Bill as Introduced

HB 1339 – AS INTRODUCED

2010 SESSION

10-2227
01/09

HOUSE BILL ***1339***

AN ACT relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.

SPONSORS: Rep. DeJoie, Merr 11

COMMITTEE: Health, Human Services and Elderly Affairs Health

ANALYSIS

This bill grants the commissioner of the department of health and human services rulemaking authority to designate an individual or entity to operate and administer a program or facility which provides services to mentally ill or developmentally impaired persons.

This bill also establishes a commission to study uncompensated care at the 10 community mental health centers.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

10-2227
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 State Services System. Amend RSA 135-C:3 to read as follows:

135-C:3 State Services System Established. The department shall establish, maintain, implement, and coordinate a system of mental health services under this chapter and a system of developmental services under RSA 171-A. Both systems shall be supervised by the commissioner. At the discretion of the commissioner, the department may directly operate and administer any program or facility which provides, or which may be established to provide, services to mentally ill or developmentally impaired persons or may [~~enter into a contract with any~~] ***designate by rules adopted pursuant to RSA 541-A, an*** individual, partnership, association, public or private, for profit or nonprofit, agency or corporation for the operation and administration of any such program or facility.

2 Commission Established. There is established a commission to study uncompensated care at the 10 community mental health centers.

3 Membership and Compensation.

I. The members of the commission shall be as follows:

(a) Two members of the house of representatives, appointed by the speaker of the house of representatives.

(b) One member of the senate, appointed by the president of the senate.

(c) The commissioner of the department of health and human services, or designee.

(d) One member appointed by the chief justice of the superior court.

(e) One member appointed by the New Hampshire Hospital Association.

(f) One member appointed by the New Hampshire Association of Counties, county corrections affiliate.

(g) Two members appointed by the New Hampshire Community Behavioral Heath Association.

(h) One member appointed by the Disabilities Rights Center.

II. Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

4 Duties. The commission shall review the contractual, statutory, and regulatory requirements for community mental health centers and shall identify areas where uncompensated care has resulted. The commission shall determine whether such requirements can be repealed or amended or whether additional funding to ensure their continuation is necessary to protect the public's health and safety.

5 Chairperson; Quorum. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named house member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Six members of the commission shall constitute a quorum.

6 Report. The commission shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2010.

7 Effective Date. This act shall take effect upon its passage.

Amendments

"NOT ADOPTED"

Rep. DeJoie, Merr. 11
February 2, 2010
2010-0435h
01/04

Amendment to HB 1339

Amend the bill by replacing section 1 with the following:

1 State Services System. Amend RSA 135-C:3 to read as follows:

135-C:3 State Services System Established. The department shall establish, maintain, implement, and coordinate a system of mental health services under this chapter and a system of developmental services under RSA 171-A. Both systems shall be supervised by the commissioner. At the discretion of the commissioner, the department may directly operate and administer any program or facility which provides, or which may be established to provide, services to mentally ill or developmentally impaired persons or may [~~enter into a contract with~~] ***establish a network for the provision of such services comprised of*** any individual, partnership, association, public or private, for profit or nonprofit, agency or corporation for the operation and administration of any such program or facility.

Amend the bill by inserting after section 1 the following and renumbering the original sections 2-7 to read as 3-8, respectively:

2 Community Mental Health Programs. Amend RSA 135-C:7 to read as follows:

135-C:7 Community Mental Health Programs. Any city, county, town, or nonprofit corporation may establish and administer a community mental health program for the purpose of providing mental health services to individuals and organizations in the area. Every program shall, at a minimum, provide emergency, medical or psychiatric screening and evaluation, case management, and psychotherapy services. The department may [~~contract with a community mental health program, pursuant to RSA 135-C:3,~~] ***establish a network of adequately credentialed individuals, partnerships, associations, agencies, or corporations*** for the operation and administration of any services which are part of the state mental health services system.

2010-0435h

AMENDED ANALYSIS

This bill authorizes the commissioner of the department of health and human services to designate an individual or entity to operate and administer a program or facility which provides services to mentally ill or developmentally impaired persons.

This bill also establishes a commission to study uncompensated care at the 10 community mental health centers.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # NB 1339 Date 2/4/2010

Committee WRS

**** Please Print All Information ****

Name	Address	Phone	Representing	(check one) Pro	Con

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1339

BILL TITLE: relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.

DATE: February 4, 2010

LOB ROOM: 205 **Time Public Hearing Called to Order:** 11:10 AM

Time Adjourned: 1:15 PM

(please circle if present)

Committee Members: Reps. Rosenwald, Donovan, French, Schulze, Tilton, Butcher, Bridgham, E. Merrick, T. Russell, D'Pentima, Miller, Batula, C. McMahon, Pilliod, Emerson, Case, Millham, Wells, Cebrowski and Kotowski.

Bill Sponsors: Rep. DeJoie, Merr 11

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Representative Frank Case – He introduced the bill for Representative DeJoie, the prime sponsor.

***Jay Couture, NH Community Behavioral Health Association –supports.** See written testimony. The system is being driven into bankruptcy. The in and out program was looked at with DHHS. The bill is needed because people in general do not know what is done/needed. They want funding. They have 15-20 grants that range from $1,000 to $3,000.

Michael Brown, Attorney General. This legislation is broad. It eliminates DHHS from contracting with anyone. It is redundant. Rule making is done by DHHS. Contracts – advance goals and objectives which are negotiating. Rule Making – takes a while to put in place. It would be impractical to draft rules to replace contracts. HHS hands would be tied if this legislation was to pass. We do not need this bill. He opposes it.

***Roland Lamy, NH Community Behavioral Health Assoication – supports.** See written testimony. They presented an amendment. We don't have a sustainable Mental Health System. He supports the contract process. The agencies want to contract but under different circumstances. Supports the bill and the contracting elements – doesn't like the requirement. The work of these organizations is in statute. The contract as it s now is flawed. We want to continue to contract, but do it in a collaborative way. The process would be the same.

Michale Skibbie, Disabilities Rights Center. There is a problem with mandating something not funded. It needs accountability. HHS is accountable for making the big decisions. The bill takes that away. He has concerns with the first part of the bill. The second part of the bill gives concerns about having another commission. We need a compensation system that reflects our priorities.

***Paul Gorman, NAMI-NH.** See written testimony. Family members should be represented on the Commission.

Commissioner Nicholas Toumpas, Commissioner, DHHS – opposes. He opposes the first part of the bill. Contracts enables DHHS to carry out its business. It defines programs and provides programs, etc. and ensures compliance. Elimination would hamper Developmental Services programs. Rules do not address specific issues. Yearly adjuncts are good. The second part of the bill does offer qualified support. What is uncompensated care? A definition is needed. Commission members should be broader. Uncompensated care involves many services. Convened a session regarding uncompensated care and invited mental health centers. A committee is already set up and will meet in the next couple of weeks. We do not need this bill. It is DHHS to manage the money. Case loads are larger than expected. We have a $43 million shortfall now and it will come back to the Legislature. Mandates services, but not paid for. The bill does not need an FN. Contracts are year to year and allow for some adjustments.

Respectfully submitted,

Rep. Joan Schulze

Representative Joan Schulze, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1339

BILL TITLE: relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.

DATE: 2/4/2018

LOB ROOM: 205 **Time Public Hearing Called to Order:** 11:10 AM

Time Adjourned:

(please circle if present)

Committee Members: Reps ~~Rosenwald~~, ~~Donovan~~, ~~French~~, ~~Schulze~~, ~~Tilton~~, ~~Butcher~~, Bridgham, ~~E. Morrick~~, ~~T. Russell~~, DiPentima, Miller, Batula, C. McMahon, Pilliod, Emerson, ~~Case~~, ~~Millham~~, ~~Wells~~, ~~Cebrowski~~ and ~~Kotowski~~.

Bill Sponsors: Rep. DeJoie, Merr 11

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* Jay Cauture NH Community Behavioh Health Assoc

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HB 1339 cont 2-4-2010

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Testimony

File HB 1339
Jay Couture

SEACOAST MENTAL HEALTH CENTER Inc.

