Approved: April 1, 2005
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:30 P.M. on January 26, 2005 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Ms. Terri Weber, Kansas Legislative Research Department
Mr. Jim Wilson, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Dr. Richard Warner, Psychiatrist, Shawnee Mission, KS.
Mr. Greg Scandlen, Director,
Galen's Center for Consumer Driven Health Care

Presentation on "HSAs: The Progress of Consumer Driven Health"

Upon calling the meeting to order, Chairperson Wagle stated that Senator Barnett had been working with the Flint Hills Policy group on HSAs (Health Saving Accounts) and had made arrangements for today's presentation, then turned the meeting over to him. Senator Barnett wanted to recognize two people: Mr. Jerry Slaughter, who had contacted him about this opportunity and Dr. Richard Warner, who knows the topic and Mr. Greg Scandlen well.

Dr. Warner offered two articles regarding health care inflation. Copies of his handouts are (Attachment 1) attached hereto and incorporated into the Minutes as referenced. He then introduced Mr. Greg Scandlen, Director of Galen's Center for Consumer Driven Health Care, who offered information regarding "Consumer Driven Health Care: New Tools for a New Paradigm." A copy of his presentation is (Attachment 2) attached hereto and incorporated into the Minutes as referenced. Highlights included:

- Essential Problems in Health Care
- Sources of Health Care Spending
- Does the US spend too much or too little on health care?
- How much change is needed?
- Third Party Payment and Two-Party Contacts
- Employer-based Health Care and Employer-based Tax Subsidy, by Household Income, 2004
- Obstacles to Reform, The New Paradigm and Milestones of Reform
- Health Reimbursement Arrangements (HRAs)
- Health Savings Accounts (HSAs)
- Prospects and Consequences, and
- Contacts

The Chair thanked Mr. Scandlen and asked the Committee for questions or comments. Senators Journey, Wagle, Barnett, and Palmer and Ms. Correll asked a range of questions including: do you have a website available, do you see how Medicaid treated with HSAs, are HRAs all that is available or do you need an additional insurance to cover something like a high cost with severe illnesses, other than HSAs where do you see us going next, centralization centers, how can we in Kansas better extend HSAs, method of reimbursement, if an employer remains a part does this mean there is need to be an offering of other plans and what type of incentive is there for low income workers with high deductible?

As there was no further questions or discussion, Chairperson Wagle thanked the conferees and the Committee.

Adjournment

As there was no further business, the meeting was adjourned. The time was 2:30 p.m.

The next meeting is scheduled for January 27, 2005.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

SENATE **HEALTH CARE STRATEGIES** COMMITTEE

GUEST LIST

45 in att.

DATE: January 26, 2005

NAME	REPRESENTING
Rebecca Bailey	KMS
Jerry Slaughter	KMS
George Pearson	Flint Hills Center
MATT HISRICH	" " "
Chad Austin	KHA
Melissa Hungerford	KHA
TERRY FORSYTH	KNEA
Brad Womack	NEA-Silver Lake
Kim Cunningham	NEA-Seaman
Jaime Holstin	NEA-Seaman
Anna Moon Bradley	MdCU TA
Jenny Davis	Conlee Consulting
Chip Wheelen	Asn of Osteopathic Med.
[illegible]	Ks Chamber
[illegible]	KID
TERRY HOLDREN	KANSAS FARM BUREAU
David Cunningham	KASB
KEN DANIEL	KsSmallBiz.com
Josie Torrez	SILCK

SENATE HEALTH CARE STRATEGIES COMMITTEE

GUEST LIST

DATE: January 26, 2005

NAME	REPRESENTING
Linda Lubensky	KS Home Care Assoc.

Relief from health care inflation may be possible

Richard Warner, MD; Guest columnist

Relief from the rapidly escalating costs of health insurance and prescriptions may now be possible, as the effects of a June Internal Revenue Service ruling start to work their way through the health care economy.

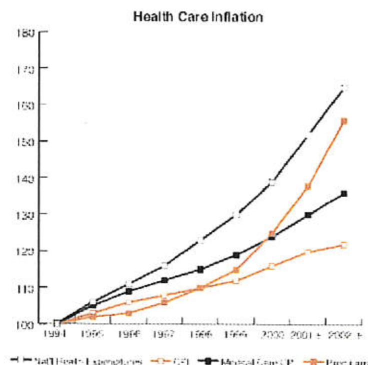
At the request of Aetna Insurance Company and many others, the IRS reviewed the tax treatment of employee personal health spending accounts. Previously these have only been available through Flexible Spending Accounts, which have been funded by the employee's pre-tax dollars. These have been "spend it or lose it" accounts, as unspent funds must revert to the employer at the end of each fiscal year.

The new ruling would allow the creation of a new kind of policy, called a Health Reimbursement Arrangement, which resembles a Medical Savings Account. These accounts can be funded by the employer. This is in addition to whatever portion of the employee's health insurance premium is paid by the employer. This allows the employee to have money available to meet first dollar expenditures, and the accounts would most logically be used with high deductible insurance. This will give individuals more control in their choice of doctors, tests, and treatments. Furthermore, employees' unspent funds can now be rolled over year to year, and the employer is authorized to allow employees continuing access to the accumulated funds in the event of their leaving the job. Instead of being drivers of medical inflation, these accounts now become inhibitors of inflation.

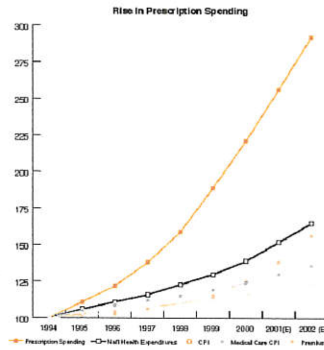
The need for this relief is illustrated in two graphs of data, adapted from a recent report from the Blue Cross and Blue Shield Association, *Drivers of Health Care Costs, 2002.*

In this first graph (below) several categories of percentage increases in spending have been represented as indexes starting with a value of 100 in 1994. The graph represents a number of trends:

- overall inflation in the U.S. economy since 1994 as measured by the Bureau of Labor and Statistics Consumer Price Index
- a sub index of the CPI representing unit cost increase of components of medical care (e.g. the price of pills, procedures, doctor's office visits, etc.)
- the rise of actual health care spending, comprised of money spent on health insurance premiums and out of pocket medical expenses
- the growth in health insurance premium spending, which in 1998 began rising more swiftly than the others.

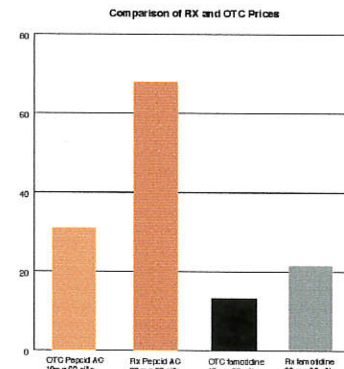


One can speculate why the health insurance premium line is rising so much more rapidly than the actual medical care CPI. I suspect it represents both increasing administrative costs of our current health insurance plans and increasing utilization (which all the increased administrative spending is failing to contain).



This second graph (above right) adds another line, representing the rise in prescription spending. Its rate of rise dwarfs the other lines and is the source of much consternation in the world of health care planning. Clearly such a rise is not sustainable, and the phenomenon is inviting Congressional action with everything from a Medicare prescription benefit to various measures that would directly modify the pharmaceutical marketplace.

I would suggest that the parabolically rising levels of prescription spending and health insurance premiums are reinforcing each other in a vicious circle. Insurance companies certainly cite the rise in prescription spending as to why their premiums are increasing at double digit rates. What is less commonly appreciated is the way in which insurance benefits are affecting the prices of prescriptions. Most insurance benefits are constructed with relatively low, fixed-dollar co-payments, to be paid by the consumer. This leaves the consumer with no incentive to care about the total cost of the prescription nor to shop in ways that would affect that cost.



The most striking evidence of this effect shows up in the pricing of a few medications that can be obtained either in higher dosage form with a doctor's prescription or in a lower dosage form across the counter. An example (illustrated above) is the popular stomach acid controller, Pepcid AC,, which can be obtained as a 20mg pill with a doctor's prescription or as a 10mg pill over-the-counter (OTC). Data provided by eight Kansas City area pharmacies found the average price of a 30 pill quantity of 20mg Pepcid AC, to be $67.94. The price of 60 pills of the 10mg OTC form of the same branded medicine was $21.33. Why the three-fold difference? The doctor prescribed form is covered by insurance. The OTC form is not.

A survey of eight pharmacies, comparing equivalent amounts of doctor-prescribed medications and their OTC counterparts, gathered data on eight medicines. They were studied both in their brand name and generic forms. In all cases the prescription pills were priced higher than the OTC pills. The price differences ranged from 20 percent to 490 percent, with half of the prescriptions costing twice as much or more than their OTC equivalents.

Another interesting finding of the survey is that prices for a prescription may vary two or three-fold among the various pharmacies.

We commonly think of prices as something set by sellers, and have too little appreciation of the role of buyers, who agree to pay prices. By having percentage based coinsurance benefits that would require their paying 20, 30, or 40 percent of the price of their medicine, consumers will exercise more discretion in the prices they are willing to play. In turn they will force pharmacies and pharmaceutical companies to be more competitive in their pricing. If linking such coinsurance requirements to personal Health Reimbursement Arrangements were to become the most common paradigm, it would likely slow the rising prices of both prescriptions and health insurance premiums.

More generally, Health Reimbursement Arrangements, by giving individual consumers an asset to protect, promise to become the most effective constraint of medical inflation. An editorial in the *Wall Street Journal* on July 2, 2002, announcing the IRS ruling, reported the fact that Humana has instituted such a plan for its employees. It says that instead of the previously projected 19 percent rise in its health care costs, it now is enjoying a less than 4 percent year over year increase. If this approach can achieve that restraint of inflation, while giving employees more choice and control in their health care decisions, it should gain rapid acceptance. ▲

Dr. Warner is a psychiatrist practicing in Shawnee Mission, Kansas.

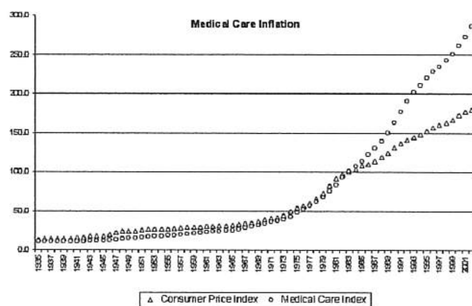
Senate Health Care Strategies Committee
Date: January 26, 2005
Attachment 1

Medical care inflation

Richard Warner, MD: KMS Second Vice President

The number of American people who do not have health insurance coverage is a matter of great concern to policymakers. We hear increasing calls for adoption of some plan for universal health coverage. Last winter the American Medical Association adopted a resolution calling for health coverage for all Americans by 2009. Politicians at both the presidential and the congressional levels are offering variations on the same theme.

As health care has become so expensive, people have come to rely as much as possible on insurance to finance their care. As universal coverage is made into an absolute value, attention is focused on questions of who would provide the insurance. Would it be a government monopolized "single payer" system? Or would all employers be mandated to provide health insurance for their employees with the federal government providing insurance for people who are not employed? Or might we encourage more individual ownership of health insurance through the use of tax credits? Unfortunately, framing the issue in terms of the urgency of achieving universal coverage distracts attention from what is a more fundamental question: How have the prices of both medical care and the insurance that would pay for it gotten as expensive as they have?



The accompanying graph of sixty-eight years of price data drawn from the Bureau of Labor Statistics illustrates two facts. First is that we live in a constantly inflationary environment with the Consumer Price Index rising dramatically and steadily since the early 1970's. That was when President Nixon ended the last vestiges of linkage of the U.S. dollar to our gold reserves and allowed the only limit on dollar creation to be the wisdom of the Federal Reserve Board of Governors. The second fact is that medical care price increases have been in the vanguard of that inflation since the early 1980's.

If we would construct an index of health insurance premiums, we would find that it rises even more precipitously than the CPI and the Medical Care Index. All of this should make us wonder, what is this inflation and what policies aggravate it?

A helpful perspective on inflation could be gained by graphing these indices in a different way, which would illustrate the loss of dollar buying power in relation to the goods and services purchased. To do so we would merely need to invert the graphs to see that the overall value of a dollar is 23% of what it was in 1972 and for medical purchases it has held only 14% of its value.

To look at the matter in terms of the value of a dollar, it is further helpful to think of the various ways in which dollars are experienced. When I make a purchase, I will use some combination of three kinds of money. For most items I will spend MH, money I have. For some purchases I will spend MEH, money I expect to have (credit). Finally, I might be able to spend ME, money to which I am entitled (insurance or government entitlement).

If I am spending MH, I will likely exercise more discretion in my purchase than I will if I am spending ME. I will search out the best value for my MH, and I will be more conscious of the price of the purchase. I will demand that I get my money's worth, and I will not continue spending on something that does not offer enough value. If I am spending ME, I might exercise more discretion if I know that I will have to pay more MH (in taxes or health insurance premiums) in the future to have access to the ME. But since my own MH contribution to the ME pool is relatively diluted, I am not nearly so motivated to shop wisely. In fact, if I think I am already paying a high price in MH to have access to the ME, then I may feel entitled to get my fair share of the ME and be motivated to spend more freely.

Too often we think of prices, particularly for medical goods and services, as simply set by the sellers. We pay too little attention to the role of the buyers in agreeing to pay the prices asked by the sellers. When individual patients are using mostly insurance or entitlement benefits to pay for prescriptions and services, their role in restraining the rise of prices is diminished. The key to restraining medical inflation is having patients participate with their own MH in some significant part of the price of each medical transaction.

