health system. Phoenix development excluded using personally identifiable information, such as Social Security Number out of concern for Health Insurance Portability and Accountability Act of 1996 regulations and privacy concerns. As a result the BBH contracts with a third party to *estimate* how many non-duplicated consumers receive services and cannot disaggregate clients to produce useful information such as tracking service utilization, multiple episodes of care, progress or outcomes, or costs associated with individual treatments.

Integration With Organizational Objectives

The BBH has not reassessed the needs of today's community mental health system to determine whether Phoenix's business requirements, developed in 2005, are still desirable to support the BBH in achieving its current and future objectives. The community mental health system has experienced many changes since the Phoenix system's business requirements were defined in 2005. Business needs dictate an organization's technology requirements and system development should align with strategic objectives. Without an appropriate IT plan, the BBH's objectives may not be fully identified and prioritized, increasing the risk the new system will not support the BBH's current or future organizational objectives.

A concurrent review of CMHC needs and capabilities along with BBH needs may identify opportunities to improve the Phoenix system's usefulness or streamline it to increase efficiency and effectiveness. For example, the BBH may be able to improve its data accuracy and oversight responsibilities by using Electronic Medical Records systems now in place or under consideration by CMHCs. Without examining the business processes in use, current capabilities, and plans for the future, opportunities for enhanced efficiency and effectiveness may go unnoticed.

Recommendations:

We recommend the BBH:

- **align information technology needs with its organizational goals;**
- **ensure Phoenix meets the current and expected needs of the community mental health system;**

- **coordinate with the DoIT to finish implementing Phoenix,**
- **conduct acceptance testing to ensure data accuracy,**
- **ensure user and training manuals, definitions, CMHC guidance, and other documentation are complete and up-to-date, and**
- **develop a method for creating unique client identifiers across all CMHCs and integrate it with Phoenix to enable client-level data capture and eliminate the need for a third party to estimate the number of non-duplicated consumers.**

Auditee Response:

We concur in part.

With regard to the comments noted about not being able to track client service utilization across multiple service providers, the observations are not entirely reflective of the capacity currently present in the system. First, BBH does have the capacity to track and monitor service utilization history, episodes of care and outcomes for all individuals within a CMHC. Although Phoenix does not have the capacity for a unique client identifier across agencies, Phoenix does assign a unique identifier within the CMHC which tracks utilization and service history for that individual with each file submitted. The identifier is designed to track utilization trends across the population in a way that ensures all individuals privacy is protected, and BBH is not able to determine the name or any PHI on those individuals in treatment, conforming to HIPAA regulations governing the use of the data- which contains information on BBH eligible and non-eligible clients. BBH does have access to Medicaid data through the MMIS system which allows for individuals to be tracked across multiple providers but it is important to note the occurrence of this is relatively small across the system- less than 5%.

Establishing a unique health identifier is beyond the authority of the Bureau. This would require legislation authorizing the collection of this information on anyone seeking services at a community mental health center, which given privacy concerns already debated in the Legislature, is not feasible at this point in time. If there is clear legislative support for BBH to collect additional information on a broader range of individuals receiving services, to include personal identifying information, BBH would consider employing a different strategy to track services within the system.

The Division of Community Based Care Services (DCBCS) has established a workgroup to explore strategies for facilitating the communication between providers to improve care and ensure a process where treatment information is transferred across programs and services when there is a change in treatment providers for the individual.

BBH does not have a separate strategic IT plan as the Department of Health and Human Services manages the overall IT plan for the Department and each of the Bureau's and Divisions. The Phoenix system is incorporated into that master plan, and we will therefore not be developing a separate plan. As future technology needs emerge, BBH will continue to identify those and incorporate them into the DHHS IT Plan.

BBH has, and will continue to assess the business needs of the organization as it relates to Phoenix, particularly as BBH moves forward with a payment reform plan which will require a new set of reporting requirements and data from the provider system. Feedback that we have received to date is that our system and organization are well aligned with what will be required to move to a new payment methodology.