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February 4, 2010

Testimony provided to The House Health and Human Services and Elderly Affairs Committee relative to HB 1339 issue of uncompensated care in the community mental health system.

Thank you for allowing me the opportunity to testify today. My name is Jay Couture. I am Executive Director of Seacoast Mental Health Center and the President of the NH Community Behavioral Health Association. I have worked in New Hampshire's community mental health system for almost 24 years so am familiar with the increasing burdens of mandated services and uncompensated care.

135-C:13 Discrimination Prohibited; Eligibility for Services. *– Every severely mentally disabled person shall be eligible for admission to the state mental health services system, and no such person shall be denied services because of race, color or religion, sex,* ***or inability to pay.*** Language requiring provision of services regardless of ability to pay is also repeated in our current contract exhibit documents.

When I began working at what was then Strafford Guidance Center in 1986 there was no such thing as a billing code for case management…that came in 1987…or MIMS…which was implemented in 1991. We had yet to hear of HIPAA or Compliance Plans. The majority of our funding was received in monthly payments to the center from the state's general fund.

Over time, with the expansion of Medicaid reimbursable codes we added services which have had a significant positive impact in the recovery journey and quality of life for tens of thousands of consumers. While clinically these new services provided positive changes to the system, the state benefited financially as well since Medicaid billing allowed for a draw down of federal matching funds thereby stretching the state's general fund dollars allocated to mental health services.

The system grew, and for a time was recognized as one of the best community mental health systems in the country. What did not grow, or even stay the same, was general fund support for services provided to clients who are not Medicaid recipients or services that are required but not covered by Medicaid at all.

In FY1994 Seacoast Mental Health Center received 52% of its revenue from billing fees for services provided to Medicaid, Medicare, commercial insurance and self pay. The balance of revenue, almost half, came predominantly from the state in the form of general fund dollars, HUD, PATH, Block Grant and other dollars passed through from the federal

government to the centers. General Fund dollars on line 481 of our state budget accounted for 39% of funding.

By FY2009 our center was generating 85% of revenue from fees (77% of fee revenue from Medicaid; 65% of total revenue from Medicaid) and General Fund dollars on line 481 of our state budget had dropped to .03% of revenue.

Medicaid payments fund services to Medicaid recipients. There are virtually no state dollars remaining in the system to fund care for those who are not eligible for Medicaid and yet we are mandated to provide services to all without regard to ability to pay. We have reached a point where this is no longer sustainable.

In Calendar year 2009 the impact of uncompensated/mandated care was as follows in several critical areas:

Emergency services – We are required to have staff on call and available for face to face services 24/7. There is also a limit of 6 billable units of service for Medicaid recipients despite the fact that many emergency visits, particularly those resulting in an IEA to NHH, last several hours. Calendar year 2009 loss - **$393,834.00**

Medicaid Spend Down – This is essentially a deductible that must be incurred each month prior to a recipient becoming eligible for Medicaid. It applies to any recipient who receives income or cash benefits greater than allowed, a very low threshold. The reality is that we are required to provide services, but these clients generally are not able to pay that incurred amount. Calendar year 2009 loss - **$640,971.00**

Sliding Fee scales are used to determine what a client should be able to pay for a self pay fee when third party reimbursement is not available. In calendar year 2009 this amounted to a loss in reimbursement of **$304,427.00**

We are required to provide an intake to determine eligibility for "state-funded" community mental health services without regard to ability to pay. In calendar year 2009 we provided uncompensated intake services in the amount of **$252,633.00**

We are required to provide community education per He-M 403. All centers respond to community tragedies, at times dispatching staff for several days to provide support to students and teachers after the death of a classmate.

We are asked, and do, send staff to participate in state, regional and local initiatives with other stakeholders. We are not compensated for these efforts, and in many cases it means that clinical staff are pulled away from providing the revenue generating services upon which we have become so dependent. Vacancies, illnesses and weather have an even more impactful effect on our ability to stay solvent than they ever have before.

The consumers of community mental health services deserve to receive the care they need in the least restrictive, most appropriate environment. To do that there needs to be

adequate funding to support the provision of those services. Providing adequate support at the community level will save money on higher cost more restrictive settings of care.

For the state to continue on the path it has followed by mandating but not funding services to some of its most vulnerable residents is not sustainable. Almost a year and a half ago we stood as partners with the state as the "Ten Year Plan" was released. We need to do the right thing and provide adequate funding for necessary services and relief from administrative burdens.

I thank you for your time.

Jay Couture, MHA
Executive Director

File HB1339
Joy Cantlin

Community Mental Health Centers in New Hampshire

FINANCIAL PERFORMANCE AND CONDITION

by: Nancy Kane, D.B.A.
Harvard School of Public Health

January, 2010

Underwritten by:

Endowment for Health/
Health Strategies of NH

Overview of the Financial Health of Ten New Hampshire Community Mental Health Centers

2004–2009

Submitted to the Endowment for Health by
Kane Consulting
January 25th, 2010

Introduction

This report analyzes the six-year financial history and current financial condition of the ten community mental health centers (the "Centers" or "CMHC") currently serving close to 50,000 mental health clients in the State of New Hampshire. It is based primarily on financial data and related information contained in the audited financial statements of the Centers for the fiscal years 2004–2009. It is the third in a series of reports on the financial condition of health providers in New Hampshire, with one on acute hospitals and another on community health centers.

The ten Centers, all organized as nonprofit New Hampshire corporations, are in alphabetical order: CLM Center for Life Management, Community Council of Nashua, Inc., Community Partners, Genesis Behavioral Health, The Mental Health Center of Greater Manchester, Monadnock Family Services, Northern Human Services, Inc., Riverbend Community Mental Health, Inc., Seacoast Mental Health Center, Inc., and West Central Behavioral Health.[1]

[1] Using d/b/a/ names where applicable

Under annually renewable contracts with the New Hampshire Department of Health and Human Services, each Center provides mental health services to residents of a specific geographic area of the State.

Summary

The Centers (CMHCs) had combined annual revenues in the most recent fiscal year, FY09, of just over $150 million. However, annual surpluses after operating expenses have been low or negative throughout the study period.

Medicaid payments account for approximately 75% of total revenue sources (which includes grants and contracts as well as patient service revenues), and roughly 85% of patient service revenue alone. As a percentage of total revenue sources, Medicaid ranges from about 65% at some centers to 80% in others. Thus the Centers' future financial viability depends on continued support from the Medicaid program.

The Centers' assets, totaling $65 million as of FY09, consist primarily of working capital and clinic and administrative premises. In some cases, premises are rented to the centers by nonprofit affiliates.

While the Centers have not experienced acute financial problems in this period, most do not have sufficient financial reserves to fund substantial operating losses.

I. Aggregate Financial Performance–Revenues and Expenses

The six-year aggregate income statement shows that the Centers had moderate revenue growth but only minimal profitability, with deficits in two of the six years. Revenues and expenses grew at roughly the same rate, and operating margins fluctuated around breakeven over the period. Grant and contract revenue has declined over the period, so all of the growth has come from patient service revenue (mostly Medicaid, with some revenues from self-paying and very few privately-insured clients). Non-operating revenues, primarily realized investment gains and donor contributions, make a minimal contribution to profitability, less than 1% of operating revenues and on a declining trend since 2007.