Based on this way of thinking, here are some policies that can contribute to the effort to contain medical inflation:

- Make prescription benefits percentage-based coinsurance rather than fixed dollar co-payments. Even tiered co-payments only influence the choice of whether to get a prescription. They do not encourage the patient to shop for the best total price. If everyone were doing so, the collective effect would be to hold down pricing.
- Use percentage-based coinsurance for physician services for the same reason.
- Indemnity benefits that pay a certain amount toward a provider's fee but allow discretion in the setting of charges above that amount would allow more flexibility in how providers set their charges. That would allow them to offer individualized discounts to patients in need.
- Open up the market for personal savings accounts, tax advantaged accounts that encourage saving money to use for coinsurance, deductibles and discretionary medical purchases. This would allow people to rely less on health insurance, and they would be able spend less on insurance premiums.
- Encourage employers to make defined contributions toward their employees' health insurance premiums and saving accounts. Allow the employees to choose from a variety of plans and pay with their own money the marginal dollars above the employer's contribution for the premium. This will bring more realism to peoples' expectations of their insurance.
- Encourage incentives for individuals and insurance companies to achieve more longitudinal relationships, rather than changing after a few years to other plans. In this way insurance plans would be able to reward younger and healthier customers to build up credits that could offset premiums later in life. Also, there would be more incentive to take prudent preventative measures.

The thrust of this analysis is to suggest that an important factor in health care and health insurance both becoming so costly has been our reliance on health insurance plans that have sought to spare people all but the least costs of their health care. To place the highest priority simply on achieving universality of health insurance coverage may only aggravate that inflation further. Whatever financing plans are developed, if they do not sufficiently consider the role of individuals in containing inflation, they will likely bring about more inflation. Our goal should be to achieve health insurance coverage that is both equitable and sustainable. ▲

1-2

Consumer Driven Health Care: New Tools for a New Paradigm

Greg Scandlen
Galen Institute

Senate Health Care Strategies Committee
Date: January 26, 2005
Attachment 2

1 Consumer Driven Health Care:
New Tools for a New Paradigm

2 Essential Problem in Health Care

3 Sources of HC Spending

4 Does the US spend too much
or too little on health care?

5 How Much Change is Needed?

6 Third Party Payment

7 Two-Party Contracts

8 Employer-Based Health Care

9 Employer-Based Tax Subsidy,
by Household Income, 2004

10 Obstacles to Reform

11 The New Paradigm

12 Milestones of Reform

13 Milestones of Reform

14 Health Reimbursement
Arrangements (HRAs)

15 Health Reimbursement
Arrangements (HRAs)

16 Health Savings Accounts (HSAs)

17 Health Savings Accounts (HSAs)

18 Health Savings Accounts (HSAs)

19 Health Savings Accounts (HSAs)

20 Health Savings Accounts (HSAs)

21 Prospects

22 Consequences

23 **Contact:**

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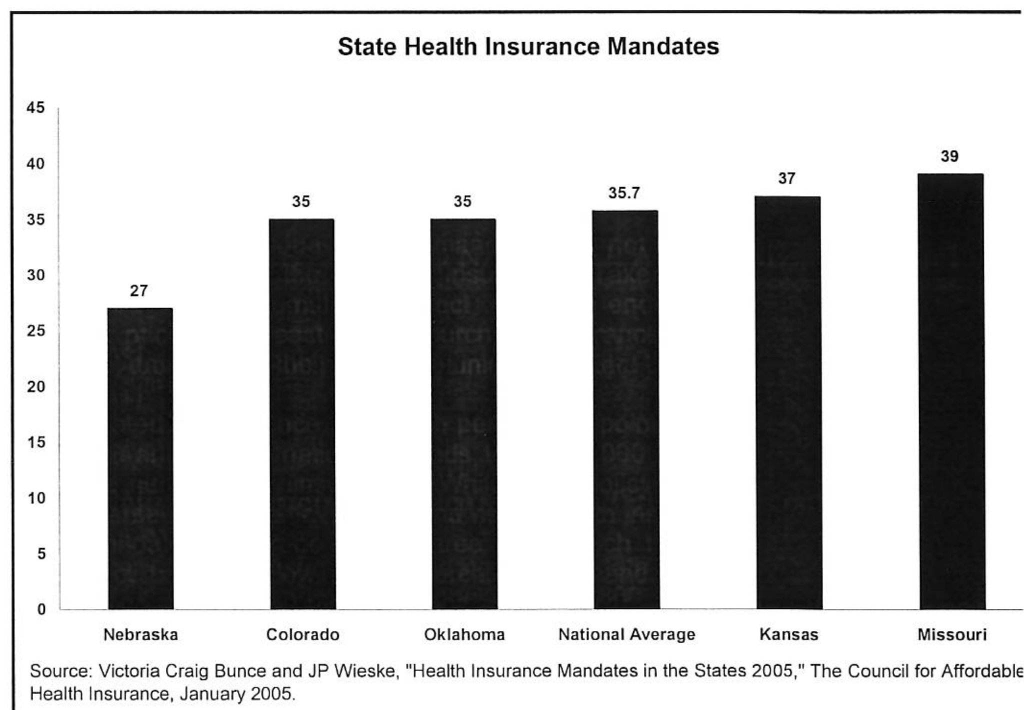
KANSAS HEALTH INSURANCE MANDATES EXCEED NATIONAL AVERAGE

The number of health insurance mandates at the state level is increasing nationally and now number over 1,800 in all. Examples of typical mandates include the coverage of diabetes supplies, mammography screening and chiropractic care. [1]

A new study reveals that Kansas outpaces the national average as well as most of its neighbors when it comes to imposing mandates on health insurance coverage. With the exception of Nebraska, Kansas and all its neighboring states hover around the national average. Kansas and Missouri, however, both exceed that average. [2]

When considered individually, each mandate may not appear to add significantly to the price of insurance. Taken as a whole, though, the cumulative effect is large enough to potentially price those least able to purchase insurance out of the market and expand the pool of the uninsured. [3]

It is estimated, for instance, that each percentage-point rise in health-insurance costs nationally leads to a 300,000 person rise in the number of uninsured. [4] While state policymakers do not oversee of all the factors behind rising health insurance costs, mandated coverage is one area over which they do have direct control. Allowing the purchase of mandate-free policies – as neighboring Colorado has already done – would offer the potential of significant savings off of traditional policies. [5]



Source: Victoria Craig Bunce and JP Wieske, "Health Insurance Mandates in the States 2005," The Council for Affordable Health Insurance, January 2005.

2-3

Notes

[1] Victoria Craig Bunce and JP Wieske, "Health Insurance Mandates in the States 2005" (Alexandria, VA: The Council for Affordable Health Insurance, January 2005). Available at: http://www.cahi.org.

[2] Ibid. These numbers include Washington, D.C. The national average rises to 36.16 with the District of Columbia removed, but Kansas and Missouri remain above average.

[3] Ibid.

[4] R. Glenn Hubbard, John F. Cogan and Daniel P. Kessler, "Healthy, Wealthy, and Wise," *The Wall Street Journal*, 4 May 2004.

[5] Matthew Hisrich, "State Mandates reduce insurance affordability," The Flint Hills Center, May 2004.

2-4

REFORMING MEDICAID

THE SOUTH CAROLINA PLAN

25

SOUTH CAROLINA MEDICAID CHOICE REFORM

- SOUTH CAROLINA MEDICAID PLAN
- A.) ACUTE CARE - FEE FOR SERVICE, SMALL HMO
- B.) DISABLED - COST BASED REIMBURSEMENT
- C.)NURSING HOME/LTC – COST BASED REIMBURSEMENT

- TYPICAL MEDICAID PLAN AND PROBLEMS
- 1.) BENEFICIARIES AND PROVIDERS HAVE THE "WRONG" INCENTIVES
- 2.) NO REAL MARKET PLACE EXISTS WITH ADMINISTERED PRICING
- 3.) NO INCENTIVE FOR INNOVATION AND
- PRODUCTIVITY
- 4.) LOW QUALITY CARE

- **ACUTE CARE REFORM**
- **A.) BENEFICIARIES WILL RECEIVE A PERSONAL HEALTH ACCOUNT (PHA) TO PAY FOR PART OF THEIR HEALTH EXPENSES**
- **B.) ACCOUNT BALANCES WILL "ROLL OVER" AND INCLUDE PARTIAL PORTABILITY TO A PRIVATE HSA OR FOR PURCHASE OF MORE TRADITIONAL HEALTH INSURANCE**
- **C.) PSA IS COMBINED WITH CATASTROPHIC COVERAGE OF LIMITED BENEFITS (INPATIENT HOSPITAL, PHYSICIANS VISITS, LIFE THREATENING DRUG COVERAGE, LAB & X-RAY)**

- D.) CATASTROPHIC COVERAGE ITEMS WILL HAVE SIGNIFICANT CO-PAYS PAYABLE WITH PSA FUNDS. PREVENTATIVE CARE ITEMS WILL NOT HAVE A CO-PAY (IMMUNIZATIONS, BLOOD PRESSURE SCREENING, ...)

- E.) PSA FUNDS MAY ALSO BE USED TO BUY DRUGS/DRUG PLAN, DENTAL, PODIATRIC, EYECARE AND SO FORTH AT MEDICAID INSURANCE & PROVIDER EXCHANGE (A HEALTH MART)

- E.) ACTUARIAL VALUE OF CATASTROPHIC COVERAGE AND PSA MAY BE USED TO BUY PRIVATE SECTOR INSURANCE PLANS AT THE IPE (NETWORK PLANS, HMO'S, PRIVATE SECTOR HSA PLANS, ...)

- F.) RISK ADJUSTMENT WILL BE THROUGH MEDICAID "REINSURANCE" OF MAJOR MEDICAID EXPENSE AREAS (NEO-NATAL, TRANSPLANTS, ...)
- G.) NEAR POOR MAY TAKE FUNDS ON A SLIDING SCALE TO PURCHASE PRIVATE INSURANCE, INDIVIDUAL AND SMALL GROUP MARKET WOULD BE ALLOWED TO BUY AT IPE
- G.) MEDICAID WILL CHANGE FROM DETERMINING PRICES TO BECOMING FINANCIER, SETTING RULES AND MINIMUM STANDARDS AND PROVIDING INFORMATION

- H.) OUTCOME – SHORT RUN REDUCED UTILIZATION BECAUSE OF COST SHARING, PREVENTATIVE CARE AND MANAGING OF HIGH DOLLAR COSTS, LONG RUN PRIVATE SECTOR INNOVATION, FEWER RECIPIENTS AND FEWER UNINSURED IN THE STATE

- **COMMUNITY CARE REFORM FOR DISABLED AND FRAIL ELDERLY**
- **INDIVIDUALS WHO ARE CARED FOR IN THE COMMUNITY AND RECEIVE SPECIFIC ITEMS AND SERVICES PAID FOR BY MEDICAID, THESE ARE STANDARD SERVICES THAT ARE OFTEN NOT TAILORED TO INDIVIDUAL NEEDS, RESULT – HIGH COST AND LOW QUALITY**

- **REFORM INVOLVES CASE RATING OF EACH INDIVIDUAL ON SEVERITY OF THEIR NEEDS, INDIVIDUALS OR GUARDIANS WILL RECEIVE PSA (80-90% OF CURRENT COSTS) FOR PURCHASES OF NEEDED GOODS AND SERVICES (INCLUDING FROM FAMILY), UNUSED FUNDS MAY BE ROLLED FOR FUTURE HEALTH CARE USE**

- **PROFESSIONAL SERVICES FOR THIS GROUP WILL BE BID AT IPE, ALSO POSSIBILITY OF VENDORS OFFERING GROUP DISCOUNTS AT IPE (WHEEL CHAIRS, OXYGEN, ...)**

- **OUTCOME**
- **DISABLED BECOME FULL CONSUMERS, SHOP FOR BEST PRICES.**
- **USE FUNDS TO DEAL WITH DIVERSE INDIVIDUAL NEEDS**
- **EXPENSIVE BUREAUCRACY OF PUBLIC FUNDED PROGRAMS IS REDUCED**

PROVIDERS CAN OFFER THEIR SERVICES IN A TRUE ECONOMIC ARENA, MEDICAID'S ROLE SHIFTS TO BENEFICIARY EDUCATION AND GUIDANCE.

- INSTITUTIONAL LONG TERM CARE
- THIS TYPE OF CARE HAS A COMMON UNIT OF SALE, DAY OF CARE, CURRENTLY REIMBURSED ON A COST BASED FORMULA FOR NURSING HOMES AND ICF'S
- RESULT IS PREPONDERANCE OF INEFFICIENT, HIGH COST PROVIDERS

- **MEDICAID WOULD DETERMINE ELIGIBLES FOR CARE AND THEN AUCTION OFF AMOUNT TO PROVIDERS, LOW BIDDER WOULD SUPPLY 100 BEDS AT $80 PER DAY, NEXT LOWEST 200 BEDS AT $85 AND SO FORTH UNTIL NEED IS COVERED**

- **BIDDING WOULD BE AS NEED ARISES SO CURRENT BENEFICIARIES WOULD NOT HAVE TO MOVE (CURRENT TURNOVER AROUND 20% PER YEAR), BIDDING WOULD BE THREE YEAR CYCLE, AMOUNT ADJUSTED ANNUALLY BY A "QUALITY" INDEX**

- OUTCOME

- ICF'S RUN BY STATE WOULD "BID" AS WELL, NO MORE COST BASED PAYMENTS, PRIVATE SECTOR PROVIDERS WOULD ALSO BE ALLOWED TO BID AT IPE WITH ADJUSTMENTS BASED ON "QUALITY" INDEX

- ELIMINATES NURSING HOME AND ICF "MONOPOLY", MARKET FORCES DRIVE EFFICIENCY AND QUALITY GAINS, STATE OVERHEAD IS REDUCED BY ELIMINATION OF AFTER THE FACT COST AUDITS

- EXPECTED PROGRAM OUTCOME

- INITIAL EFFICIENCY GAINS IN RANGE OF 5-15% DEPENDING ON STATE PLAN

- SLOWDOWN IN LONG-RUN GROWTH RATE AS INNOVATION PRODUCES GREATER EFFICENCY

Empoweredcare.com
Florida Medicaid Reform Plan
Tuesday January 11, 2005

GOVERNOR BUSH ANNOUNCES PLAN TO TRANSFORM MEDICAID
~Proposals to put patients first~

TALLAHASSEE – Governor Bush today unveiled his plan to ensure Florida's most vulnerable families continue to receive the quality health care they need, recommending reforms that will empower Medicaid patients to direct their own health care as never before. The reforms will also bring predictability to state spending on Florida's $14 billion Medicaid program. Medicaid, the state-federal partnership charged with providing health care to more than 2.1 million vulnerable, disabled and elderly Floridians, has not undergone significant reform since its inception more than 30 years ago.