We concur with the recommendations that DoIT allocate additional resources to complete the project, but have been unsuccessful in attaining that goal.

Observation No. 14

Improve Dartmouth Medical School Contract

The New Hampshire Hospital (NHH) has a $62 million contract with Dartmouth Medical School (Dartmouth) for SFYs 2008-2011, including $1.4 million in BBH funds for assistance with implementing evidence-based practices (EBP) at the CMHCs. The Department of Administrative Services *Administrative Handbook* requires service contracts over $2,500 include Exhibit A, outlining anticipated scope of work, and Exhibit B, outlining payment provisions for those services. Exhibits A and B of the NHH contract describe the anticipated scope of work and method of payment for the NHH portion of the contract, but do not describe the scope of work for the BBH.

Instead, over the audit period, the BBH created a separate "deliverables plan" (not part of the contract) for SFYs 2008 and 2009. According to BBH managers, a draft document written by a member of the Dartmouth staff, dated February 2007, later became the deliverables plan. However, the Bureau could not provide a final version of the deliverables plan and the contract manager identified a proposed contract amendment as the final plan.

The NHH contract with Dartmouth is an insufficient control to ensure the BBH receives the services expected from Dartmouth personnel. According to the Office of Federal Procurement Policy's *Best Practices for Contract Administration*, a contract administration plan should include how to measure the contractor's performance and link performance with payment. Performance measures and management reporting can help ensure accountability and foster performance improvement, by allowing agencies to evaluate vendors while simultaneously measuring how effectively the contract attains stated goals.

Recommendation:

We recommend the BBH improve management of its portion of the Dartmouth Medical School contract by ensuring it includes descriptions of work scope for review by the Governor and Council and by linking payment with deliverables and performance outcomes.

Auditee Response:

We concur.

BBH has already revised its deliverables plan and oversight of the Dartmouth contract and has a new process in place. BBH has a detailed scope of services document, with specific deliverables, outcomes and funding amounts detailed and overseen by BBH and Dartmouth. Reporting done during the year and an end of year summary report will provide the back up documentation to support the provision of all contracted deliverables under the contract. The categories of service and general deliverables will be detailed in the future master contract with New Hampshire Hospital, but the specific training activities, work of the medical director and other staff are negotiated annually, and at times adjusted for in writing during the course of the year and will be detailed in the deliverables contract. We believe this will meet the objectives outlined in the recommendations.

OTHER ISSUES AND CONCERNS

In this section we present issues we consider noteworthy, but not developed into formal observations. The Bureau of Behavioral Health (BBH) and the Legislature may wish to consider whether these issues and concerns deserve further study or action.

BBH Should Reassess Its Management Role

Based on our interviews with current and former BBH personnel, community mental health center (CMHC) officials, and other stakeholders, we noted a number of related comments describing the BBH having a weakened role in the community mental health system. These opinions are subjective in nature, but we found them to be prevalent both within and outside of the Bureau. There is, however, less agreement on the causes of the Bureau's weakened role.

Bureau Perceptions

According to a former Bureau official, the community mental health system was identified as having a more centralized perspective with a system-wide approach in the past. Additionally, the Department of Health and Human Services (DHHS), Governor, Legislature, consumers, and consumer families were reportedly more integrated and aligned in system advocacy allowing for better development, visibility, and accountability. Both BBH and CMHC officials told us the BBH's role has changed over the last several years. Five BBH officials stated the Bureau's influence within the community mental system has been weakened as a result of the current Medicaid-centered payment structure, which reduced the Bureau's use of non-Medicaid general funds to affect changes. Officials stated the Bureau's oversight ability is compromised because Medicaid is an entitlement program and CMHCs receive payment regardless of treatment outcomes.

Bureau officials have expressed concern with the Bureau's authority and inability to make certain changes. They said they can not dictate changes to the contracts with the CMHCs, including the ability to require CMHCs to measure outcomes, and cannot force CMHC cooperation for certain data collection without a Legislative mandate. A review by the federal Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, also noted the BBH reported struggling to establish "appropriate leverage" with CMHCs to enforce data collection and reporting requirements. According to the review, the Bureau could learn ways in which to develop an appropriate balance of power that would enable the State to properly provide the necessary oversight and administration of the community mental health system.