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

	2004	2005	2006	2007	2008	2009	Change 2004–2009	Average Annual Change
OPERATING REVENUE								
Net Patient Service Revenue	105,417	106,766	111,398	123,667	130,692	140,356	33%	
Other Operating Revenue:								
Grants	9,594	9,675	10,124	10,553	9,235	8,904	-7%	
Assets Released From Restricts–Operations	163	178	182	181	340	258	58%	
Other	7,882	7,165	6,885	5,940	6,329	5,464	-31%	
Total Other Operating Revenues	17,782	17,161	17,334	16,817	16,108	14,626	-18%	
Total Operating Revenue	**123,184**	**123,926**	**128,732**	**140,484**	**146,800**	**154,982**	**26%**	**4.67%**
OPERATING EXPENSES								
Salaries, Payroll Taxes, Fringes	88,998	90,858	94,334	101,639	108,043	110,574	24%	
Depreciation	1,952	1,981	1,969	1,969	2,234	2,331	19%	
Interest	520	473	696	689	904	806	55%	
Other operating expenses	30,528	32,365	30,593	35,986	38,049	39,808	30%	
Total operating expenses	**121,998**	**125,677**	**127,592**	**140,283**	**149,230**	**153,519**	**26%**	**3.29%**
Net Operating Income	**1,186**	**-1,751**	**1140**	**201**	**-2,430**	**1,463**	**23%**	
Interest and Dividends	68	152	242	454	353	265	290%	
Realized Gains (Losses)	190	120	628	1,392	2	-358	-288%	
Other Income (Expense)	865	1,114	837	838	978	1,009	17%	
Total non-operating revenue	972	1,243	1564	2,541	1,129	916	-6%	
Excess of revenue over expenses	2,166	-508	2,704	2,742	-1,301	2,379	10%	
Extraordinary Gains (Losses)	0	0	2	641	0	0	0%	
Total Surplus/Deficit	**2,166**	**-508**	**2,706**	**3,386**	**-1,300**	**2,378**	**9%**	
Aggregate Operating Margin	**0.96%**	**-1.41%**	**0.89%**	**0.14%**	**-1.66%**	**0.94%**		
Aggregate Total Margin	**1.75%**	**-0.41%**	**2.08%**	**2.37%**	**-0.88%**	**1.53%**		

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

- Aggregate operating revenues and expenses have grown at a similar pace, with average annual growth in operating revenues (4.67%) exceeding average annual growth of operating expenses (3.29%) by about 1.3 percentage points.
- Operating income has fluctuated with losses in two years; adding it across all six years yields a net loss of $191,000.
- Total surplus was lower in FY09 than in FY06 and FY07. The weakening trend was due to a drop in grant revenue as well as non-operating revenue, primarily reductions in realized gains from investments (reflecting general capital markets).Adding total surplus across all six years yielded just over $8 million, or less than 1% of total operating and non-operating revenue.
- Aggregate operating and total margins fluctuate around breakeven (plus or minus 2%).

II. Aggregate Financial Performance–Cash Flow

The five-year aggregate cash flow (sources and uses) analysis shows a healthy pattern in aggregate, with cash from operating activities financing a larger cash cushion and some moderate investment in property and plant.

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

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

- Positive cash flow from operating sources (surplus, noncash expenses, working capital) totaled 48% of total sources of cash; another 10% of cash was generated by selling fixed assets (at four CMHCs).
- Outside sources of capital are primarily long-term debt (35% of total sources), with some assistance from related entities (7% of total sources). The average equity financing ratio (amount of equity versus debt: higher is better) was 47%, improving slightly from 45% in 2004. Debt service appears adequate in 2009, with average debt service coverage of 3.7 times (but significantly lower at certain centers).
- The largest use of cash is investment in clinic and administrative premises (referred to as Property, Plant, and Equipment or PP&E). Five centers spent over $1 million on PP&E over the five years; however, average age of plant in 2009 was almost 20 years, up from 13 years in 2004. Some centers operate from premises that are owned by affiliates whose financial statements are not combined with those of the center, so the full picture is not complete on CMHC capital requirements and their ability to meet them.
- Most of the rest of the cash was used to increase working capital cash (18% of total uses) or investments in marketable securities (17%), which generate non-operating revenues; days cash on hand (all sources including marketable securities investments) improved to 57 in 2009, up from only 27 days in 2004.[4]

[2] Excludes FY 2009 cash flow data for West Central, which became available only after this report was prepared; however, it was not material to the aggregate cash flows depicted in this table.

[3] Increases to cash balances are treated as a use of cash therefore a minus sign is attached.

[4] The positive cumulative cash generation shown is consistent with analysis of the bank lines of credit maintained by the Centers. Most of the Centers had lines of credit of $1 million or less with local banks during this period, but most lines remained unused and only one Center borrowed to any significant degree.

III. New Hampshire Community Mental Health Centers Compared to New Hampshire Community Health Centers

Figure 1: Comparison of Total Margins of CHCs and CMHCs in New Hampshire

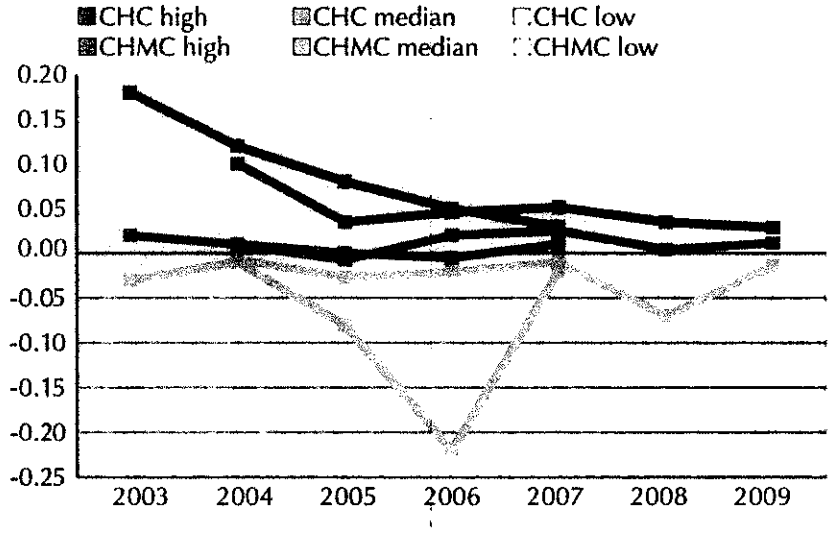
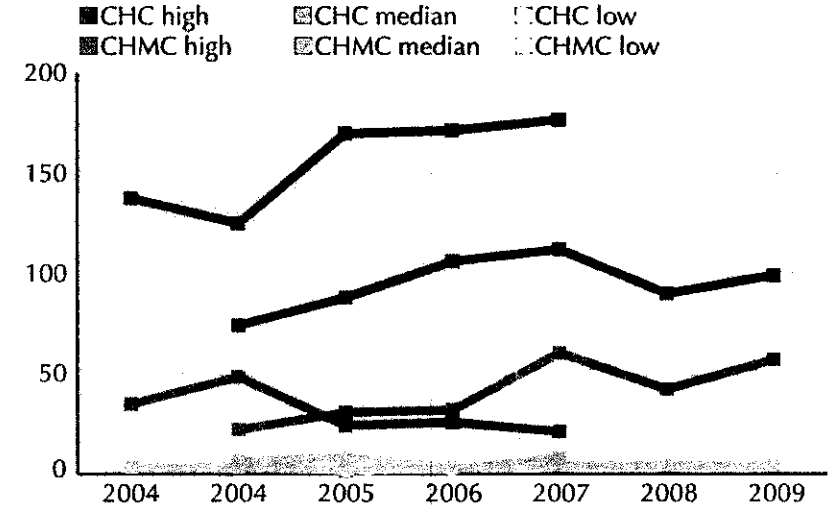


Figure 2: Comparison of CHC and CMHC Days Cash On Hand



Compared to our earlier analysis (2002–2007) of community health centers (CHCs) in New Hampshire, CMHCs show a narrower range of performance (not as weak as the weakest CHCs nor as strong as the strongest). Appendix A provides a definition of the ratios used in this analysis.

Figure 1 compares the trend in total margins between CHCs and CHMCs. Over the period 2002–2007, CHCs generally experienced declining total margins and a convergence toward the middle, with the exception of the worst-performing quartile, which recovered somewhat in 2007 after suffering very large deficits in 2006. The CMHCs' quartile trends range between -.02 and +.03 over the period, with no clear upward or downward trend over the period 2004–2009. The 2009 interquartile range is less than two percentage points, compared to six percentage points for the CHCs; thus financial performance in the sector is more uniform across the individual centers than with the CHCs.