"To fulfill our commitment to Florida's Medicaid program, we must transform it completely so that the number one priority is patient wellbeing and the last consideration is government control," said Governor Bush. "Our proposals put the focus back on the patient by encouraging strong patient-doctor relationships and allowing competition in the market to drive access and quality of care up from current levels in the Medicaid system."

The multi-faceted growth of Medicaid has produced a complex maze of multiple, even conflicting components. Medicaid in Florida has continued to grow unchecked. If Florida's Medicaid program continues to grow at its present rate, it will consume nearly 60 percent of the state's budget by 2015. While state tax revenue has grown by 24 percent between 1998 and 2004, Florida's share of Medicaid has grown by 88 percent in the same period. At a total cost of $14 billion this year, combined federal and state spending on Medicaid has grown by 112 percent since 1999.

"Florida's Medicaid system will collapse under its own weight if we do not fundamentally transform the way it operates," said Governor Bush. "The changes we're proposing will help create more predictable and sustainable growth in Medicaid costs and ensure the program meets the needs of Floridians who rely on it for health care."

Governor Bush today announced the major components of his Medicaid transformation initiative, empowering participants and putting patients first, which includes the following:

Defining a Patient-Centered Vision

• The transformation begins by empowering Medicaid participants to make choices about their own care. Health care providers will create benefit packages falling into a combination of three components: basic care, catastrophic care and flexible spending. Participants — with the help of choice counselors — will choose the plan that best meets their

2-19

needs.

• Medicaid participants will be able to build a "bridge to independence" by "opting out" of Medicaid plans and using their state-paid premium to purchase insurance in the private market.

• Participants will also be able to participate in a new feature of the benefit structure that encourages healthy practices and responsible lifestyle choices by giving Floridians the ability to earn enhanced benefits through flexible spending accounts. These enhanced benefits will give participants extra funds to buy increased coverage or services through their care plan.

Creating a Medicaid Marketplace:

• Governor Bush's reform proposal will give providers greatly improved flexibility in designing service plans. In addition to basic, catastrophic and flexible spending services, providers will be free to compete for the membership of participants by offering innovative care, convenient networks, and optional services. Participants won't be limited to HMOs and insurance plans. Options like Provider Service Networks and innovative community-based systems will also be available to meet the unique medical needs of participants.

• Participants in the basic or catastrophic plan will have access to all types of mandatory health services such as professional care, hospitalizations, and diagnostic services among others.

• Instead of the state setting the amount or scope of services, the competing vendors will be allowed to offer different packages that may appeal to different consumers. The state will continue to allocate the premium to each of the three categories based on historic spending patterns.

"Florida can't afford to wait any longer for real Medicaid reform legislation. This proposal is the starting point for a Medicaid program that Florida can live with well into the future," said Agency for Health Care Administration Secretary Alan Levine.

The Governor was also joined in Tallahassee by Department of Health Secretary John Agwunobi, M.D., M.P.H., M.B.A., Department of Elder Affairs Interim Secretary Susan Tucker, Department of Children and Families Secretary Lucy Hadi, Agency for Persons with Disabilities Director Shelly Brantley and Dr. Nelson Adams of PhyTrust.

Mrs. Amparo Valdes, a Medicaid participant from Miami who was diagnosed with diabetes, was also in attendance. Under the reformed Medicaid system, Mrs. Valdes and her doctor would enjoy much greater flexibility in managing her care.

The Florida Agency for Health Care Administration last year held a series of public meetings to engage participants, providers, physicians, the business community, non-profits, advocates and the media to collect feedback and ideas for reforming Medicaid. The discussions resulted in many approaches and strategies that contributed to the formulation of Governor Bush's proposals to the Florida Legislature.

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For more information on Governor Bush's proposal, please visit, www.empoweredcare.com or www.myflorida.com.

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New Hampshire's

GraniteCare

Recommendations to Modernize Medicaid

John A. Stephen, Commissioner
New Hampshire Department of Health and Human Services
November 10, 2004

In Memory of Terry L. Morton
Commissioner, Department of Health and Human Services
1995 – 1999

The following editorial appeared in the March 22, 1998 edition of Foster's Daily Democrat. The late Terry Morton, Commissioner of the Department at that time, foresaw a looming problem for New Hampshire based on the growth of its elderly population and the State's lack of response to the social and financial implications of this growth. Published more than 5 years ago, the editorial credited Commissioner Morton with having "rung the alarm bell" by predicting an upcoming financial crisis for the State greater than the school funding issue. That crisis is now on the State's doorstep:

03/22/98

It will happen

Long-term health care has to undergo change

Editorial by *Foster's Daily Democrat*

Terry Morton will have to fight this year's battle to change long-term health care legislation by himself. Gov. Jeanne Shaheen isn't signing on - not right now, at least.

Morton and his people at the state's Department of Health and Human Services have developed a program that, if enacted, would make some far-reaching changes in terms of public policy in long-term health care practices.

Morton's plan is to shift the emphasis of long-term care from nursing homes to intermediate care facilities and home care. Intermediate care is generally defined as adult day-care, shared or congregate housing, assisted living and residential care.

The direction in which Morton wants to take long-term health care in New Hampshire is not without good reason. The elderly share of the population is growing more rapidly than any other segment. We are not many years away from a socio-economic crisis that, according to the health and human services commissioner, will outstrip the one in Social Security.

We're living longer than we used to, and medical science will have us living even longer.

The rising level of life expectancy is going to create a genuine crisis in the not-too-distant future. While we live longer, so too will we be dependent on long-term care longer. We aren't curing diseases of the aged as rapidly as people are aging.

Terry Morton is telling us something we seldom like to hear - we are at the point where someone has to make some hard choices.

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We don't blame Gov. Shaheen for wanting to move slowly on the subject. It's political dynamite. She doesn't want to be labeled as the governor who started kicking people out of nursing homes.

The fact is that Morton's plan has nothing to do throwing people out of nursing homes. It has everything to do with providing the care that is needed and doing it in a cost-effective manner. Don't think for one moment that the association representing New Hampshire's ten counties would be behind Morton on this one if they expected to hear wails of anguish from patients or the families of patients who are in county nursing homes.

The cost of long-term care for the elderly poor in New Hampshire reached $175 million at the end of June. It is expected to soar to $210 million in little more than two years.

Gov. Shaheen says the long-term health care program has commendable goals, but she doesn't want to see the current system changed too quickly.

She has little to worry about. The Legislature has no more desire to take on the private nursing home industry and patient advocate groups than does the governor. Terry Morton's plan is dead on arrival.

Morton is a lightning rod. He is the kind of person who works best with expanded authority - the kind of authority that has been given to him by the Legislature to cut costs. He is riding herd on an agency that has an operating budget of almost $1.5 billion for the current biennium.

And the Legislature has been happy to leave him out in the field holding a five-iron in the air. And when the storm clouds gather - as they certainly have in the past - it's Terry Morton who gets hit with the lightning bolt.

Morton's proposal on long-term health care is one that suggests he is ahead of the curve. But it's not a place in which elected officials want to be, so Morton will stand alone in the weeks and months ahead and - most likely - he'll be back in the private sector when his term expires in January.

Long-term health care reform, like Social Security, will be delayed until the state's fiscal well-being is threatened to an even greater extent than it is in the wake of Claremont II.

When it happens, we hope someone has enough integrity to admit it was Terry Morton who rang the alarm bell in the closing days of the winter of 1998.

Please note chart on page 55 relative to New Hampshire's budget drivers from 1993 through 2003

Message from the Commissioner

The New Hampshire Department of Health and Human Services (DHHS) is pleased to present "GraniteCare," its proposed concepts, to modernize and rebalance the State's Medicaid program. The Department began this effort over 7 months ago when challenged by federal Secretary of Health and Human Services, Tommy Thompson, to design a Medicaid program specifically for New Hampshire.

The demographics of New Hampshire, like the nation, are shifting. Population data suggest a rapid expansion of residents over 65, and particularly those over 85 - the seniors most likely to need medical assistance for their long-term care. The cost of providing long-term care for these individuals will expand enormously should change not be made. New Hampshire currently does not have the institutional capacity to treat the influx of these needy seniors, and the cost to do so would have a substantial impact on the taxpayers of the State. The Department's current spending on long-term care is projected to increase from $279 million this year to over $557 million by 2015 (see page 56).

The cost structure of the existing Medicaid Program is unsustainable. Medical cost inflation, the aging population and an increase in consumers receiving care in costly settings have created a growth rate that will outstrip State and county ability to fund these services without sizeable and repeated tax increases or significant reductions in eligibility and benefits. At present, Medicaid is the largest item in the state's budget totaling $800 million. In 10 years, without changes, that number will grow to $1.96 billion. (Please note Medicaid Spending Trend on page 57). In addition, the State faces the loss of over $100 million of federal Medicaid funding in the upcoming biennium.

This challenge is one that each state faces. According to the National Association of State Budget Officers' annual State Expenditure Report, Medicaid has now become the largest single cost to states nationally. In New Hampshire, Medicaid is the largest single expenditure item for the State.

The State is rapidly approaching the point at which decisions for the future need to be made. GraniteCare is the Department of Health and Human Services' recommendations for change.

The Department welcomes your review of the GraniteCare proposals. It understands there will be much discussion on the concepts presented. The Department knows and appreciates the federal and legislative oversight to which the GraniteCare proposals will be subject.

Following the introductory material on the next several pages, please find the GraniteCare proposals, divided into 3 sections. In the first section are the proposals that the Department labels as transformative. These are significant changes proposed to New Hampshire's current Medicaid Program. Section II contains proposals to help support and round out GraniteCare. The third section consists of recommendations and ideas that were formulated during GraniteCare's development. Although they may not be directly associated with designing a new Medicaid program, each deserves consideration on its own individual merit.

The Department believes GraniteCare best safeguards the future well being of both the consumer who uses Medicaid services and the citizens whose tax dollars fund those services.

The Department seeks your input on GraniteCare. In developing the GraniteCare proposals, the Department listened to, and appreciated, the comments and suggestions received from a variety of stakeholders and the general public. Your input continues to be critical as GraniteCare is refined. Directions for commenting are found at the end of this report.

John A. Stephen
Commissioner

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Background - GraniteCare

"Of all the social policy and state budget challenges we face, Commissioner, I'm sure you would agree that Medicaid is the most complex." (Rockingham County Community Forum)

At present, Medicaid serves approximately 138,000 people each year. However, there are a large number of people who enter and leave Medicaid during the course of the year as the approximate length of stay on Medicaid averages 6 months. At any given time, the number of New Hampshire residents using services is approximately 98,000.

Generally, Medicaid eligibles include low income adults with children; elderly individuals with little income; disabled adults, including both physically and mentally disabled adults and those with traumatic brain injury; pregnant women with certain income levels; and children living at home with a single parent at certain income levels. For a breakdown of the income levels for certain eligible Medicaid recepients and the designated percentage of the federal poverty levels, please see pages 58 – 59.

This fiscal year, New Hampshire will expend a projected total of $881 million for direct Medicaid services. $440.7 million in federal funds; $376.7 million in General Funds. Please see page 60 for DHHS' Medicaid expenditures by programs/services in SFY 2003.

New Hampshire's current Medicaid program is collection of processes that run inefficiently and often are disconnected from one another. This is not the result of malice or a desire for waste. Instead, each process was designed separately and placed under the umbrella of DHHS. There is little systematic coordination among service delivery systems and a lack of integration. This disorganization of resources poorly serves both Medicaid consumers, who do not receive the best treatment, and the taxpayers of the State who must pay for these services.

New Hampshire's Medicaid Program has separate operations that direct care for people with developmental disabilities and behavioral health, long-term care and substance abuse needs. In many ways, there exist walls between these functions that force those who have co-occurring illnesses to leave one system to enter another. For instance, studies estimate that 65% of those with behavioral health illnesses also have a substance abuse problem. The services systems can be described as "silo" structures, which breed inefficiency and force users into separate systems of care, as opposed to individualizing services to them to meet their needs.

Additionally, those using Medicaid often have little choice over the services they receive. Consumer empowerment is limited at best in today's Medicaid. While the private health care market is moving to consumer-directed care, Medicaid rigidly directs consumers to predetermined vendors, who may or may not possess particular expertise with the person's needs.

The long-term care of New Hampshire's poor seniors is primarily provided in nursing homes. Despite the stated desire of many seniors to stay in their own homes as well as the significantly lower cost of home and community based care, Medicaid is designed to serve these individuals in a nursing

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facility environment. While the State has moved away from institutional settings within both its mental and developmental disability populations, New Hampshire continues to rely too heavily on nursing facilities for its seniors who need long-term care (see page 61).

Moreover, the Medicaid program also has only limited services that focus on prevention. Instead, Medicaid users often wait for conditions to worsen until they require more costly acute care, often in emergency rooms. There is no care management, with goals and activities to achieve better health outcomes, nor do consumers have a "medical home." Disease management is not practiced.

Finally, there lacks consistent standards for the determination of rates paid to providers across the Medicaid program. There is no incentive to produce quality health outcomes on the basis of performance for those who use Medicaid services. Presently, rates are often set on the basis of advocacy to the legislature during the budget process, with no mechanism to pay for performance. A handful of states across the country have implemented a performance-based rate structure that incentivizes providers to deliver quality outcomes based on defined performance measurements.