Stakeholders Perceptions

Three stakeholders noted the BBH used to have more clout and influence over the mental health system, identifying resource shortages, the current organizational structure, and changes in the

coordination by CMHCs as possible causes for this loss of authority. Nine of the ten CMHCs voiced various concerns regarding the Bureau's advocacy and policy role, citing the lack of:

- a system-wide approach,
- priority setting,
- policy development,
- flexibility,
- resources or seeking alternative funding sources,
- power and authority, and
- ability to "step outside the box."

According to three CMHCs, the BBH previously served as a policymaker and advocate for the CMHCs, setting statewide policy while providing guidance to individual centers. The CMHCs reported over time, the BBH has developed a more regulatory role. This apparent shift appears to be reflected in the BBH's organizational structure, as a number of policy-oriented positions have gone unfilled and staff members have been reassigned to review-related functions. While the Bureau has established a full-time Senior Medicaid Policy Analyst Position, we note not all BBH-eligible consumers are Medicaid recipients. Similarly, BBH officials in the Quality Improvement Unit cited a lack of time to consider processes and set policy on a wider scale because all team members must be actively engaged in reviews. Nonetheless, we note the apparent increased emphasis on regulatory functions, while potentially bothersome to the CMHCs, may be an appropriate decision to ensure adequate management control over the system.

Generally, interviews with CMHC personnel indicated frustration over their perception of the BBH's lack of a system-wide vision. Officials in seven CMHCs stated the BBH is not currently ensuring a coordinated system of care for those with severe mental illness across the State. While six CMHCs attributed this situation at least in part to a lack of resources, five noted the BBH could be doing more to provide guidance and coordinate a system-wide approach. CMHC officials also identified some strengths of the Bureau including: five commenting on open communication, four on collaboration, and four on the helpfulness of some of the Bureau personnel.

We note, both the CMHCs and the BBH currently need each other; the centers are the providers of community mental health services, and the majority of the centers' revenues are Medicaid reimbursements. The Bureau must balance its need to work cooperatively with CMHCs and reduce administrative burden on centers, while ensuring adequate management controls are in place to serve the State's severely mentally ill in the most efficient and effective manner. As structural changes within the DHHS, resource cuts, and position changes have apparently created a different approach than in the past, we suggest the BBH consider strengthening its leadership, advocacy, and policy development.

Ensure Complaints Of Abuse, Neglect, Or Exploitation Are Adequately Addressed

Administrative Rule He-M 202.06 requires a CMHC to report to either the DHHS Bureau of Elderly and Adult Services (BEAS) or the Division of Children, Youth and Families (DCYF) whenever it has "reason to believe" a consumer was subject to abuse, neglect, or exploitation. The clause requiring a center to have "reason to believe" a consumer is subject to abuse, neglect, or exploitation may inadvertently create an excessively high reporting threshold. "Reason to believe" can be interpreted as forming a conclusion instead of merely having evidence to suspect an incident occurred. If there is evidence to suspect abuse, neglect, or exploitation occurred but a CMHC erroneously concludes it did not, a CMHC can effectively prevent the DHHS from learning of the most serious complaints. Allowing CMHCs to determine on their own whether a formal investigation should transpire does not provide the BBH with adequate controls or ensure consumers are sufficiently protected.

In addition, the Administrative Rules are inadequate because the investigations of abuse, neglect, or exploitation by the DCYF or the BEAS do not cover a substantial portion of the CMHC consumer population, including consumer to consumer actions. The BEAS is statutorily allowed only to conduct investigations of abuse, neglect, or exploitation of incapacitated adults, defined by RSA 161-F:43 (VII) as someone who is unable to manage or delegate responsibility for personal, home, or financial affairs in his or her own best interests. Also, interviews with DCYF personnel indicate they would only investigate a complaint of abuse, neglect, or exploitation of a child at a CMHC if a parent is the alleged cause of the complaint. If it is caused by someone else, the DCYF would refer the matter back to the BBH, and if necessary, contact law enforcement.