Figure 2 compares the minimum, median, and maximum values for CHC and CMHC days cash on hand, a common measure of liquidity. CHC's show a wide disparity in the distribution of liquidity, with the bottom 50% having very low and/or deteriorating liquidity, while the top

center experiencing rapidly growing liquidity, going well beyond 100 days cash on hand in 2009. In contrast, the CMHC's have a positive upward trend generally, but a smaller range, tilted toward the lower end of liquidity. The lowest ratio of days cash on hand in 2009 among the CMHC's was only 4 days, and no CHMC's days cash on hand reached 100 days as of 2009.

IV. Community Mental Health Center Financial Analysis by Groups of Relative Strength

With less disparity than the eight CHCs, the ten CMHCs still vary in their financial performance. This section provides a picture of the differences in financial performance among three groups of CMHCs over the period 2004 – 2009. Group 1 ("low") consists of the three CMHCs with the lowest profitability margins over the period; Group 2 ("medium") are the four CMHCs with margins in the middle of the range; and Group 3 ("high) are the three CMHCs with margins at the high end of the range. Since none of the CMHCs are financially strong, it is best to think of these three groups as "high, medium, and low" relative to each other, but not in an absolute sense (e.g., high does not mean very healthy, and low does not mean in severe financial distress). Mean values for each group are shown in the figures below.

Two of the centers in the medium performance group deliver developmental services in addition to mental health services, and revenues and expenses associated with developmental services are substantial in both cases. The two lines of service are governed by separate contracts with New Hampshire DHHS and funded under separate Medicaid arrangements. Separate income statements, not shown here, were prepared for these centers using only mental health-related revenues and expenses. Although partly based on estimates, the results of this analysis indicated that the two centers would remain in the medium group in terms of total and operating margins shown in Figures 3 and 4. With the data available, we concluded that providing mental health services was not materially more or less profitable than providing developmental services.

Figure 3: Total Margins by CMHC Financial Group

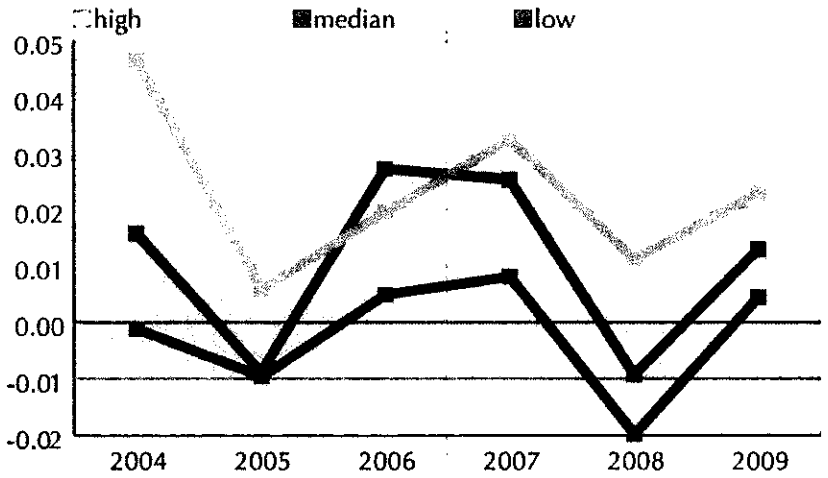


Figure 3 shows total profitability for full operations of all Centers; it includes the profits from operations as well as investment income (inter-

est, dividends, realized gains). Major findings include:

- All three groups experienced no clear trend across the years.
- The "high" group centers almost always achieved positive total margins.
- Both "medium" and "low" centers fell into negative margins in 2005 and 2008.
- Lower performers tended to be smaller (in terms of annual revenues).

Figure 4: Operating Margins by CMHC Financial Group

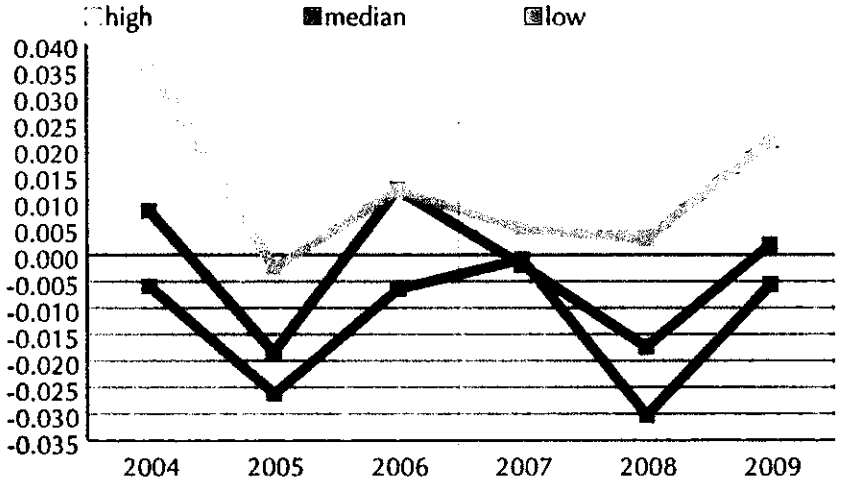


Figure 4 shows operating profitability of all Centers, which excludes investment income and other nonoperating revenues from the numerator and denominator. Results track closely to total profitability results in the preceding chart because investment income is not significant for most centers:

- Again, no clear trend in profitability is apparent for any group.
- However, the three centers in the "low" category lost money over all six years of our analysis.
- The "medium" group experienced operating profits at or above 1% in only two of the six years; these basically were at "breakeven" on operations.
- The "high" group achieved 2% or higher operating margins in only two of the six years; mean profit margins for the other four years hovered between 0 and 1%.

Figure 5: Current Ratio by CMHC Financial Group

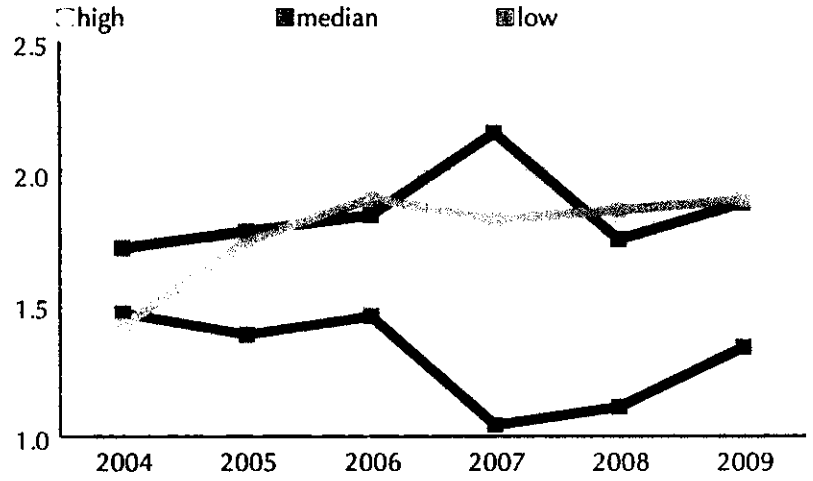


Figure 5 shows generally rising liquidity for the "high" and "medium" groups, but deteriorating liquidity for the "low" group. Both the "high" and "medium" groups maintained a satisfactory ratio of current assets to current obligations; only one center fell below the commonly accepted sufficient ratio of 1.5 in multiple years. However, the "low" group centers averaged below the 1.5 benchmark and some experienced a current ratio below one in some years, indicating a challenge in meeting everyday cash needs like payroll and paying suppliers.