GraniteCare is a proposed system of care that would address these issues without reducing eligibility levels or services. GraniteCare provides medical, developmental and rehabilitative services to those in need in New Hampshire, including those citizens with disabilities, both behavioral and physical, and the poor, with an emphasis on children and seniors. Administered by the Department of Health and Human Services, GraniteCare would reform the service delivery system to focus on each consumer and to shape the treatment to meet the needs of that individual. Its goal is to view each consumer as a whole and deliver care in a manner that emphasizes prevention, improvement and independence. Unlike many health insurance plans, GraniteCare strives to reduce the number of those served, for that means GraniteCare has helped these consumers achieve independence.

The concepts driving GraniteCare are the result of an open planning process that sought broad community and key stakeholder input. The development process for GraniteCare has been one that has sought public input across the State and across a wide spectrum of disciplines of those who would be familiar with the effects of the transformation of the current Medicaid program. Community forums were held in each of the New Hampshire's ten counties, with two forums conducted in Hillsborough County. A dedicated electronic mail account was established for written comment.

In response to this outreach, over 1400 people attended the forums, and over 300 spoke. DHHS received over 200 e-mails as well as additional comments from postal mail. Staff in the Department have reviewed each of these comments and have worked to incorporate them in our planning effort to the extent feasible.

In addition to these comments, DHHS personnel met with many groups with interests in this plan, including counties, hospitals, community health centers, community mental health centers, developmental services area agencies, community action programs, legislative leaders and many others, providing opportunities for all to express their perspectives and ideas for change.

An Advisory Council to the Commissioner has also met regularly to advise DHHS through this process. Composed of representatives from the various components of the provider networks as well as the legislature, this Council provided valuable insight and information. In addition, a Quality

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Forum group of medical professionals participated in ongoing sessions to address this need in Medicaid. Both groups were an important resource to the construction of GraniteCare.

Synthesizing that public input with the reasons for change, several key principles emerged. These have guided every component within the development of GraniteCare and are the bedrock on which the proposed plan rests. They are as follows:

- Quality and Prevention:

  One of the surest ways to reduce the cost of expensive treatment of disease is to prevent that illness from occurring. This involves patients receiving high quality services before a physical or mental illness requires an intense intervention. This also means providing incentives to seek out quality care. Not only is this cost effective, it is good medicine and the right thing to do. GraniteCare embraces the adage that an "ounce of prevention is worth a pound of cure."

- Consumer Empowerment and Choice:

  Among the most frequent comments expressed during the community forum process from those who utilize Medicaid has been the desire for more choice and control over services provided. Whether a pregnant woman or a parent of a disabled child, GraniteCare is built around a concept that these individuals should be empowered to make the care decisions that affect their lives. Additionally, when those who are empowered make healthy choices they should be rewarded. At a time when private health care is moving to giving customers more choices, Medicaid should do the same.

- Personal Responsibility:

  With choice and control comes responsibility. In the community forums held throughout the State, the same people who said they wanted more choice also made clear that they should be held accountable for those choices. GraniteCare supports the premise that individual consumers with access to good medical information, and in some cases with a fiscal intermediary, can become better shoppers for their care. Ultimately, technology will play a strong component in measuring the success and failure of any care plan to show what does and what does not work.

- Community Solutions:

  Starting in the 1960s, the Department of Health and Human Services and the State began a deliberate strategy of moving people out of institutional settings and into the community. This plan maintains and strengthens that goal. While there are some individuals who are best suited for an institutional environment for health and safety reasons, there are many more who could remain in the community. To accomplish

this community based approach, DHHS also needs to examine what support exits for those who would use GraniteCare, both from families and from resources within the local community.

- Independence:

  The goal of any health entity must be focused on moving toward recovery and independence. While this is not feasible for all who will use GraniteCare, DHHS nevertheless believes that all Medicaid consumers are entitled to an individualized strategy for improvement. Every consumer should have the opportunity for progress.

- Competition:

  Competition is a critical component to improving service and restraining costs. To date, there has been little competition within the State's Medicaid program. GraniteCare will work to increase competition so that consumers ultimately receive quality services at a reasonable cost. This is a key component to the success of any health care initiative in today's diverse market place.

While many of these principles are new to the State's Medicaid program, they are not new to the health industry. In fact, many of these elements are setting the direction of the private health care market. Some of the concepts have not been implemented in Medicaid in any of the 50 states, and GraniteCare provides New Hampshire with the opportunity to become a national leader by developing the nation's most modern Medicaid Program.

GraniteCare will be the safety net for those in most need in New Hampshire. There is no way this could be done in a vacuum. The Department thanks the many concerned people who took the time to contribute to the final product.

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INTRODUCING GRANITECARE

New Hampshire's Medicaid program is clearly at a crossroads. Changes in federal rules regarding the level of federal government support for state Medicaid programs will result in the loss of approximately $100 million over the biennium in federal Medicaid funding to New Hampshire. Without substantial changes, New Hampshire's ability to sustain vital healthcare services to our most vulnerable citizens is in jeopardy.

In the late 1990s and early 2000s, New Hampshire was able to obtain federal funds through a variety of then-approved techniques that are no longer acceptable to the federal government. Many states are in the same situation. In addition to the loss of federal funds, New Hampshire faces other challenges.

Unlike many states, New Hampshire has not availed itself of opportunities to be more efficient in the delivery of Medicaid services, instead relying on the financing techniques to obtain sufficient federal funds to balance its budget. This has resulted in a system of care and payment that is expected to grow at a rate of 8% over the next ten years.

In some areas, New Hampshire's current Medicaid program works exceptionally well and serves as a model for other states across the country. One such area is the home-and community-based program for people with physical and mental disabilities. In other areas, however, New Hampshire's Medicaid program is uncoordinated, care is unmanaged, and services are just not available. Also, too many consumers are forced into institutional settings when they would be much better served in their own homes or in community settings.

In responding to the changes in federal policy as well as in light of difficult State budgetary times, many if not the vast majority of states are choosing to (1) raise taxes to provide additional state funds for the Medicaid program; (2) eliminate Medicaid services altogether for some clients; and (3) cut provider payment rates (reference as background documentation, the Kaiser Commission on Medicaid and the Uninsured, *Results from a 50-State Survey*, October 2004). However, some states are also similarly recommending Medicaid system redesign (background documentation, the New Mexico Human Services Department, *Medicaid System Redesign; Ideas and Possibilities*, June 17, 2003). GraniteCare proposes a different path.

While this plan will require changes on the part of State government, consumers and private providers as well as the cooperation of the federal government, it will not require new taxes or the elimination of eligibility for current Medicaid clients. It will also place New Hampshire's Medicaid program on a sustainable course in which the program can focus on the health of its clients and not on year-to-year budget maneuvers and program and provider cuts for program survival (see page 62 for New Hampshire's projected Medicaid expenditure trend changes through 2015).

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I. GRANITECARE INITIATIVES

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A. Rebalancing the Long-Term Care System

"It doesn't take an accountant to figure out how much money could have been saved over the years if I could have stayed out of a nursing home." (Medicaid Feedback)

"Nursing homes are the last level of care. Everybody wants to stay in their homes and everybody's family wants them to stay in their homes as long as they can." (Coos County Community Forum)

"In addition, the vast majority of members feel that if they or a family member needed long-term care that it would be very important to have services available to enable them to stay at home as long as possible." (Home and Community Based Long-Term Care: A Survey of AARP New Hampshire Members, published July 2004; also background documentation)

New Hampshire's current long-term care system is marked by an imbalance between the resources devoted to nursing facility care and those devoted to care provided in individuals' own homes and other community-based settings. Not only is nursing facility care less desirable to many persons, it is more expensive. As a consequence, the Department's expenditures for nursing facility care make up approximately 85 percent of the total outlay for long-term care for seniors, depending upon the method of calculation (see page 63).

Addressing the current resource imbalance by itself would do little to reposition New Hampshire to meet the needs of its elderly and disabled residents due to the looming explosion in the number of citizens likely to require long-term care, regardless of their need for public assistance. The aging of the Baby Boomers threatens to overwhelm care systems and create demands on financial and other resources that will be a challenge for the State to meet.

There are several additional factors that contribute to the excessive utilization of nursing home care, some of which DHHS has made efforts to address. The system of alternative and community-based care has not grown as called for in earlier plans designed to reshape the long-term care system. There is clear evidence from other states that a significant growth in home and community options will result in significant savings. For example, the State of Wisconsin has experienced a savings of almost 25% of the cost of nursing home care by offering community based options to its seniors (State Legislative Report of National Conference of State Legislators, Vol. 24, No. 2 (Personal Assistance Services, January 1999)).

There is a general lack of information readily accessible by applicants and their families regarding the alternatives to nursing home care that do exist. DHHS has supported the development and operation of information, referral, assessment and counseling systems across the State to encourage diversion from nursing homes. The Servicelink network has been helpful in this regard, but it has been hampered by a lack of service alternatives.

There is general agreement that some current residents of nursing homes should never have been admitted to institutional care. Even now, some of these residents could be appropriately cared for in less restrictive and less costly settings. This situation came about for several reasons. The first is that the screening to determine the level of care needed for a nursing home applicant is not carried out through a uniform process that would make use of a standard assessment tool. Second, federal rules and the State Medicaid Plan have created nursing home care as an entitlement, meaning that

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applicants can choose a nursing home placement over a less costly community-based alternative. This poses a particular problem in cases in which applicants are not Medicaid recipients at the time they enter nursing homes but who spend down their resources and later become eligible for Medicaid. These individuals are not subject to initial screening and possible diversion to other less costly settings by the state, and it is much more difficult to relocate individuals who have already become acclimated to and dependent upon a nursing facility.

The specific initiatives proposed by GraniteCare fall into three categories: Diversion, System Development and Demand Reduction.

- Diversion: These initiatives focus on redirecting prospective nursing home admissions into other levels of care, care settings that are less restrictive, generally less costly, and that can make greater use of natural supports such as supportive care by family members. Diversion activities include:

  - Creating a uniform statewide assessment and counseling system for all proposed admissions into nursing facilities and other levels of long term care. The use of a standardized screening instrument will help reduce unnecessary admissions and will facilitate the development of realistic alternative care plans.
    - ❖ Requesting legislation to require screening for all persons seeking to enter nursing facilities whether or not they are eligible for Medicaid at the time of admission.
    - ❖ Intensifying the level of care requirements for admission to a nursing facility. The bar for nursing home admissions is set too low, and the State should require evidence of more areas of inability to provide self-care. This does not mean that individuals would be ineligible for Medicaid services, just not in a nursing home. Services to support seniors in their homes and the community would be made available.
    - ❖ Gradually reducing the cap on the number of Medicaid nursing facility beds in the State Medicaid Plan by 30% over 5 years (see page 65). The positive effects of the diversion efforts will disappear if Medicaid beds remain available for new admissions. As alternatives are developed and diversion activities take effect, the State will have to amend the Medicaid State Plan to reduce the cap on total Medicaid beds to assure that nursing homes are active participants in the diversion process.
    - ❖ GraniteCare views these changes as prospective in nature and would not require the removal of residents currently residing in nursing facilities, unless the individual chooses to seek out home and community based care.

- System Development: These activities are directed toward the task of creating alternatives to placement in nursing homes. It is not enough to limit admissions to facilities if the State does not at the same time assure that more suitable community-based options are available. System development activities will include:

  - Enhancing the community-based infrastructure through redirecting budgetary resources from nursing facilities to community care options. This will require an annual growth of 18% in alternative community placement capacity over the first five years. GraniteCare assumes a rebalancing of some of the funds that would otherwise be targeted to nursing homes.

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- Creating tiered reimbursement structures for supported residential living, adult medical day care, adult foster care and assisted living services. Additional resources need to be shifted to the community-based care system. Rates need to be adjusted to ensure the capacity of qualified medical personnel, as well as personal care attendants to support a broader range of recipient care needs as more persons are diverted from entry into nursing homes.
- Managing the "woodwork effect." The theory behind the "woodwork effect" is that states, by making it easier for consumers to pay for services in their homes, will not save money by providing access to home and community based services as an alternative to nursing home care; that is, citizens who currently rely on family and friends to remain out of nursing homes, will now "come out of the woodwork" and rely on publicly funded home and community care. DHHS proposes to manage the woodwork effect through a variety of means, including
  - Single Entry Points based on standardized comprehensive assessment, including natural supports, choice of providers and individualized budgets.
  - Care management that includes comprehensive health services and supports integration, primary medical care, prevention and wellness activities.

- Demand Reduction: In the long run, the State will not be able to meet the needs of a rapidly increasing population that will require various levels of nursing care. Actions to reduce the need for care and to decrease the degree of reliance on public funds when care is given will have to be pursued. Demand Reduction activities will include:

  - Promoting greater use of wellness activities and specific programs targeted at nursing need risk factors.
  - Providing information and advice to persons who are caring for a friend or family member.
  - Encouraging greater personal responsibility through acquisition of long-term care insurance. GraniteCare proposes incentivizing the use of long-term care insurance to the public and working to creating access to group long-term care insurance for State employees and other large employers in New Hampshire.

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B. Responsibility for Long-Term Care Costs

We have to ensure that the people who are indeed getting Medicaid services are the people who haven't taken their dollars and transferred them to children, neighbors, siblings, whoever, and they are not doing that in order to go on to the Medicaid system and have services that are identical to services that they otherwise would have to pay for themselves." (Merrimack County Community Forum)

"There are those who 'hide' assets for the benefit of themselves or their children by the merging of assets and the use of trusts. Estate planners and elder attorneys 'push' such action. I know of instances where the responsible relative could well afford the expense. Is this an equitable or fair policy?" (Medicaid Feedback)

Most people in the United States do not plan in advance for long-term care, often end up in nursing homes using Medicaid services instead of remaining in preferable community-based settings, and fail to access the equity in their homes or to buy private insurance for long-term care expenses.