Administrative Rules He-M 202 expire on July 24, 2010, and BBH personnel have stated they are utilizing this opportunity to make significant changes. A preliminary draft of proposed rule changes indicate the BBH is advocating for alterations which would explicitly base the reporting threshold on a potentially qualifying incident instead of only a "reason to believe." In addition, the drafted changes delegate responsibility to the DHHS Office of Client and Legal Services to initiate a complaint of abuse, neglect, or exploitation and assign a complaint investigator. We suggest the BBH continue advocating for these changes during the rulemaking process.

Improve Consistency Of Policy Distribution And CMHC Access To Guidance

The BBH has taken steps to improve its guidance to CMHCs, yet additional improvements should be made. Annual reviews conducted by the BBH during the audit period found inconsistent practices and interpretations of relevant laws and Administrative Rules among CMHCs. Our interviews with the CMHCs found some uncertainty as to how to proceed with different initiatives or changes in procedures.

During the audit period, the BBH began compiling questions posed by the CMHCs along with the BBH's response into a binder for easy reference by BBH personnel. When a question has potential implications for other centers, the BBH forwards those questions and responses to the Directors of Quality Improvement at the other CMHCs informing them of the correct practice,

procedure, or interpretation. However, this information is not readily accessible to other staff within the centers or other stakeholders.

According to the Government Accountability Office, effective information and communication are necessary for an agency to manage its operations effectively. Without reliable access to consistent guidance, CMHCs may not comply with State or federal laws and Rules. We suggest the BBH:

- provide additional access to CMHC staff and other stakeholders to written guidance and answers to policy questions using the Internet by posting the directives and interpretations on the BBH's website; and
- identify and clarify commonly misunderstood or misinterpreted laws, Rules, and procedures using a frequently asked questions section on the BBH's website.

CONCLUSION

While we found the Bureau of Behavioral Health (BBH) is generally meeting its statutory obligation to maintain a system of community mental health services for eligible consumers, our audit found the BBH should improve its management oversight of community mental health centers (CMHC) to ensure service delivery is efficient and effective. Inadequate oversight and a lack of outcome measures prevents the BBH from determining whether funds are being spent prudently to provide care that reduces the need for mental health services and promotes consumers' recovery and independence.

The State's increasing use of the Medicaid program to fund the community mental health system has resulted in a number of challenges. Discrepancies between the funding structure and statutory mandate have resulted in the CMHCs providing uncompensated care. We found the CMHCs provide an unknown amount of uncompensated care to BBH-eligible consumers who are not covered by a third-party payer (government or private) and may not have sufficient resources to fully pay for services. This is in addition to the CMHCs self-reported $5 million worth of services not reimbursed due to Medicaid spend-down for consumers on the Medicaid In-and-Out program. The cost of uncompensated services are covered by CMHCs' other revenue sources.

Bureau officials informed us the high dependence on the Medicaid program to fund the CMHCs limits the Bureau's ability to affect change in the community mental health system because under the fee-for-service model as used by the BBH, services are reimbursed regardless of the treatment outcome. A review by the federal Substance Abuse and Mental Health Services Administration, Center for Mental Health Services also noted the Bureau "could learn of ways to develop the appropriate balance of power" to enable the State to provide the necessary oversight and administration of the community mental health system. We agree with this conclusion and believe additional statutory authority could help the BBH to more effectively manage the community mental health system.

We found consumers have a positive impression of the system and services. Recent surveys conducted in collaboration between the University of New Hampshire Institute on Disability and the BBH reported consumers' identified numerous strengths of the system, including responsive individual CMHC staff, effective supports, and improved outcomes. We also found the BBH:

- has implemented two evidence-based practices statewide, which are considered to be best practices,
- engages in regular communications with the CMHCs,
- has participated in some planning efforts to identify weaknesses in the community mental health system (e.g., the lack of various types of residential facilities used to keep consumers out of New Hampshire Hospital), and
- continues to explore ways to improve the system.