Figure 6: Days in Accounts Receivable by CMCH Financial Group

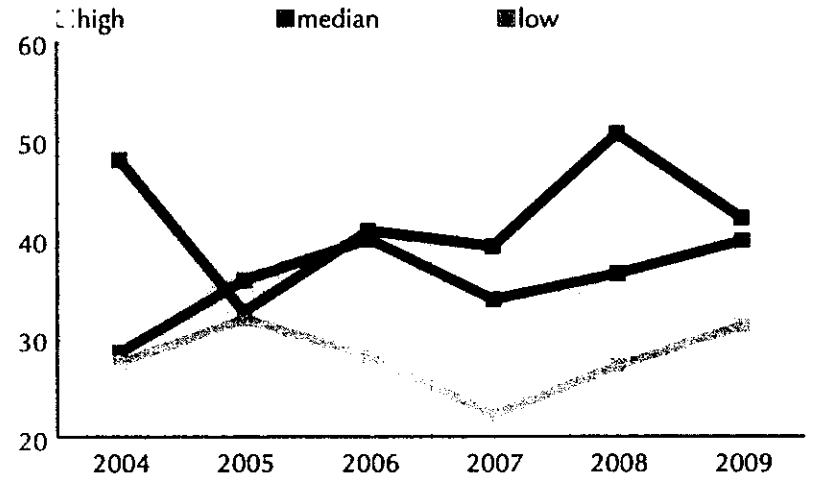


Figure 7: Days Cash on Hand by CMHC Financial Group

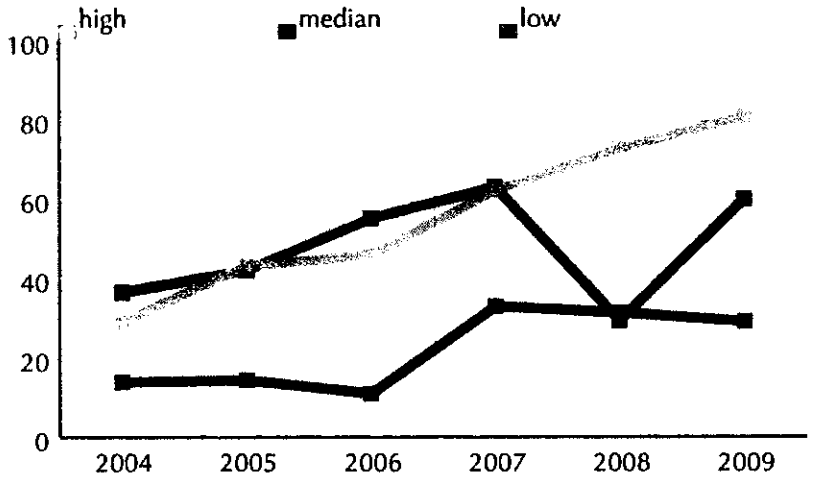


Figure 8: Equity Financing for CMHC Financial Groups

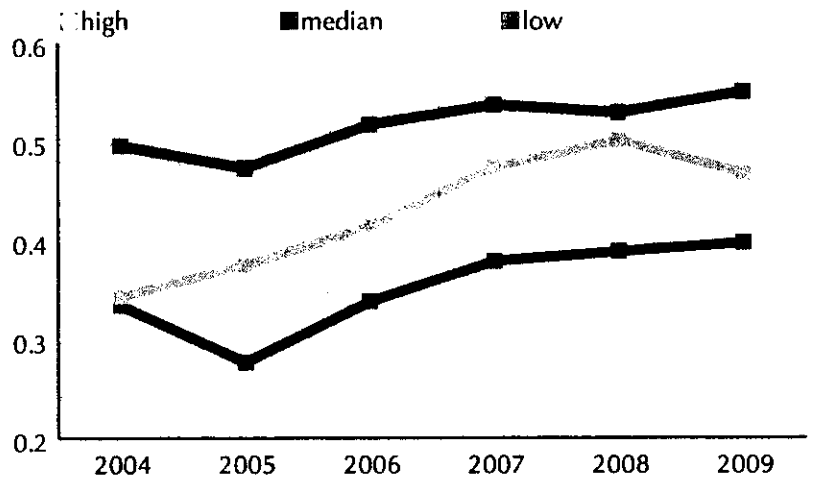


Figure 6 indicates that higher performers had the lowest days in accounts receivable, collecting on their accounts more quickly than either the medium or lower performing centers. All financial groups are collecting receivables within two months, which is generally good (for example, hospitals average 60 days to collect receivables).

Figure 7 shows a generally rising trend in days cash on hand , including marketable securities and cash accounts, a favorable financial trend for the sector. The large dip in 2008 for medium performers resulted from a combination of plant investments (using cash to build offices/ clinics/add equipment) and significant negative margins for the year.

However, two centers have precariously low levels of cash; in 2009, one had enough cash to cover only 4 days of expenses, and the other only 8. While there are no "industry standards" of cash levels for community mental health centers, in the hospital sector 100 days of cash on hand is considered good. In our earlier New Hampshire CHC analysis, the median ranged between 20 and 50 days cash.

Figure 8 shows a favorable, upward trend for the amount of equity (relative to debt) that the Centers had on their balance sheets over time. Medium performers had the least debt, financing the largest portion of their assets through equity (accumulated profits). Centers in the low category financed the largest portion of their assets through debt and liabilities,[5] as

[5] Low performers' equity financing ratio may be overstated because two Centers in this category guarantee debt of unconsolidated affiliates, to whom they have long-term property rental obligations.

Figure 9: Debt Service Coverage by CMHC Financial Group

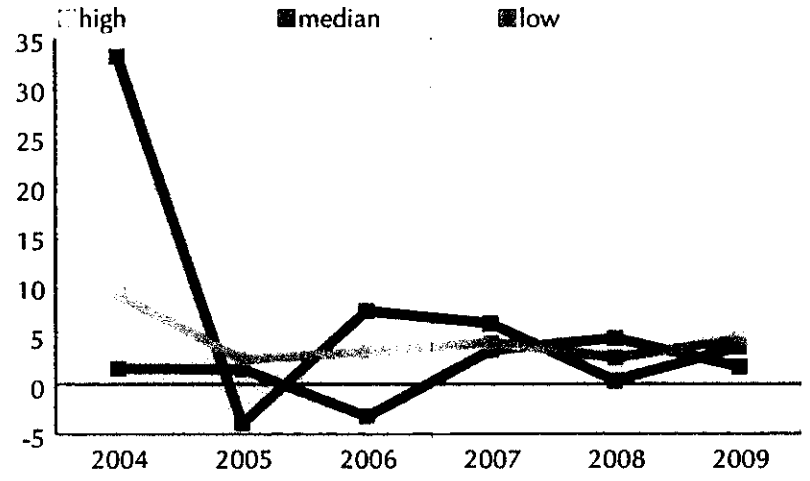
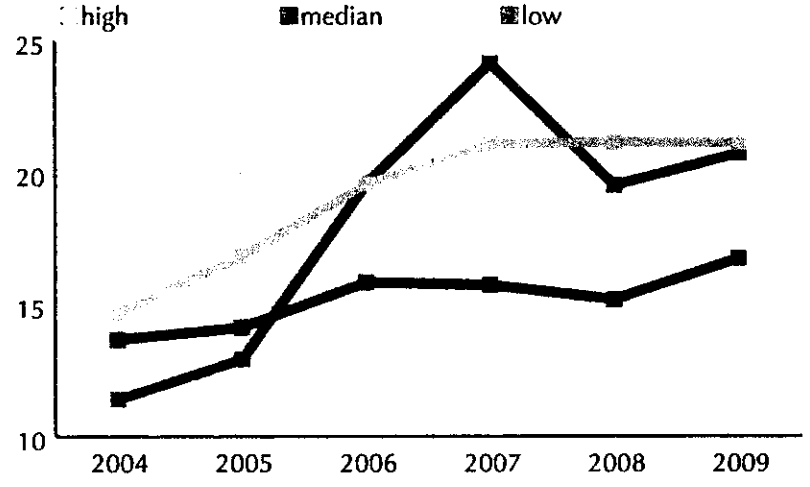


Figure 10: Plant Age by CMHC Financial Group



they lacked the accumulated profits needed to finance their asset needs. Low performers tended to rely on short-term bank and affiliate loans and liabilities to other creditors, as only one center in this category had long-term debt. Relative to NH community health centers, where the median equity financing ratio ranged between 20–40%, CMHCs had higher (more favorable) equity financing ratios. However, their heavy reliance on short-term sources of debt means that they are very vulnerable to being unable to repay loans or to access new debt if they experience significant deterioration in their financial performance.

Debt service coverage measures the ability of the Centers to repay their long-term debt (so those with only short-term debt and no long-term debt are not included). Higher performers consistently earned, on average, two to four times their annual interest and principle payment requirements. However, medium and low performers experienced dramatic volatility in this ratio, as it is tied to total margins and debt repayment cycles.