A major contributor to the long-term care cost dilemma is the current ability of individuals and families to avoid personal responsibility for the cost of long-term care. Under existing law, individuals are able to transfer assets without significant consequences, and certain significant assets are exempt from consideration in eligibility determinations, thereby shifting responsibility for the cost of care from the individual and his or her family to the taxpayer. Medicaid in effect has become the long-term care insurance for the middle class.

According to Stephen Moses, President of the Center for Long Term Care Financing, "Most people qualify easily for Medicaid nursing home benefits, and virtually anyone can qualify quickly with the right advice." The following excerpt from a legal self-help book that provides Medicaid estate planning advice to the lay public is reflective of the aggressive marketing that certain New Hampshire attorneys engage in to assist seniors in estate planning aimed at divesting seniors of assets for the purpose of becoming Medicaid eligible.

> "So, is there any practical way to juggle assets to qualify for Medicaid - before losing everything? The answer is yes! By following the tips on these pages an older person or couple can save most of their savings, despite our lawmakers' best efforts.... Here are the best options: Hide money in exempt assets.... Transfer assets directly to children tax-free...Pay children for their help...Juggle assets between spouses... Transfer a home while retaining a life estate.... Change wills and title to property... Write a durable power of attorney... Set up a Medicaid trust... Get a divorce...." (Armond D. Budsih, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 34)

In recent years, New Hampshire has been seeing a higher incidence of individuals who are divesting themselves of their assets for less than fair market value in order to make themselves eligible for coverage of their medical expenses through Medicaid. In any given week, it is possible to find advertisements pertaining to "Medicaid estate planning" or "how to protect one's assets from medical expenses" in any of New Hampshire's major newspapers and on various websites. At the same time, rapidly increasing Medicaid expenditures, State budget deficits, and Federal budget concerns

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make it imperative that New Hampshire's dwindling resources be dedicated to those most needy citizens in need of healthcare, in line with the true purpose of the Medicaid Program. Medicaid was never intended to be long-term care insurance for the middle and upper classes.

The Medicaid Program was created in 1965 for the purpose of providing federal financial assistance to states that chose to reimburse certain costs of medical treatment for *needy* persons (emphasis added). In order to ensure the continued viability of the Medicaid Program, states must hearken back to the original purpose of the program and ensure that only those individuals who are truly financially "needy" qualify for benefits. This will require review and revision of State and federal law and regulations. To date, New Hampshire has done little to control Medicaid eligibility growth or to encourage reliance on alternative resources to support provision of long-term care.

Significant steps can be taken to discourage unwarranted reliance on public assistance for the costs of long-term care and to assure that only the truly financially needy are eligible to receive Medicaid supported services. Those steps include:

- Change Medicaid financial eligibility rules by closing legal loopholes that enable individuals to divest themselves of assets and resources in order to become eligible for Medicaid. This would ensure that only the truly needy are eligible for Medicaid supported services.
- Encourage personal responsibility for the costs of long-term care through appropriate cost sharing and incentivize the purchase of long- term care insurance. Create a New Hampshire Long Term Care Partnership program. New York, California, Connecticut, Massachusetts and Indiana have implemented programs whereby residents who purchase certain levels of long-term care insurance can protect a portion of their assets from the Medicaid spend down provisions.
- Close existing legal loopholes that enable individuals to divest themselves of assets and resources in order to become eligible for Medicaid
- Aggressively enforce existing laws related to eligibility and recovery. DHHS should enhance its efforts regarding aggressive enforcement of asset divesture law.
- Mount comprehensive public awareness campaign to educate the public on the purpose of Medicaid and personal responsibility for paying for long term care. The Connecticut Long Term Care Partnership Act also establishes a public education program for educating consumers regarding long-term care and methods of financing it.
- Promote reliance on natural supports and volunteerism for the provision of community-based long-term care.
- Create a New Hampshire legislative commission to explore and recommend additional cost-sharing ideas to reduce the burden of Medicaid costs on the State.

Although the Social Security Act has requirements for the treatment of transfers of assets for less than fair market value, the requirements contain gaps and loopholes that allow asset-rich individuals to dispose of their assets to make them eligible for Medicaid. The Department has undertaken the process for an 1115 waiver to discourage individuals from making large transfers of assets in order to qualify for Medicaid, as directed by the legislature in the current state budget, to accomplish the following:

- Apply penalty periods due to uncompensated transfers of assets of more than $7,500 for applicants/recipients of Medicaid that includes all Medicaid services for a calculated period.

- Increase the “look-back” period to 60 months for transfers of assets to an individual and 120 months for transfers to trusts.
- Begin the transfer penalty period for applicants when an individual applies for Medicaid and is determined to be otherwise eligible, or when the agency becomes aware of the transfer, whichever is later. The transfer penalty period for recipients would begin when the agency becomes aware of the transfer or following an existing penalty period, whichever is later.
- Limit permissible transfers of other assets to a disabled child to transfers into a trust for the child’s sole benefit. The trust must contain a provision that upon the disabled child’s death, the trust will reimburse the State for Medicaid payments made for the grantor and the beneficiary of the trust.
- No longer permit, without penalty, transfers to trusts for individuals with a disability who are under age 65 and who are not the children, adopted children, or stepchildren of the transferor for whom there is no legal obligation.

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C. Integrated Community Based Care – Single Point of Entry: Behavioral Health (BH), Developmental Disabilities (DD) and Long Term Care for the Elderly

"The health care landscape is littered with silos.... Fostering integration will improve care and reduce costs." (NH Hospital Association)

"With the development of home and community-based services, states have changed the way services are organized and administered to reduce fragmentation, inform consumers about the range of service and program options available, and facilitate access to a coordinated array of long term and supportive services. Comprehensive single entry points (SEPs) streamline access to services." ("Single Entry Point Systems: State Survey Results"- Rutgers Center for State Health Policy/National Academy for State Health Policy, Centers for Medicare and Medicaid Services (CMS) funded: 8/03)

"I'm looking at the bill, and we're paying this health provider $36 an hour to provide LPN care. I could save the state 50% by hiring the LPN myself....and go without that middleman." (Sullivan County Community Forum)

New Hampshire has developed many effective programs of community and evidence-based services in the current systems of behavioral health and developmental disabilities. The lack of a comprehensive managed plan of care for these persons, however, (inclusive of primary and disability specific/long term care services, primary care, and prevention) is a barrier to many consumers' receiving integrated, effective, and cost efficient care. Current systemic inefficiencies also result in a significant lack of individual choice of providers coupled with the lack of a competitive provider environment. New Hampshire is committed to translating current evidence-based practice into a more competitive provider environment.

Many models have been suggested for a revised system response to the lack of service integration across the current service networks. For example, the State of Colorado's home and community-based support systems are based on a single point of entry that focuses on long term supports for older persons and adults with physical disabilities. The Single Point of Entry (SPE) model "addresses multiple aspects of community long term support systems in order to improve responsiveness to participants' needs and preferences. These initiatives are developing entirely new ways of designing, organizing, and managing community based supports as a system rather than a random collection of uncoordinated individual services. In some cases this has required states to make fundamental changes to the administrative infrastructure of their home and community based support programs." (Background documentation, Centers for Medicare and Medicaid Services, *Promising Practices in Long Term Care Systems Reform: Colorado's Single Entry Point System*, December 18, 2003).

In New Hampshire, consolidation and integration of mental health and developmental services regional agencies along with a broadened focus on resource centers serving elders is one approach. In this approach, the elder care system could at a later date be blended into the combined MH/DD network. Another possibility raised was the integration of elder and developmental services systems to take advantage of the similarities in the long-term care services needed by these populations, leaving the community mental health system as a separate structure. For discussion purposes, GraniteCare is putting forth the model described below, recognizing that any significant change would most likely need to be phased in over a few years and perhaps piloted in one or more areas before any final design is agreed upon.

2-40

GraniteCare contemplates a comprehensive initiative designed to plan and implement a model that integrates and improves the service delivery system for developmental disabilities, behavioral health and long term care for the aging through the creation of a centrally managed organization, or contractually combined organizations, that manage approximately 10 integrated community-based Single Point of Entry/resource centers throughout New Hampshire. Current service providers, including counties, community mental health centers, area agencies and community health centers could all be eligible to be an SPE. GraniteCare does not envision an SPE that results in additional bureaucracy, but a streamlined and efficient, integrated, model, consisting mostly of existing resources. A state-of-the-art Request for Proposals would be issued for outsourced management and operations of these centers. GraniteCare resource centers will be the single points of entry for all Medicaid clients who are developmentally disabled, have severe and persistent behavioral health needs, or are elderly persons with long term care needs who wish to avail themselves of care.

The resource centers will:

- Provide diagnosis, assessment, treatment planning.
- Be responsible for the ongoing care management of all consumers. The care manager will be detached from the actual service provider and will be an integral part of the consumer's care planning. Currently, there are numerous case managers embedded across the various systems of care; employed by service providers. Some of these case management functions will be extracted from the current service delivery system. The long-term care delivery system is an example where care managers are already independent of providers.
- Establish and monitor individualized budgets for consumer services.
- Assure consumer participation in selection of available choices.
- Coordinate with local providers for provision of services to the consumers.
- Provide information, referral, and relevant access triage.

The centers will be linked by an information technology state of the art system, accessible by identified professional participants and providers.

Financial and case management services currently provided to the disabled, behavioral health and elderly waiver clients will continue; at a date specific point, the management, assessment, and treatment planning process of new clients and annual treatment plan reviews of existing clients will be transferred to the appropriate resource center in a planned, safe, and documented manner. The Single Point of Entry model envisions short-term steps to ensure continuity of existing services and long-term steps to achieve the goal of a comprehensive and integrated community based system. Safeguards will be put in place to protect persons who may find themselves in crisis during the transition process.

All consumers will receive prior notice of the changes and linkage with the center. Current providers of services will develop contractual and/or operational relationships with the centers through which the care of their consumers will be managed.

Funds currently used for diagnosis, assessment, treatment planning and case management services will be extracted from the current provider systems to serve as the investment resources for the Integrated Community-Based Care model, thus avoiding any unnecessary and duplicative cost.

2-41

Person Centered Individualized Assessment and Treatment Planning, Care Management, Individualized Budgets, and Consumer Choice means:

- Customization for individual assessment and treatment planning based on best practice and personal involvement
- Customized individual budgets controlled by the individual, with assistance from a designated care manager, based on maximum independence, personal responsibility, and recovery potential
- Customized individual choice of licensed providers based on the person's preferences
- Care management assistance and linkage to primary medical care, prevention, and treatment plan adherence or change when indicated

The Single Point of Entry Model, based on specialized clinical assessment procedures, will:

- Assess an individual's medical status and comprehensive needs using state of the art assessment instruments
- Generate an individualized treatment plan based on the findings of the assessment process and the involvement of the consumer and their family
- Create an individualized budget that is based on the documentation of need(s) generated by the individualized treatment plan.
- An assigned "care manager" will assure the individual's understanding of their treatment plan and individualized budget and assist the individual with exercising their choice of providers for the services approved in their treatment plan
- The individualized Medicaid Report card will track the person's progress and outcomes resulting in educative information for the individual and care manager

2-42

D. Health Service Accounts

"An HSA...will create an incentive for you to care about cost and reduce over-utilization, and will create an economic preference for having cheaper preventative care instead of waiting for more expensive emergency care." (Josiah Bartlett Center for Public Policy Newsletter, August 2004)

"Individuals who clearly take a proactive role in their own care should be rewarded accordingly." (Medicaid Feedback)

Certain individuals with income levels below 133% of the federal poverty level are categorically eligible for Medicaid by federal law. At levels above 133%, states are allowed to cover other populations optionally. Please see pages 67 - 69. In New Hampshire, the legislature has chosen to offer Medicaid optional services to a group of New Hampshire consumers – those otherwise eligible for Medicaid but with incomes from 133% to 300% of the Federal Poverty Levels (see the FPL level s on pages 58 - 59).

The purpose of Health Services Accounts is to encourage the use of preventive services for the consumer, provide for self-management of non-emergency health care, and to ensure careful management of, and payment for, emergency health care through Medicaid. Those who follow prevention guidelines set by clinicians (see page 64) will receive incentives for this healthy behavior. The HSA model will result in better health outcomes and reduced need for utilizations of medical services. This model also includes a primary care physician assigned to each consumer, as well as a Medicaid report card with defined goals and objectives.

GraniteCare proposes the establishment of health services accounts for all non-disabled Medicaid consumers above 133% of the federal poverty level. Each consumer will be given an individualized budget with two accounts, one for preventive services based on clinical guidelines, and one for use for non-emergency services. The preventive account will cover regular physician and dental visits, as well as immunizations. Finally, a catastrophic pool will be established to pay for emergency care, as defined by the legislature. Doctors will also be allowed to waive patients with chronic illnesses, like asthma or diabetes, or those with significant acute conditions, such as pregnant women, into the catastrophic pool. In addition, under this model, pregnant women will be given a budget to cover all of their pre-natal care. See page 66.

One important aspect of the HSA will be an incentive-based system that will consist of two parts. Those who fulfill their prevention requirements, and meet any other health and wellness targets set by their primary care physician, would be given monetary vouchers to be used for wellness related activities, child care, housing, transportation and/or education. Temporary Assistance to Needy Families (TANF) funds or general funds will be used to cover this incentive. The benchmarks will be identified in the Medicaid report card, transferred to the Department via electronic form. For those that do not utilize all of their non-emergency account and meet their prevention goals, a portion of the remaining funds will be returned to the consumer in the form of vouchers to be used for wellness related activities, summer camp for a child, and any other activity as determined by the legislature.

The Health Services Accounts initiative will include the following components:

- For the qualifying population, a catastrophic coverage pool will be established that will pay for hospitalization and emergency care. The department will create an internal re-insurance pool based on an actuarially sound estimate of the share of current services that are catastrophic. The catastrophic pool would be managed, proactively, by the Department.