We believe implementation of the recommendations in this report could improve the effectiveness and efficiency of the State's community mental health system.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX
BUREAU RESPONSE TO AUDIT

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH

105 PLEASANT STREET, CONCORD, NH 03301
603-271-5000 1-800-852-3345 Ext. 5000
Fax: 603-271-5058 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

Nancy L. Rollins
Associate Commissioner

July 7, 2010

The Honorable Marjorie K. Smith, Chair
Fiscal Committee of the General Court
Legislative Budget Assistant's Office
State House, Room 102
Concord, NH 03301

Re: Performance Audit, Community Mental Health System

Dear Representative Smith:

Thank you for the opportunity to comment on the audit by the Office of the Legislative Budget Assistant of the New Hampshire community mental health system. The Bureau of Behavioral Health is appreciative of the time spent in developing a set of recommendations which affirm BBH's current plan to reform payment for community mental health services, ensure a greater degree of accountability for the entire system, and establish a payment methodology that is linked to outcomes and performance measures established in contract. BBH embraces these principles, and as reflected in the recommendations made in the report, and our responses to each of those recommendations, we look forward to having support to implement these recommendations in the context of continuing to improve our service delivery system.

Although we did not concur with all of the observations contained in this report, we found the process that resulted helpful internally in ensuring that both our current and future planning processes aligned with our understanding of the intent of the audit. We recognize that the audit process, as currently designed, looks at program operations in a critical manner, and does not necessarily balance areas needing improvement with existing strengths of the Bureau. There are a number of areas that BBH remains committed to for the future, and is proud of accomplishing, particularly in the context of an extremely challenging fiscal environment.

We would like to take the opportunity to highlight some of these, particularly as they relate to improving the efficiency and effectiveness of care provided in the community.

- BBH has been recognized nationally in its efforts at implementing and sustaining Evidence Based Practices, those practices proven most effective at promoting the best recovery based

outcomes measures, on a statewide basis, including Illness Management and Recovery, Assertive Community Treatment Teams, and Supported Employment.

- The development of a 10-year strategic plan for community mental health services, outlining the necessary changes that need to occur in order to address critical shortages in community mental health services and develop an infrastructure to promote an efficient, effective service delivery system that reduces the need for costly inpatient care.
- The successful implementation of BBH's Housing Bridge Subsidy Program which has currently enrolled 23 individuals with a severe mental illness. These individuals were either stuck in an institutional setting or were homeless due to their inability to afford an apartment in the community and long waiting periods for Section-8 assistance. They now have their own apartments in the community and have demonstrated positive outcomes in improved community tenure measures.
- The opening of the first consumer-run Peer Support Agency in Nashua, which has recently become a not-for-profit organization serving adults who have a severe mental illness. Peer to peer services improve social connectedness outcomes, promote recovery, and reduce isolation in the community.
- Implementation of Assertive Community Treatment teams in the North Country. In response to the closure of an inpatient unit there, funds were reinvested within the community mental health system to improve care and reduce the need for costly hospitalizations. Outcomes measures based on inpatient bed days were significantly improved, by over 50%, with bed days reduced from over 6,000 per year to 3,000 per year.
- State wide roll-out of In-Shape, a health promotion program developed here in NH that has already achieved national recognition for its ability to improve health outcomes and recovery for individuals with severe mental illness.

Please feel free to contact me at 271-5007 or at eriera@dhhs.state.nh.us should you have any questions regarding the Department's response to the Audit report and its observations.