Figure 10 shows that plant and equipment grew older over the study period for each category. While this aging trend is not as meaningful as in a medical context where equipment technology plays a critical role, the centers still need to maintain buildings and invest in information technology. Due to the number of centers whose properties are, or were in some years, owned by non-consolidated real estate affiliates, these numbers may not be comparable over time (some started consolidating these affiliates in only the last 2–3 years) or across centers (two have not yet consolidated their real estate affiliates).

IV. Projected Impact of Medicaid Cuts in FY 2010

Information received from NH State authorities indicates that total Medicaid payment reductions to the Centers for mental health services will approach $8 million for FY10, or about 7% of Medicaid FY09 payment levels. The payment reductions will take the form of reduced reimbursement rates for specific services performed by the Centers. Table 3 reflects the estimated reductions in FY10 Medicaid reimbursements, as prepared by each of the CMHCs.

Because Medicaid is 75% or more of total operating revenue, and a still higher percentage of net patient service revenue, overall financial performance is impacted severely by Medicaid payment and coverage policies, as Table 3 shows.

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

Center	Surplus FY09 ($$000s)	Surplus FY10 (est.) ($$000s)	Estimated Medicaid cuts FY10	Pro Forma Surplus (Loss) with cuts	Loss as a % of 2009 Net Worth
A	363	363	1,655	(1,292)	30%
B	186	0	490	(490)	24%
C	595	100	814	(714)	15%
D	426	426	1,173	(747)	8%
E	41	268	854	(586)	49%
F	103	103	564	(461)	16%
G	549	0	800	(800)	24%
H	109	84	568	(484)	22%
I	-23	-373	372	(745)	118%
J	50	-7	396	(403)	34%
Total	**$2,399**	**$964**	**$7,686**	**$(6,722)**	**20%**

The estimated Medicaid reductions for each center vary according to both the volume and particular mix of services performed by that center; the exact financial impact on each center will not be known until the fiscal year closes on 6/30/10. However, all Centers will be forced to make significant adjustments to avoid large operating losses for the fiscal year. The $6.7 million in potential losses is nearly three times greater than the largest operating loss experienced by the Centers in any year between 2004–2009 ($2.4 million in 2008–see Table 1). These cuts would wipe out roughly 20% of the aggregate 2009 net worth of the Centers; individual Centers would lose between 8% and 118% of their 2009 net worth.

[6] Three Centers did not provide income statement estimates for FY10, this analysis uses FY09 income statements for these Centers.

Financial options such as covering losses with investment reserves are limited. Most of the Centers do not have financial assets that can be liquidated on the scale required, and to the extent that these are used in 2010, there would be no financial cushion for losses in subsequent years. Employee compensation reductions may not be practical or desirable without impacting the quality of service delivery. Centers that have bank lines of credit are not likely to be able to use them to cover recurring operating losses. Two centers were already forecasting losses that would be amplified by the Medicaid cuts.

The only practicable response to the Medicaid payment reductions may be to reduce the volume of services, which could come in several forms, including tighter eligibility rules, longer wait times, and decreased visit frequencies. In practice, each Center will improvise its own adjustment based on its specific operating context. Table 4 below illustrates just one perspective by using average revenues per client to express the reduction in Medicaid dollars in terms of number of patients served. This model indicates a 7% reduction in patient volume affecting over 3,000 people.

Table 4. Average Revenues per Medicaid Client at NH CMHCs.

Center	FY09 Program Service Fees(NPSR)[7] $000s	Mental health clients at 6/30/09	Revenues client $$	Number of clients equiv. to Medicaid cuts
A	16,430	7,409	2,220	745
B	7,619	2,230	3,420	143
C	18,952	9,000	2,110	386
D	11,920	4,060	2,999	391
E	10,135	4,386	2,310	370
F	8,876	5,079	1,750	322
G	7,890	2,969	2,657	301
H	9,520	4,773	1,990	285
I	8,908	3,394	2,620	142
J	7,317	4,093	1,790	221
Total	**$114,884**	**47,393**	**(avg) $2,424**	**3,306**

In conclusion, the Community Mental Health Centers have improved their financial position over the last six years from fragile to more secure, but they have not accumulated the financial reserves to withstand major cuts in revenues from Medicaid, their primary source of revenue. The likely outcome of such cuts will be a reduction in service levels for the population at a time when the demand for mental health services may well be rising due to growing unemployment and a slow economic recovery.

[7] Mental health program service fees only in the case of the two Centers that also provide developmental services.

Appendix A: Definition of Ratios Used in Report

Profitability:	**Purpose**	**Calculation**
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources. Higher is better.	Ratio of (Operating Income and Non-operating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues. Higher is better	Ratio of Operating Income/Total Operating Revenue
Liquidity:	**Purpose**	**Calculation**
Current Ratio	Measures the extent to which current assets are available to meet current liabilities. Higher (above 1.5) is better.	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers (lower is better)	Patient Accounts Receivable/ (Net Patient Service Revenue / 365)
Days Cash on Hand	Measures how many days the organization could continue to operate if no additional cash were collected (higher is better)	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:	**Purpose**	**Calculation**
Equity Financing Ratio	Measures the percentage of the organization's capital structure that is equity (as opposed to debt, which must be repaid). Higher is better.	Unrestricted Net Assets/Total Assets
Average Age of Plant	Measures the relative age of fixed assets (Lower is better)	Accumulated Depreciation/ Depreciation Expense

File HB 1339 Joy Cautione

NHCBHA
2009 Losses

Calendar Year 2009

	CLM	GNMHC@CC	Comm.Partners	Genesis	MHCGM	MFS	NHS	Riverbend	Seacoast	W.Central
Losses from Uncompensatied Emergency Services	($250,000.00)	$237,227.00 Included ES and Brief Hosp losses	$595,629.00	$359,893.00		$229,338	$323,190* Please note that in FY08 our loss was $415K and we project our loss in FY 10 to be $407K	($634,018.00)	$393,834.00	$75,000.00
Losses from Spend Down	($436,000.00)	700000 Estimate	$544,975.08	$368,027.00		$605,280	$176,864.00	($819,614.00)	$640,971.00	$441,099.00
Losses from Application of Sliding Fee Schedule to Self Pay	($80,000.00)	This really isn't available. We wrote off $1,013,174 in	$557,708.98	$354,746.00		$644,422	$1,443,141** Difference between the full charge and the	($678,106.00)	$304,427.00	$505,869.00
Loss of Uncompensated In-Take Services	($162,000.00)	$193,816.00	$231,241.00	in with ES		$284,137	$175,923.00	$0.00	$252,633.00	$38,541.00
Total for All Centers:	($928,000.00)		$1,929,554	$1,082,666.00		$1,763,177		($2,131,738.00)	$1,591,865.00	$1,060,509.00

Included ES and Brief Hosp losses

Roland Lamy - File
HB 1339

NH Community Behavioral Health ASSOCIATION

1 Pillsbury Street, Suite 200 Concord, NH 03301-3570 603-225-6633 FAX 603-225-4739

February 4, 2010

The Honorable Representative Cindy Rosenwald
Chairperson
House Health Human Services and Elderly Affairs
107 North Main Street
Concord, NH 03301

Dear Representative Rosenwald:

I am writing on behalf of the New Hampshire Community Behavioral Health Association (NHCBHA) and its ten community mental health center members that provide community based mental health services to approximately 50,000 New Hampshire residents. This letter is provided as supporting testimony in favor of the proposed House Bill 1339 (HB 1339).

HB 1339 is proposed to address two concerns that NHCBHA has in regard to the interactions between the community mental health centers and the State of New Hampshire while they act as a critical part of the State's "safety net" system.

The first is the growing concern over unfunded requirements or mandates imposed on community mental health centers to care for certain populations with a specified set of services for which no payment is provided. In an economic climate where expenses are growing rapidly and no corresponding increase in revenue is provided this jeopardizes the sustainability of the system of community based mental health services. As noted in a recent study by the Endowment for Health regarding the economic health of our community mental health system the Centers have realized a net operating loss over the past 6 years. The continuing expectation to do more with less will likely erode our system of care and seriously impact the ability to provide access to New Hampshire residents needing community based mental health care services.