- Preventive services will continue to be paid on a fee-for-service basis, based upon EPSDT guidelines on page 64.

- Individual budgets, constituting the Health Services Accounts, will be created for eligible persons with incomes greater than 133% of the federal poverty level. At the end of specified period, if a consumer has resources available in his or her Health Services Account, and has met certain goals for preventive care (i.e. routine physicals, etc.), a portion of the resources will be returned to the consumer.

- Consumers will also have a drug discount card, depending on provider participation that will give access to discounted prices if the consumer has used all the funds in the HSA.

Please note page 70.

2-44

E. Care Management – Medical Homes

"Adults and children enrolled in Medicaid do have difficulty accessing primary care, simply because many providers in the area will not accept them." (Hillsborough County Community Forum)

"It simply makes good sense for everybody to do all that is necessary to create medical homes within community health centers for Medicaid cardholders. Cost efficiencies are there. It is a win-win situation for those needing care, those providing it and those who are footing the bill." (Hillsborough County Community Forum)

"By having a PCP, Medicaid patients could receive preventive care, have easier access to care when they are sick, avoid expensive ER visits, and most of all, get help navigating the complex health care system." (Sullivan County Community Forum)

It is widely recognized; both in the private and public health care markets, that care management is an essential component of any modern health care delivery system. New Hampshire's Medicaid program is, for the most part, unmanaged. This means that consumers access the system wherever and whenever they choose, resulting in a high rate of expenditure and less than optimal care. It is anticipated that by continuing to operate without a care management system, New Hampshire's rate of growth in Medicaid spending would range between 13 and 16 percent over the next 10 years. This is a rate of growth that the New Hampshire budget cannot sustain and would likely result in substantial cuts in services or eligibility absent other fundamental change. Managed care would help control costs (see page 71).

GraniteCare would move to a system of state-wide care management that is based on the fundamental principle that every Medicaid consumer should be under a care management program and have a primary care physician or other medical home. Furthermore, for certain high-cost and highly vulnerable consumers (including the elderly and consumers with developmental disabilities or chronic mental illnesses), a more comprehensive and coordinated system of care would be established that would ensure that these clients receive the specialized services that are vital to addressing their health concerns and that permit them to have more options and choices in their care.

The proposed GraniteCare care management system includes the following programs:

- Primary Care Case Management, including disease management. for all federally qualified individuals enrolled in the Medicaid program.
- An innovative program of catastrophic coverage, plus fee-for-service payments for certain specific services and a new Health Services Account for optional services for those individuals above 133% of the poverty level.
- Resource centers to serve as the single point of entry for the developmentally disabled, those with behavioral health issues and the elderly enrolled in waiver programs. These centers will be responsible for managing the care of all persons receiving these services.
- Medical Report Cards to provide all Medicaid consumers with up-to-date information on the cost and quality of health care providers and services in order to permit consumers to make informed decisions when accessing the health care system.

- Nursing home pre-admission review, significantly enhanced, to make sure that consumers know and understand their options and that only those individuals truly needing care in institutional settings are admitted to nursing homes.

2-46

F. Prevention

"I hope you look at preventive services as the key to improving the bottom line." (Cheshire County Community Forum)

"With enrollment capturing clients at a time when they are less ill, if you will, medical treatments can commence before becoming big costly cases to the NH Medicaid program." (Medicaid Feedback)

"We see as one of our major responsibilities the need to teach people to take charge of their own health again. Let's start with the simple things: teaching people that it is important to brush your teeth daily; to take your medicine as directed; to exercise and watch the French fries and Twinkies.... We recognize the price we are paying for obesity today, especially among children. We have to do all we can to get people, young people, from getting so big and sluggish that a decade from now they are the diabetics who we are treating." (Hillsborough County Community Forum)

GraniteCare will encourage and reward preventive services in the Medicaid program for both consumers and providers. This strategy will significantly improve the health and well being of Medicaid recipients by helping them to avoid preventable and more serious long-term health complications. Consumers will be rewarded for meeting certain minimum preventive care requirements, and providers will also have incentives for delivering routine preventive care to their Medicaid consumers. Over the long term, this strategy will create a healthier population who subsequently will require significantly less intensive and less costly medical intervention and will result in considerable savings to the Medicaid Program.

In addition to encouraging the use of more preventive services within the Medicaid eligible population, GraniteCare would also provide preventive care to those individuals most at risk for nursing home placement. Individuals entering nursing homes often become Medicaid eligible after they have spent down their resources shortly after admission. Targeting this at-risk population with preventive care could reduce their likelihood of future nursing facility admission, thus eliminating their need for Medicaid support.

GraniteCare proposes the following initiatives:

- Incentives for Consumers: All non-federally-mandated Medicaid recipients whose income is above 133% of the poverty level will receive Health Services Accounts to cover expenses not related to hospitalization, emergent care or prevention. (The same could be pursued for Medicaid recipients under 133% of the poverty level, but GraniteCare only addresses programs for which states have options). If there are funds remaining in a consumer's HSA at the end of the year and he/she has fulfilled specified preventive care requirements (i.e., annual physicals, oral health screenings, immunizations, prenatal care, well-child visits, etc.), the consumer will be eligible to receive part of the remaining funds back. Thus, consumers will be given an incentive for engaging in preventive care.
- Incentives for Providers: Just as consumers will be rewarded for meeting their preventive care requirements, providers will also be rewarded for delivering preventive services. Providers who meet the required level of preventive care will qualify for incentives such as enhanced reimbursement.
- Medicaid Report Cards for Consumers: Report cards will track the progress of Medicaid consumers (see page 26).

2-47

- Report Cards for Providers: Report cards measuring service and quality levels for providers will be prepared and published for public access. Please see page 26.
- Reducing Nursing Home Admissions: In this initiative, the State will direct services to the frail elderly and identify those people most at risk of nursing home placement, regardless of their current Medicaid eligibility status. Since most nursing home residents end up becoming Medicaid eligible during their stay at a nursing facility, targeting services to those most at risk of being placed in a nursing home could delay or prevent unnecessary nursing home admissions, thus eliminating this population's need for long-term Medicaid support. Evidence-based programs for this population will include exercise and strength training, fall prevention, home modifications, nutrition counseling, etc. Please see page 11.

2-48

G. Report Cards

Currently, DHHS does not do enough to hold providers, consumers or even itself responsible for their respective roles in the Medicaid program. In addition, there is a lack of information available to consumers to assist them in choosing effective healthcare providers. Therefore, measuring and analyzing the quality of care delivered by health care providers, the level of adherence to individual care plans and preventive care guidelines on the part of Medicaid consumers, and the overall management and health outcomes of the Medicaid Program by DHHS are essential to the enhancement of the system and the ultimate improvement of health for the Medicaid population.

Medical Report Cards will be developed to track quality measures in the Medicaid Program for providers, consumers and DHHS. The Report Cards for providers and DHHS will be made available to the public and will offer information concerning the quality of care provided to consumers, the delivery of preventive services and overall health outcomes and program management. Individual Medical Report Cards will be prepared for consumers to track their own health outcomes and measure adherence to their individual care plans and preventive health goals. All Report Cards will be prepared in compliance with HIPAA (Health Insurance Portability and Accountability Act) privacy standards:

- Report Cards for Providers: Report Cards offering quality of care information for all Medicaid providers will be designed and made available to the public. These Report Cards will enable Medicaid consumers to make informed choices about their healthcare providers, encouraging higher standards of care from providers and creating healthier outcomes for consumers.

- Medical Report Cards for Consumers: Report Cards will also be designed to track the progress of Medicaid consumers. These Report Cards will keep track of consumers' adherence to their individual care plans as well as their meeting preventive care guidelines. This initiative will enable consumers and providers to track health outcomes more easily and will encourage both parties to take greater responsibility for their respective roles in their health management partnership. In addition, the Report Cards will serve to measure progress in consumers moving towards independence. For those non-federally-mandated Medicaid consumers whose incomes are above 133% of poverty, the Report Cards will be also serve as a tool to determine which consumers have met their preventive care requirements, thus making them eligible to receive back a proportion of any funds remaining in their Health Services Accounts at the end of each year.

- Report Card for DHHS: Report Cards measuring the overall quality of the healthcare being provided to the Medicaid population in the State of New Hampshire will be developed and made available to the public. By using a standard set of quality measures, GraniteCare can be compared to other Medicaid programs as well as to care provided in the private sector. The Report Cards will be used as a tool to develop programs and to address healthcare disparities within the Medicaid Program.

2-49

H. GraniteCare Job Corp -Transitioning TANF from Medicaid

"Managing the problem [of Medicaid funding] must include a strong initiative to assist NH citizens to remain or become gainfully employed. We need to provide incentives to work." (Medicaid Feedback)

Encouraging TANF recipients to pursue careers in the healthcare field by providing an innovative educational incentive in return for community based care employment could help to reduce the shortage of healthcare workers in New Hampshire as well as increase the State's capacity to provide more home- and community-based services to consumers. In addition, providing support to TANF consumers to enter health care professions would increase their independence and reduce their likelihood of needing future public assistance. This new program would be entitled, "GraniteCare Job Corp."

GraniteCare proposes the following initiatives:

- Establish a career ladder for TANF recipients to enter health care careers, particularly those in support of home- and community-based care.
- Grant tuition vouchers for TANF beneficiaries, up to 4 years of paid, post secondary education, in return for an equivalent time of paid community based health care employment, with one year of service required for each year of paid education.
- Utilize vouchers for direct payment to the educational facilities.
- Increase capacity in New Hampshire's education system and clinical settings in order to augment the number of available slots for individuals entering the nursing profession.
- Work with health care providers, HUD and NHHFA to use current funds and obtain additional grants to develop on-site housing and Section 8 vouchers for individuals in health care training programs and jobs.
- Provide stipends for home health care volunteers.
- Extend Medicaid for individuals who lose their TANF eligibility due to increased earnings for an extra 12 months.
- Promote greater cooperation between health care agencies and organizations to identify current needs in health care employment and develop strategies for meeting those needs, including establishment of an automated directory of jobs and programs designed to address worker shortages.

2-50

I. Paying for Performance/Rate Setting

GraniteCare recognizes that by investing in prevention, and by improving the clinical quality of care delivered to Medicaid consumers, the number of Medicaid patients who receive effective care will increase, the efficiency of the program will improve, and most importantly, the health outcomes of the State's most vulnerable populations will improve. GraniteCare also believes disease prevention should be considered a primary cost-containment strategy for health care financing.

Current payment methods provide physicians with little incentive to improve quality of care. "Even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions," according to *Crossing the Quality Chasm: A New Health System For The 21st Century,* March 2001, the Institute of Medicine (IOM). Background documentation also includes *Building Quality Into Rite Care: How Rhode Island Is Improving Health Care For Its Low-Income Populations*, January 2003.

Paying for performance has two fundamental principles:

- Common evidence-based quality performance measures for physicians, clinics, hospitals, etc., which also include patient satisfaction and information technology investment measures. The measures will be developed by health care quality experts and come from nationally recognized sources widely used in the private sector. More than 35 health plans now offer pay-for-performance programs.

- Significant financial payments based on that performance. The network of primary care providers willing to care for New Hampshire's Medicaid consumers has eroded due to reimbursement rates that are below the market rate and, in many cases, even below the cost of delivering the service. By increasing reimbursement, while providing incentives for desired provider behavior, the State will increase its provider network base while driving quality improvement.

In addition, Medicaid rate setting and reimbursement is currently spread throughout several divisions within DHHS. This scattered responsibility encourages inconsistency in rates and in policy development and implementation. For example, the Department can reimburse a physician several different ways for the same service, depending how a Medicaid consumer entered the service delivery system. Additionally, this creates complexity and confusion for the provider. As part of GraniteCare and an extension of its reorganization efforts, DHHS will look to consolidate its rate-setting responsibilities into one unit; this will also facilitate the implementation of a paying for performance based reimbursement methodology.

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II. INITIATIVES IN SUPPORT OF GRANITECARE

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A. Purchasing Strategies

"We stopped going to the butcher for our sausage and the farm for our eggs – for good reasons." (Advisory Council Comment)

"They also noted that Medicaid paid $20.00.... for a specialized feeding bottle, which they saw on sale at K-Mart for $3.59." (Write-up of a home visit)

New Hampshire's Medicaid Program is among the largest purchasers of health care services in the State and is uniquely positioned to leverage its purchasing power to act as a more prudent purchaser of health care. GraniteCare focuses the following:

- Selective Contracting: Private sector healthcare purchasing significantly relies on selective contracting with a limited group of vendors in order to obtain the best prices and achieve defined outcomes. Until now, New Hampshire's Medicaid Program has not pursued this practice. GraniteCare proposes to seek competitive proposals for non-emergent transportation, durable medical equipment and certain inpatient hospital services (births, transplants, etc.) and will define vendor requirements to assure adequate access, quality and prices that are competitive in the healthcare marketplace. The State will establish oversight mechanisms to ensure that contract requirements are met, or, where improvements are needed, that corrective actions are taken to protect the health and safety of Medicaid recipients. The State will make information about service utilization, actual expenditures, and specified outcomes achieved available to the public, so that all interested parties, including health care providers, Medicaid recipients, state Medicaid program managers, and legislators, will be able to evaluate the benefits of this purchasing strategy

- Paying for Performance: The State will define quality benchmarks for specified services and conditions. It will measure performance against those benchmarks through standard quality oversight and improvement techniques, including health data reporting, review of complaints and grievances, quality improvement projects, and the production and release of user-friendly Medical report cards. Please see page 28.

2-53

B. Information and Communication Technology

"DHHS has a wide variety of data systems available, but none of them are well suited for monitoring and improving Medicaid performance." (NH Hospital Association comment)

"Pharmacies would like to see DHHS institute Electronic Funds transfer when paying providers." (E-mail from Capitol Insights Group).