Sincerely;

Erik G. Riera
Bureau Administrator

PERFORMANCE AUDITS
ISSUED BY THE
OFFICE OF LEGISLATIVE BUDGET ASSISTANT

TITLE OF REPORT	DATE
Fuel Oil Discharge Cleanup Fund	December 2009
State Board for the Licensing and Regulation of Plumbers	December 2009
Bureau of Elderly and Adult Services Medicaid Long-Term Care Program	July 2009
Liquor Commission	April 2009
State of New Hampshire Service Contracting	March 2009
Department of Resources and Economic Development Division of Parks and Recreation Revenues of the State Park Fund	September 2008
Fleet Management	September 2008
Office of Information Technology	July 2008
State of New Hampshire Succession Planning	July 2008
Board of Medicine	April 2008
Department of Fish and Game	January 2008
Department of Environmental Services Alteration of Terrain and Wetlands Permitting	August 2007
Insurance Department Consumer Protection Functions	August 2007
Department of Education No Child Left Behind Fund Distribution	February 2007
Insurance Procurement Practices	September 2006
Enhanced 911 System	January 2006
Department of Education Adequate Education Grant Data	December 2004
Board of Mental Health Practice	November 2004

PERFORMANCE AUDITS
ISSUED BY THE
OFFICE OF LEGISLATIVE BUDGET ASSISTANT

TITLE OF REPORT	DATE
Home Care for Children with Severe Disabilities	April 2004
Department of Corrections Division of Field Services	December 2003
Judicial Branch Administration	November 2003
Department of Health and Human Services Division of Elderly and Adult Services Home and Community-Based Care	April 2003
Department of Corrections – Inmate Health Care	January 2003
Department of Corrections – Sexual Harassment and Misconduct	October 2002
Department of Environmental Services Performance-Based Budgeting	March 2002
Department of Safety – Division of Fire Safety	November 2001
Department of Education – Construction and Renovation Programs	September 2001
Department of Health and Human Services Division for Children, Youth and Families Foster Family Care	September 2001
Department of Education – Bureau of Vocational Rehabilitation and Service Delivery	August 2001
Department of Transportation – Bureau of Turnpikes Performance-Based Budgeting	April 2001
Judicial Branch – Family Division Pilot Program	January 2000
Year 2000 Computing Crisis – Special Report – Update	July 1999
Special Education – Catastrophic Aid Program	July 1999
Year 2000 Computing Crisis – Special Report	March 1999
Juvenile Justice Organization	November 1998

PERFORMANCE AUDITS
ISSUED BY THE
OFFICE OF LEGISLATIVE BUDGET ASSISTANT

TITLE OF REPORT	DATE
Marine Patrol Bureau Staffing	March 1998
Health Services Planning and Review Board	January 1998
Economic Development Programs	October 1997
Job Opportunities and Basic Skills Training Program	May 1997
Child Support Services	December 1995
Multiple DWI Offender Program	December 1995
Managed Care Programs for Workers' Compensation	November 1995
State Liquor Commission	July 1994
Property and Casualty Loss Control Program	November 1993
Child Settlement Program	March 1993
Workers' Compensation Program for State Employees	January 1993
Prison Expansion	April 1992
Developmental Services System	April 1991
Department of Administrative Services Division of Plant and Property Management State Procurement and Property Management Services	June 1990
Mental Health Services System	January 1990
Hazardous Waste Management Program	June 1989
Review of the Indigent Defense Program	January 1989
Review of the Allocation of Highway Fund Resources to Support Agencies and Programs	March 1988
Review of the Public Employees' Deferred Compensation Plan	December 1987

PERFORMANCE AUDITS
ISSUED BY THE
OFFICE OF LEGISLATIVE BUDGET ASSISTANT

TITLE OF REPORT	DATE
Review of the Management and Use of State-Owned Passenger Vehicles and Privately Owned Vehicles Used at State Expense	August 1984
Management Review of the Policies and Procedures of the Division of Plant and Property Management	June 1984

Copies of previously issued reports may be received by request from:

State of New Hampshire
Office of Legislative Budget Assistant
107 North Main Street, Room 102
Concord, New Hampshire 03301-4906
(603) 271-2785

For summaries of audit reports,
please visit our web site at:
www.gencourt.state.nh.us/lba