The second element of HB 1339 addresses a concern that arose this past year over proposed rule changes that govern our community mental health care system. While the rule changes addressed several elements of the system, NHCBHA testified before the Joint Legislative Committee on Administrative Rules (JLCAR) regarding concerns over an element of the rule that "required" community mental health centers to be under contract in order to be a qualified Medicaid provider. NHCBHA believes this rule is onerous and in conflict with the intent of the law (RSA 135 C) which requires the Commissioner of the Department of Health and Human

Services to establish a system of mental health services that is already done under our statutory designation. Community mental health centers are designated by statute and must meet certain requirements already defined by that statute in order to be a designated community mental health center and provider. Although the ten community mental health centers are one of very few Medicaid providers that agree to a formal contract, NHCBHA has worked with the Department of Health and Human Services (the Department) over the past several years to address concerns in the existing contract language that are dated and not representative of the actual administration and agreement between the State and its community mental health care system. While some progress has been made, it has been done through an effective negotiation process. Requiring a contract by administrative rule essentially negates the ability to effectively negotiate with the Department in good faith toward a mutually agreeable outcome. Essentially, in order to continue to act as the State's safety net for community mental health services, the Centers would have to sign agreements no matter what language was put forth in them. This seriously undermines the negotiation process and conflicts with the role of an independent Board of Directors of each of the ten community health centers who must recognize their own fiduciary responsibility to the Center.

NHCHBA supports HB 1339 and would appreciate the support of this Committee in helping to address the two areas of concern. While these are difficult economic times, the ten community mental health centers and NHCBHA continue to focus our attention on the care of New Hampshire's residents and the growing need for a sustainable community mental health care system. Thank you in advance for your consideration.

Sincerely,

Roland P. Lamy

Roland P. Lamy
Executive Director

CC: Members of the House Health Human Services and Elderly Affairs Committee

Paul Gorman File
HB1339

NAMI New Hampshire

New Hampshire's Voice on Mental Illness

To: Chair, Cindy Rosenwald

Re: Testimony - HB 1339

From: Paul Gorman, Vice Chair of the Board of NAMI-NH,
National Alliance on Mental Illness.

Chair Rosenwald and Members of the Committee:

My name is Paul Gorman. I live in New London, NH. Today I appear before you as the vice chair of the Board of NAMI NH, the National Alliance on Mental Illness. We represent families and consumers working to improve the quality of life of all persons affected by mental illness and severe emotional disorders. A primary focus of our mission is to educate the public about mental illness, to improve their understanding of its impact on individuals and families and to advocate for improved access to and coverage for quality treatment.

I am here to present the NAMI NH position on HB 1339. Although NAMI NH cannot comment on the specific fiscal impact and organizational challenges of the present contract policy of DHHS with the CMHCs or the contractual requirements to provide uncompensated care to any citizen of NH, we would like to make a number of statements about the impact of uncompensated care, this legislation and the contracting process in general.

First, in considering HB1339 NAMI NH would first like to encourage you to think about this from a human perspective.

The citizens of NH who present for care and are unable to pay for that care are generally those who have no insurance or have inadequate coverage to address their psychiatric needs. These are the uninsured or the underinsured people in our state. What is known from long experience in providing care to this population is that they very often wait to seek care. They are apprehensive because they know they are unable to meet the financial charges that they will incur or they wait because of the stigma associated with having a mental health problem. So they wait and, as they do so, their illnesses worsen. Thus they present to the treatment provider, often at the CMHCs, in a much more complicated clinical condition than if they had come when their condition first appeared. That they need care is undisputed, that they can't pay is also clear.

We are talking about people who may present with psychoses, severe depression, mania, suicidal ideation or any number of other psychiatric illnesses. They need immediate clinical intervention by trained professionals to ameliorate their suffering. That is a

- Over -

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minimum of what our society should provide, and what the Centers do. NAMI NH believes that this service is critically important to our citizens, in particular, in this time of increased psychological stress due to unemployment or military deployment. Data shows that demand for emergency services is growing rapidly in NH. Adequate compensation for emergency service, and policies and procedures, must be in place so that the emergency response does not take away from the needs of individuals and families already in treatment at the Centers - many NAMI families. Taking from Peter to pay Paul does not work - no one wins.

The individuals and/or families who present for emergency care and who cannot pay for that care will get some care in some way - the cost will shift to another entity. The common alternatives to a carefully managed and funded psychiatric emergency service are the local hospital emergency room and/or the local jail. Neither of these institutions is especially prepared or trained to recognize, diagnose and intervene in a psychiatric emergency; and it costs more.

To better meet the needs of persons in crises and those already in treatment at the Centers, NAMI NH supports the development and implementation of a discrete psychiatric emergency service, perhaps coordinated program between the CMHCs, local hospital emergency rooms and/or the inclusion of local health centers. This more integrated and multi-agency approach may help address both funding and capacity issues currently facing the CMHCs. It is critical that the state ensure an adequately funded and available psychiatric emergency service, much of where uncompensated care costs fall, in each region across the state and that the financial burden for this service does not solely fall to the CMHCs. The state needs to ensure that this service is available to its citizens in time of greatest need.

Second, although contracting processes can, at times, be contentious, we believe that they have value to assure oversight from the state's mental health authority in two areas; programmatic and financial. We believe that this oversight function is the responsibility of the state and a contract can assure that - not an administrative rule. However, we believe the state has a significant responsibility to establish and develop a contracting process that ultimately assures the financial viability of the Centers, since they play a critical role in serving the state's most seriously ill population; many NAMI NH individuals and families, and we need them to treat our loved ones and promote their recovery.

Third, if there is to be a Commission, we believe it is critical that families are part of that Commission. Although, on the surface, the proposed Commission is about uncompensated care; it really is about the services that are provided and/or impacted because of uncompensated care. NAMI NH has a stake in the services provided by the Centers. We should have a seat at the table. We recommend that the proposed legislation be amended to include NAMI NH as one of the Commission members.

Thank you. I am happy to answer any questions.

File
HB 1339

Keene agency forced to cut staff

By Jessica Arriens - Keene Sentinel - Friday, January 29, 2010

Coping with a major reduction in Medicaid reimbursements, Monadnock Family Services announced staffing cuts today.

The announcement coincides with a report detailing the fragile financial health of New Hampshire's community mental health centers. The report, released Thursday by the N.H. Endowment for Health, says that the centers are doing better financially compared to a few years ago, but will likely be forced to reduce services due to additional Medicaid cuts.

Monadnock Family Services is coping with a $400,000 cut in Medicaid revenue, said CEO Jayme J. Collins. The center was expecting only a $270,000 shortfall until the end of December, when the state announced a retroactive cut in Medicaid payments.

"That was a much bigger hit than what we had planned on," she said. "And so we weren't as strong as what we had hoped."

Thursday night, the center's board of directors approved a response plan to the cuts, which includes eliminating seven full-time positions, Collins said. The employees will be notified of the layoffs today. The center is also reorganizing some administrative positions, meaning some employees have to take on additional duties, she said.

The response plan will save Monadnock Family Services a half-million dollars, Collins said. "This is really to try to regain our strength from this first cut and be in stable condition when we face the next cut," she said.

The state's Department of Health and Human Services will announce a second round of Medicaid reimbursement reductions in mid-February. The amount of the cut won't be known until then, but Collins said it could be around $300,000 for Monadnock Family Services.

Medicaid payments account for about three-quarters of the revenue for the state's 10 nonprofit community mental health centers. The state plans to cut Medicaid payments by $8 million this fiscal year.

According to the endowment report, the cuts would wipe out roughly 20 percent of the centers' net worth. The centers have improved their financial position but don't have enough money to withstand the cuts without reducing services, the report said.

Monadnock Family Services will continue to look for ways to be more efficient to withstand the cuts, Collins said. But the goal of any response plan — including the one approved Thursday night — is to leave the services provided by Monadnock Family Services intact.