The transformation of the Medicaid program requires a range of technology solutions enabling the defined concepts to achieve the goals and objectives. The primary purpose of the IT components is to enable all partners and players in GraniteCare to seamlessly exchange information concerning services, clients and performance with appropriate authorizations and safeguards. The initiatives below represent elements that would be phased in over a 5-year period:

- Establish a linkage to NH's core financial eligibility management system.
- Capture essential client information regarding their needs and document in a comprehensive care plan.
- Evolve an "electronic medical record" where multiple providers access and update a comprehensive and integrated plan, with appropriate privacy controls.
- Provide a linkage to a Health Services Account where an individual budget has been set along with specific actions upon which incentives for the client can be realized.
- Use electronic funds transfer or electronic benefits transfer for the consumer to procure a range of services including transportation, substance abuse treatment and housing.
- Create a broadband network infrastructure to seamlessly link all key parties to the program. The Medicaid Information Network serves as the foundation for the deployment of multiple applications enabling communication of data, voice and video across all parties. Such a network is critical in providing information enabling choice and personal responsibility.
- Provide information distribution using multiple media forms including paper, the World Wide Web, telephone, video and touch screen kiosks enabling clients to access needed information.
- Develop a range of applications from accessing static information on resources to checking availability and scheduling services to advisory services such as "ask-a-nurse."
- Complement these information distribution services with comprehensive language translation services to address the increasing number of language barriers.
- Provide cross training and collaboration across multiple disciplines using telemedicine and video to reduce costs.
- Implement web enabled applications including: billing to ease burden of doing business, purchasing by providers and consumers alike, bulletin boards for mobilizing volunteers and the development of registries in support of the provider networks.
- Establish backend database systems to capture data from multiple systems, internal and external, for transformation of data into knowledge. This platform supports the development of report cards for providers, the Department and the consumer.

- Integrate best practices and medical pathways to continually refine disease management strategies.

2-55

C. Quality

"It is not good enough to have services; you have to have high quality services." (Strafford County Community Forum)

The health care system, as currently structured, does not, on the whole, make the best use of its resources. Medical errors, overuse of services, and a fragmented delivery system are examples of a few of the problems associated with the current system (*Crossing the Quality Chasm: A New Health System for the 21st Century*; Institute of Medicine 2001). These inefficiencies have created ample opportunity for improving the quality of care provided to health care consumers, particularly those receiving Medicaid benefits. Quality initiatives under GraniteCare include:

- Report Cards: As described previously, Report Cards will be designed and made available to the public as a way to hold providers accountable for delivering high quality care. In addition, Medical Report Cards will be developed as a means of holding consumers responsible for adhering to their individual care plans as well as engaging in basic preventive care.
- Incentives for Providers: Physicians and other clinical providers will be paid based on performance with financial incentives for prevention, office-based systems and outcomes. These incentives will result in increased use of practice guidelines, improved patient safety, better clinical outcomes and reductions in medical errors and cost.
- Incentives for Consumers: Consumers will be rewarded for obtaining preventive care and for meeting behavioral goals. These incentives will result in earlier detection of health problems and early intervention to reduce health-defeating behaviors. In addition, the incentives will work to improve provider-patient relationships and reduce acute health care expenses.
- Care Management: An intensive care management system will be implemented that includes Primary Care Case Management (PCCM), Disease Management and Utilization Review. This coordination of care will work to improve health outcomes while making the management of resources more efficient.
- Substance Abuse and Tobacco Benefit: DHHS recommends both treatment and prevention programs for substance abuse and tobacco (as described later).
- Technology: Web-based patient registries will be developed to enable all members of a consumer's health care team to access patient information and track progress.
- Translation Services: DHHS will work to provide trained interpreters in health care settings. Having trained interpreters present will reduce medical errors resulting from language difficulties and will encourage those not fluent in English to access Medicaid programs with the goal of improving their health outcomes.

2-56

D. Transportation

"I am more than willing and capable of working. But in order for me to do that, I need access to public transportation, which I presently don't have." (Medicaid Feedback)

Transportation related services are essential to the health and human services delivery system for the Medicaid program. Transportation services are largely fragmented with some assets unable to keep up with demand while other assets sit idle. Some 62 agencies at the Federal level provide transportation related funding to the states. Historically, there has been little, if any, coordination of these funds.

DHHS will work with the Legislature, Department of Transportation and the Human Service Transportation Task Force to effect:

- A brokerage model to perform a number of functions, including but not limited to the following:
    - Reservations and intake
    - Determination of eligibility for services
    - Schedule
    - Dispatch
    - Operations coordination and delivery
    - Customer services
    - Billing and invoicing
    - Reporting

- A Statewide Coordinating Council through which the expenditures of transportation related funding for Medicaid and other human services programs would be coordinated.

- A small number of Regional Coordinating Councils, perhaps 6-10, to function as regional brokerages. The regional brokerage will mobilize available assets including those provided by the State, provider agencies, fixed transit systems and volunteers.

2-57

E. Regulatory and Administrative Relief

"Clinicians are unable to spend more than half their time in direct service given the current administration requirements." (Hillsborough County Community Forum)

"I work with a lot of wonderful people at the state, but there are people at the state who sit there and generate email all day and forms. We don't need them. We need people who will work for us." (Cheshire County Community Forum)

"No doubt about it, all of us in this business have a huge amount of red tape and rules that we have to follow every day." (Strafford County Community Forum)

Since its inception, the Medicaid program has struggled with detailed requirements and rules that, while intended to protect and support Medicaid clients, have resulted in a system with a great deal of administrative burden. This burden often causes frustration on the part of consumers, providers and the state and results in inefficiencies and increased costs.

In order to provide regulatory and administrative relief, DHHS proposes to implement the following initiatives:

- DHHS will review the administrative burden of paperwork imposed by regulations and reduce it where possible. In addition, prior to their adoption, new regulations will be assessed to verify that they do not impose unnecessary paperwork requirements. The increased and efficient use of paperless, electronic communications will be implemented where possible.

- DHHS will seek legislation to mandate "Paperwork Reduction."

- All DHHS rules will comply with the following:
    - Rules will be consistent with and not go beyond state or federal statutory authority. They shall be consistent with legislative intent.
    - Key stakeholders will be involved in the drafting of rules.
    - Rules will be kept to the minimum level necessary to adequately promote and advance the health, safety and well being of the populations they serve.
    - Rules will strike an appropriate balance between the protections afforded and the costs of implementation. The cost/benefit analysis will take into consideration the expense to both the state and providers.
    - Rules shall be appropriate to the setting and take into account the relative size of the providers.
    - Existing rules will be reviewed. Unnecessary, outdated, or unduly burdensome rules will be identified and revised or repealed as appropriate.

F. New Hampshire's Blueprint for Health Management

Health care management provides coordinated care throughout the healthcare continuum including preventive, elective, acute, and end of life care. It offers an opportunity to improve health outcomes while managing resources by make use of both case management (care coordination) and utilization management tools. There is evidence that health care management can reduce the cost of illness, often beyond just medical costs while improving health outcomes.

Case management (care coordination) includes the coordination of covered and non-covered services to assist an individual in gaining access to needed medical, social, educational, financial and other services. This includes health risk assessment, disease management, demand management, and care coordination.

Utilization management is the process of evaluating the medical necessity and appropriateness of healthcare services against established criteria. This employs the techniques of prior authorization and utilization review.

Case management has been used as a revenue maximizing initiative for providers without much accountability for improved outcomes (e.g. access, efficiency, quality of care). In New Hampshire, numerous providers and state agencies bill for case management services but little is known about the quality and comprehensiveness of services delivered. For DHHS, health management programs are compartmentalized by program (i.e. Developmental Disabilities, Behavioral Health, Elderly and Adult Services). Currently, NH Medicaid does not provide a comprehensive, holistic, patient centered health management program.

An integrated health management program will have one point of entry into the health management system and one integrated health management plan. The centralized coordination of services within a health care management program will have:

- A patient centric focus,
- Develop and consistently apply evidence based criteria to prior authorizations, particularly for DME,
- Consistent credentials for providers,
- A common, coordinated, and written care plans
- Subject matter expertise to review and approval for emerging medical technology
- Predictive modeling to anticipate medically complex and high cost cases
- Case management

GraniteCare proposes to improve the health outcomes of Medicaid consumers through a blueprint for better health that emphasizes care management, consumer education, support to providers and quality based utilization management. Concurrently, implementation of the blueprint would serve to achieve cost savings over the long term through a reduction in the need for acute and chronic medical care. There would be five critical aspects to health management:

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- One component of the blueprint is an aggressive disease management program. Reference background documentation from the Centers for Medicare and Medicaid Services, SMDL #04-002, dated February 25, 2004 in which CMS addresses significant improvement in care delivered to Medicaid consumers with chronic conditions as a result of disease management and particularly, the use of disease management as part of an overall care coordination effort. Disease management under GraniteCare will include:

    - Asthma management
    - Diabetes management
    - COPD management
    - Heart related disease management

- Under disease management, consumers would have:

    - Access to a 24/7 nurse advice line
    - Case management services
    - Educational mailings

- Medicaid providers, in conjunction with DHHS, would be responsible for:

    - Issuing health status alerts
    - Providing case management services
    - Providing educational services

- The second blueprint component would be to approach disease management from a proactive perspective that focuses on the 1% of Medicaid consumers who account for 25% of all medical costs. These high-risk individuals are consumers who:

    - Are diagnosed with multiple co-morbidities
    - Are at risk for high acuity care within a year
    - Are deteriorating clinically
    - Receive uncoordinated care across the traditional service silos that exist within DHHS

- Elements of a proactive disease management program include:
    - Highly personalized interventions
    - Motivating consumers to change negative health behaviors through use of personal health care goals

- Educating consumers to be more self-reliant and knowledgeable about illness and services
    - Maintaining close relationships between consumers and their primary care physicians

- A third component of the blueprint involves:

    - A care management program that is quality based
    - Integration of behavioral health and medical health services
    - Coordination of Title V (SMS), waiver services for the disabled, mental health services and child protective services

- The fourth component is the provision of preventative health programs such as:

    - Nutrition programs including diet quality and shopping selections

- The last component of the blueprint is the promotion of healthy lifestyle programs provided through the Department's Division of Public Health Services in collaboration with community partners.

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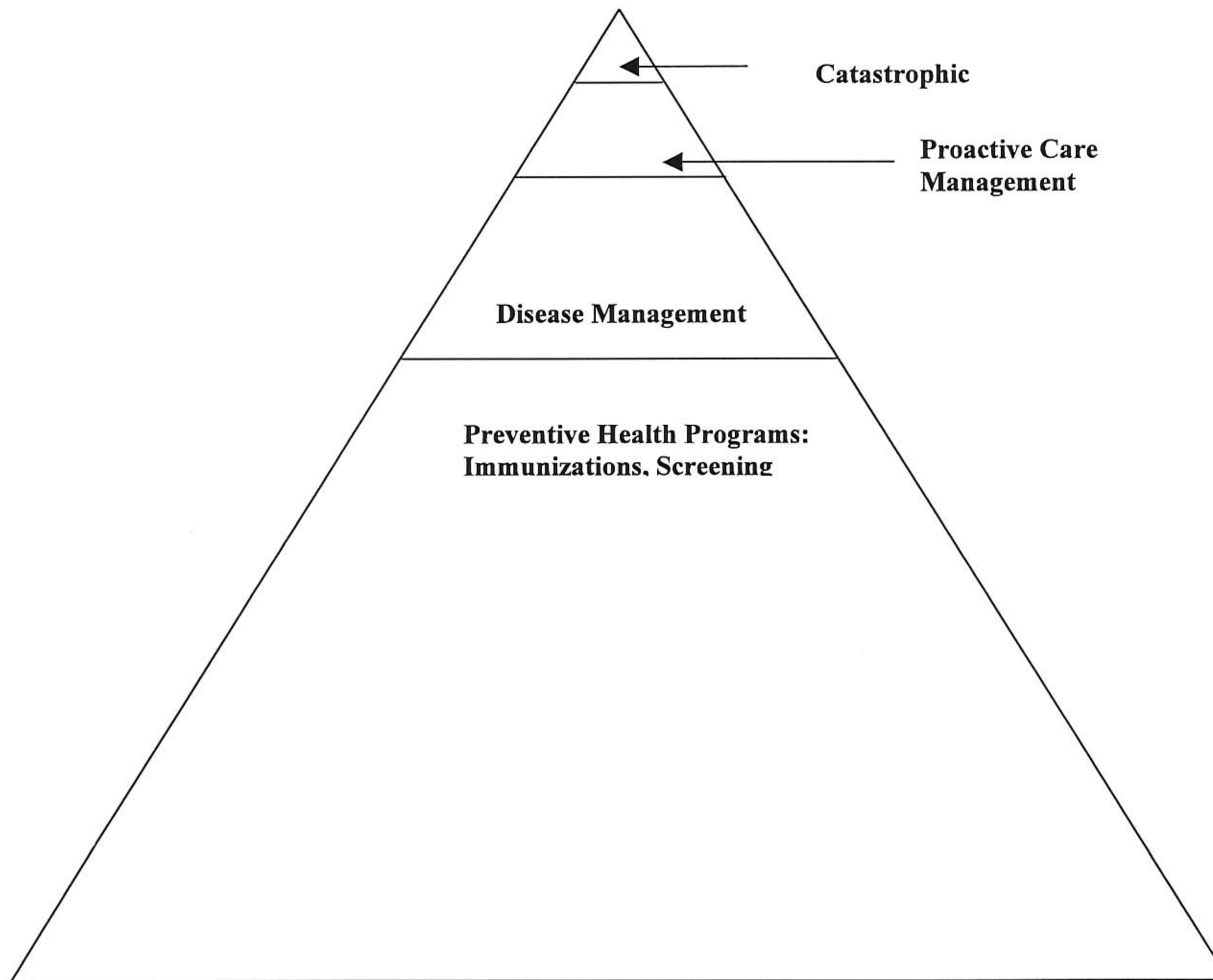
HEALTH MANAGEMENT PYRAMID



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I. Medicaid Fraud and Estate Recoveries

The Department has identified fiscal and programmatic integrity as top priorities for the Department that are critical to the successful implementation of GraniteCare. The emphasis on integrity is reflected in a number of recent changes made to increase the capacity of DHHS' Surveillance and Utilization Review Subsystem (SURS) Unit to effectively identify fraud and abuse within the New Hampshire Medicaid Program. Those changes include:

- Moving the SURS Unit from the Medicaid Administration Bureau to the newly created Bureau of Improvement and Integrity within the Office of the Commissioner to ensure the independence of the unit.
- Implementation and Development of the Medstat product. The SURS Unit designed all profiles used in the development of the Medstat Advantage Suite database currently being implemented at the Department. Implementation of Medstat Advantage Suite significantly increases the SURS Unit's analytic and reporting capacity.
- Civil False Claims – Senate Bill 509, passed by the New Hampshire General Court on May 6, 2004, takes effect on January 1, 2005. The bill provides for civil recoveries of a false claim paid or approved by the Department.
- Staff Trainings – Access to relevant training for SURS Unit staff has increased significantly. Recent trainings were conducted on Access and Excel, the Accordia review system, and Medstat Advantage Suite, and nurses receive ongoing professional licensure training.