"That's the last thing that we want to have impacted by this," she said. "We will do everything we can before we have to give up a particular service."

Some changes in service were made in 2008, when the center was coping with a $500,000 deficit due, in part, to Medicaid cuts. The center also eliminated eight positions that year, and slashed the work week of all employees — a reduction still in place, Collins said.

The biggest change in service involved the closure of Monadnock Family Services' general outpatient department, which serves people who are not seriously and persistently mentally ill, Collins said.

"We could not offer ongoing psychotherapy to folks who really couldn't pay for it."

Instead, the center designed an "acute care" department. Anyone who calls Monadnock Family Services looking for help gets an immediate assessment, and is able to find out about available resources — either at the center or somewhere else in the community.

"That's really a big piece of the community safety net that we're responsible for," Collins said.

When people call with a mental health issue, they need the ability to access help within 10 days, she said.

"We're still providing all of that."

But according to the endowment report, further revenue cuts to the state's mental health centers could ultimately lead to a reduction in services, at a time when the centers are seeing a rise in demand.

Nancy Kane, the report's author and a professor at the Harvard School of Public Health, analyzed financial information for each center in fiscal years 2004-2009.

The centers did not experience acute financial problems during that time, and many reported increasing amounts of cash on hand. But operating expenses exceeded revenue some years.

Dr. Jim Squires, the endowment's president, said he fears a court ruling earlier Thursday would hurt the community mental health centers even more. In the ruling, the state Supreme Court rejected the state's claim to $110 million in surplus from a fund that underwrites medical malpractice insurance.

Associate Health Commissioner Nancy Rollins said it was too soon to say how that decision would affect the planned Medicaid cuts.

She said payment reform is a critical part of the long-term solution, along with coordinating mental health care with primary care and substance abuse treatment.

Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1339

BILL TITLE: **relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.**

DATE: February 9, 2010

LOB ROOM: 205

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, (ITL), Interim Study (Please circle one.)

Moved by Rep. R. DiPentima

Seconded by Rep. R. Bridgham

Vote: 19-0 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 19-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Joan H. Schulze, Clerk

Rep Joan H. Schulze

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1339

BILL TITLE: **relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.**

DATE: 2/9/2010

LOB ROOM: 205

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, (ITL), Interim Study (Please circle one.)

Moved by Rep. De Pentima

Seconded by Rep. Bridgham

Vote: 19-0 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: Consent

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Joan H. Schulze, Clerk

OFFICE OF THE HOUSE CLERK 2009 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 1339 Title: relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.

PH Date: 2/4/10 Exec Session Date: 2/8/2010

Motion: OTL Amendment #:

MEMBER	YEAS	NAYS
Rosenwald, Cindy, Chairman	19	
Donovan, Thomas E, V Chairman	1	
French, Barbara C	2	
Schulze, Joan H, Clerk	3	
Tilton, Joy K	4	
Butcher, Suzanne S	5	
Bridgham, Robert G	6	
Merrick, Evalyn S	7	
Russell, Trinka T	8	
DiPentima, Rich T	9	
Miller, Kate W	10	
Batula, Peter L	11	
McMahon, Charles E	12	
Pilliod, James P	13	
Emerson, Susan	14	
Case, Frank G	15	
Millham, Alida I	16	
Wells, Roger G	—	
Cebrowski, John W	17	
Kotowski, Frank R	18	
	19 0	
TOTAL VOTE:		

Printed: 1/12/2009

Committee Report

CONSENT CALENDAR

February 17, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB1339,

AN ACT relative to the state services system and establishing a commission to study uncompensated care at community mental health centers. Having considered the same, report the same with the following Resolution: RESOLVED, That it is INEXPEDIENT TO LEGISLATE.

Rep. Rich T DiPentima

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS**
Bill Number:	**HB1339**
Title:	**relative to the state services system and establishing a commission to study uncompensated care at community mental health centers.**
Date:	**February 9, 2010**
Consent Calendar:	**YES**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

The committee agrees that removing the contractual agreements between the state and the community mental health centers would not be in the best interest of either party. The use of the rulemaking process to replace contracts would not achieve the same results and would be extremely cumbersome. The committee understands that the mental health centers in New Hampshire are currently underfunded and provide substantial amounts of uncompensated care. The community mental health centers provide vital and even life-saving services to thousands of clients even in the absence of adequate state funding. These services also save the state a great deal of money by preventing the need for emergency medical care and correctional expenses. However, the committee feels that establishing a study commission is unnecessary since the problem of uncompensated care is well documented and already widely understood to be real. The resolution of this problem rests with the legislature providing the necessary funding, not with studying what we already know.

Vote 19-0.

Rep. Rich T DiPentima
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

CONSENT CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

HB1339, relative to the state services system and establishing a commission to study uncompensated care at community mental health centers. **INEXPEDIENT TO LEGISLATE.** Rep. Rich T DiPentima for HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. The committee agrees that removing the contractual agreements between the state and the community mental health centers would not be in the best interest of either party. The use of the rulemaking process to replace contracts would not achieve the same results and would be extremely cumbersome. The committee understands that the mental health centers in New Hampshire are currently underfunded and provide substantial amounts of uncompensated care. The community mental health centers provide vital and even life-saving services to thousands of clients even in the absence of adequate state funding. These services also save the state a great deal of money by preventing the need for emergency medical care and correctional expenses. However, the committee feels that establishing a study commission is unnecessary since the problem of uncompensated care is well documented and already widely understood to be real. The resolution of this problem rests with the legislature providing the necessary funding, not with studying what we already know. **Vote 19-0.**

Original: House Clerk
Cc: Committee Bill File

Rep. Dr Pentima

COMMITTEE REPORT

COMMITTEE: HHS + E

BILL NUMBER: HB 1339

TITLE: Relative to the state services system + establishing a commission to study uncompensated care at community mental health centers

DATE: 2/9/2010 **CONSENT CALENDAR:** YES [X] NO [ ]

- [ ] **OUGHT TO PASS**
- [ ] **OUGHT TO PASS W/ AMENDMENT**
- [X] **INEXPEDIENT TO LEGISLATE**
- [ ] **INTERIM STUDY** (Available only 2nd year of biennium)

Amendment No. _____

STATEMENT OF INTENT:

HB 1339, relative to the state services system and establishing a commission to study uncompensated care at community mental health centers. **INEXPEDIENT TO LEGISLATE.**

Rep Rich T. DiPentima for the Health, Human Services and Elderly Affairs: The commitee agrees that removing the contractual agreements between the state and the community mental health centers would not be in the best interest of either party. The use of the rulemaking process to replace contracts would not achieve the same results and would be extremely cumbersome. The committee understands that the mental health centers in New Hampshire are currently underfunded and provide substantial amounts of uncompensated care. The community mental health centers provide vital and even life-saving services to thousands of clients even in the absence of adequate state funding. These services also save the state a great deal of money by preventing the need for medical care and correctional expenses. However, the committee feels that establishing a study commission is unnecessary since the problem of uncompensated care is well documented and already widely understood to be real. The resolution of this problem rests with the legislature providing the necessary funding, not with studying what we already know. **Vote 19-0**

- Copy to Committee Bill File
- Use Another Report for Minority Report

RESPECTFULLY SUBMITTED,

Rep. _____
For the Committee

Rev. 02/01/07 - Yellow

HB 1339 R. DiPentima ITL 19-0 CC

The committee agrees that removing the contractual agreements between the state and the community mental health centers would not be in the best interest of either party. The use of the rulemaking process to replace contracts would not achieve the same results and would be extremely cumbersome. The committee understands that the mental health centers in New Hampshire are currently underfunded and provide substantial amounts of uncompensated care. The community mental health centers provide vital and even life-saving services to thousands of clients even in the absence of adequate state funding. These services also save the state a great deal of money by preventing the need for emergency medical care and correctional expenses. However, the committee feels that establishing a study commission is unnecessary since the problem of uncompensated care is well documented and already widely understood to be real. The resolution of this problem rests with the legislature providing the necessary funding, not with studying what we already know.