As a result of the Department's increased emphasis on Medicaid Program integrity, combined SURS and Medicaid Fraud Control Unit (MFCU) recoveries have increased substantially from State Fiscal Years (SFY) 2002 to 2004. In SFY 2002, the combined SURS/MFCU recoveries were $616,865; in SFY 2003, the combined recoveries totaled $971,826; and, in SFY 2004, the combined recoveries totaled $1,354,396. However, with additional resources, the Department would likely be able to do a more effective job at detecting and preventing fraud and abuse in the Medicaid Program, and increasing the amount of recoveries and recoupments.

The Department recognizes that efforts to detect and prevent fraud and abuse in the Medicaid program must be based on partnerships and cooperative efforts with beneficiaries, Medicaid providers, contractors, and state and federal agencies such as state Medicaid Fraud Control Units, other state Surveillance and Utilization Review Units, the Office of the Inspector General, the Federal Bureau of Investigation, the Department of Justice and Congress. In addition, the Department recognizes the importance of systemic risk assessment to identify potential problems and program vulnerabilities; the ability of technology solutions to help find and fight fraud; the usefulness of surveys and site visits to increase assurance that billers are qualified and legitimate; and, the importance of reaching out to partners to gain their participation in efforts to protect the integrity of the Medicaid Program.

Recognizing that fraud and abuse drain the Medicaid Program of funds needed to provide medical services to those individuals truly in need, the Department will seek additional resources needed to:

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- Conduct fraud and abuse risk assessments on an ongoing basis, so that Department investigative resources can be directed at the areas of highest risk for Medicaid fraud and abuse.
- Maximize reliance on technology to detect and prevent Medicaid fraud and abuse.
- Investigate and prosecute all potential Medicaid fraud and abuse.
- Establish more effective controls to prevent Medicaid fraud and abuse.
- Work more collaboratively with state and federal partners to prevent, detect, and prosecute Medicaid fraud and abuse.

SURS staff positions are 75% federal and 25% general fund. The Department believes that any additional SURS position will bring in far in excess of the total appropriated.

DHHS traditionally has managed an aggressive estate recoveries activity. In State Fiscal Year 2003, the Department's Estate Recovery Unit collected $5.2 million from liens, estate claims, special needs trusts and assorted other collections. Under GraniteCare, DHHS proposes to expand its recovery efforts even further by:

- Revising administrative rules that limit the Department to recoveries from improperly paid Medicaid claims only when eligibility errors occur as a result of "willful" action by a consumer. Elimination of "willful" would allow the State to recoup improperly paid claims in instance of negligence and simple intends to defraud.
- Expanding the number of programs from which recovery is mandated to include the Medicaid for Employed Adults with Disabilities Program (MEAD) and the Aid to the Needy Blind Program (ANB).
- Expanding assets subject to recovery to include those that pass outside of probate, including irrevocable trusts, joint tenancies, life estates and annuities. Currently, DHHS pursues only probatable assets and only when those assets are properly contained in a probate estate.
- Dedicating a full-time DHHS attorney to estate recoveries and estate management.

III. OTHER INITIATIVES/RECOMMENDATIONS

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A. Substance Abuse Benefit

"I am a little nervous. Almost two hours and no one has mentioned a chronic disease called alcoholism." (Cheshire County Community Forum)

By improving alcohol, tobacco, and other drug prevention, intervention, and treatment services for Medicaid enrollees, health outcomes will improve, and savings will accrue to the program by averting the direct medical costs associated with drug, alcohol, and tobacco use. For example, more than 27% of all smoking-caused healthcare expenditures within the State are paid for by the NH Medicaid program. Alcohol dependence and alcohol-related disorders are prevalent within the medical care setting. Among Medicaid clients, 26% of general medical patients present with alcohol-related disorders. This is a prevalence rate similar to other chronic diseases such as hypertension and diabetes. Over 72 conditions that require hospitalization are wholly or partially attributable to alcohol use.

The first component being proposed is targeted towards the primary care setting and reflects a synthesis of evidence-based recommendations, with over 20 years of scientific study and evaluation demonstrating reduction of alcohol and tobacco consumption and its associated problems. The basic features consist of providing reimbursement and possibly incentives to primary care providers for 1) screening; 2) brief office-based intervention with ongoing monitoring and follow up; and 3) referral of high-risk patients to specialty care.

Additional components of a comprehensive substance abuse benefit could include some of the following program ideas. Each would need additional analysis to assess feasibility of implementation and cost-effectiveness:

- Establish patient incentives for smoking cessation at 3-, 6-, and 12-month maintenance intervals (e.g., mug, coupons, cash).
- Provide patient reimbursement for enrolling children and youth in activity-based or academic after school and/or summer programs (e.g., YMCA, Scouting, Boys & Girls Clubs) to address risk factors for substance abuse among youth.
- Give provider incentives for referring patients/family members for activity-based or academic after school and/or summer programs to address risk factors for substance abuse among youth.
- Give provider incentives for making referrals to the REAP program (Resident Education Assistance and Prevention Program), which serves older and disabled adults living in subsidized housing with substance abuse/misuse prevention, early problem identification, and referral services. Explore the feasibility of having REAP services reimbursable under Medicaid.
- Replicate Vermont's use of the EPSDT program to support Student Assistance Programs in schools through the administrative claiming provision plus assess making Student Assistance Services available to all schools in New Hampshire.
- Expand the number of prevention services (e.g., education, screening, early intervention, alternative activities) reimbursable under Medicaid by making Certified Prevention Specialists eligible providers for a specified class of services.
- Enroll approved Substance Abuse treatment contractors as Medicaid eligible providers as well as Licensed Alcohol and Drug Abuse Counselor (LADAC) staff within those facilities. Medicaid could reimburse counselor hours for face-to-face contact, individual and group treatment and management and assessment.

- Provide aggressive outreach to the Medicaid population could increase the number of individuals seen in treatment, allowing treatment funds to be reallocated to provide more services to adolescents.

B. New Hampshire Hospital

A significant portion of the financial resources allocated to mental health care in the State is spent at New Hampshire Hospital (NHH). New Hampshire can be proud of the quality of care provided in its state mental health institution, but many believe that a greater share of the resources should be shifted to community care. DHHS is exploring ways to move more patients into community care settings and to ensure that resources move with them. Studies are underway to determine how groups of patients can be transferred from NHH to community programs allowing closure of wards at NHH. Also under consideration is making NHH psychiatrists available to provide assistance through community mental health centers for one or two days each week.

C. De-Coupling the Home and Community-Based Services (HCBS) Waiver Program from the Institutional (ICF/MR) Model

"Frequent reauthorization for individuals whose disability is permanent and unlikely to change is unnecessary, intrusive and very expensive." (Family Advisory Committee comment)

Since the 1980s, states across the nation have increasingly provided services to people with developmental disabilities (DD) through home- and community-based service arrangements while reducing or eliminating institutional services. This shift away from the institutional service model has been driven by the fact that, in general, community-based services have been demonstrated to be more effective in both quality and cost. Moreover, the strong preference toward community-based services has not only been sought by states but also been firmly expressed by the recipients of services, their families, and advocates. Lastly, the federal government, through its publications from the Centers for Medicare and Medicaid Services (CMS), has distinctly and repeatedly articulated its focus on and promotion of community-based service options over institutional care. Yet, the principal funding source for the preferred home- and community-based service options (Medicaid's HCBS Waivers) continues to exist as a derivative of and secondary to the institutional funding stream (ICF/MR), requiring extensive staff time and paper work to demonstrate the "need for institutional care" for individuals who clearly meet the criteria for developmental services.

The State of New Hampshire, which closed its mental retardation institution in 1991, believes it is time to advance the system and establish community-based services as the primary model of services and funding for people with developmental disabilities. The Department will assess the feasibility of a Medicaid-funded and completely community-based DD service system without any institutional connections or requirements. Under such a system, funding for home and community services would be available on its own merit without any references or requirements associated with institutional service or funding models, eliminating the need for additional annual reviews of each person's "qualification for an institutional level of care," reviews that consume a considerable amount of staff time and funding resources from the area agencies and the Department.

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D. Unused Drugs

DHHS is reviewing a proposal to allow the donation of unused prescription drugs to State residents who can't afford them. It is estimated that individuals and health care facilities discard millions of dollars of usable medications each year after prescriptions change, nursing home residents die, etc. Recycling unopened and unexpired medications could greatly benefit medically indigent persons and could cut down on the chemical pollution of our rivers and drinking water systems. Several states have undertaken such programs, but Oklahoma's is reported to be the most extensive.

E. Liability Limitations

"Limit malpractice exposure, and you will find many more providers willing to participate." (New Hampshire Hospital Association)

There are many factors that affect access to health care providers for Medicaid recipients. Health care providers indicate that one factor is their reluctance to assume additional liability risks at the reimbursements levels available under Medicaid. A proposal under consideration would place limits on the malpractice liability of health care providers when treating Medicaid and other medically indigent patients, arguably improving access for both populations.

F. Critical Access Home Care

One goal of GraniteCare is to support home health services and hospice care in an effort to reduce nursing home utilization. This can be challenging in rural areas because rural, not-for-profit home health agencies often have large service areas with low density population, with home health personnel having to travel long distances to serve a relatively small number of clients. Because these agencies are a key link between homebound, frail elderly persons and sometimes distant medical services, such as a community hospital, clinic, health center or physician practice, GraniteCare proposes the creation of a critical access home health agency designation, analogous to the critical access hospital designation that New Hampshire successfully employs as part of the federal Rural Hospital Flexibility Program. In that program, rural hospitals qualify for a special designation if they have a limited number of beds and agree to a number of provisions to improve access and quality of care and to support rural networks. With this designation comes an enhanced Medicare reimbursement rate in the outpatient setting.

DHHS proposes to use the critical access hospital program as a model to designate critical access home health agencies that would obtain enhanced Medicare reimbursement. In turn, the State could pay enhanced Medicaid reimbursement. The cost of increased reimbursement to home health agencies would be more than offset by savings from decreased nursing home admissions. This would require CMS participation, involving Medicare as well as Medicaid. In this program, DHHS could negotiate with providers in the same way it currently does with hospitals seeking critical access designation. In exchange for enhanced reimbursement, these agencies would have the responsibility to focus their efforts on the delivery of services specifically intended to avert nursing home utilization. An example might be to expand hospice-related services. The Department may also require that they be affiliated with a critical access hospital or a community health center, in order to facilitate the linkages between home care and medical care.

G. Children's Purchased Services

"Medicaid should work collaboratively with schools and other services to meet the needs of NH citizens." (Family Advisory Committee comment)

Currently, children and youth who have extensive needs for rehabilitative services and supports often do not receive the services they need, when and where they most need them. No single point of entry to the system exists, making the coordination of care extremely difficult as the services are provided by the Department's Division for Children, Youth and Families (DCYF), the Division for Juvenile Justice Services (DJJS), the Division of Community Based Care Services (DCBS) and the Department of Education (DOE). Furthermore, the services provided are often driven by the specific "door" through which the child enters the system rather than by the individual needs of children and their families. Finally, this disparate system creates a situation in which many children and families see multiple case managers across divisions and agencies, creating a lack of continuity as well as a duplication of effort.

To address the disconnectedness that is currently a reality in the management of rehabilitative services for children and youth, DHHS proposes to create an Administrative Service Organization (ASO) within its existing infrastructure through a rebalancing of current resources. The ASO will maintain responsibility for managing the rehabilitative services provided by DHHS and DOE for children and youth who are coded as needing Special Education Services in an Individualized Educational Plan (IEP). The ASO will provide a single point of access for the entire population and offer a standardized assessment for the entire breadth of services offered. The ASO will also offer care management, provide comprehensive treatment and services planning within the local community, and ensure parent and consumer participation.

The specific initiatives the ASO will undertake fall into 2 general categories: (1) improving the quality of care for consumers; and (2) increasing the efficient use of available funds.

The ASO would focus on the following:

- Home-and community-based services: The ASO will contract with local provider systems/networks for the delivery of a comprehensive array of community-based rehabilitative services and supports that will seek to maintain children/youth in their own homes and communities whenever possible, to achieve a better quality of life, and to avoid unnecessary hospital and residential care.
- Single point of entry: The single point of entry will enable the ASO to assess the needs of each consumer and offer a comprehensive array of community-based rehabilitative services to serve their individual needs.
- Consumer participation: The ASO will fully engage consumers and their families in the management of their care, providing consumers with increased choice and responsibility over their own care.
- Development of a resource guide: The resource guide will enable families to have a better understanding of the community services available for their child(ren).

The creation of an ASO to manage the delivery of public rehabilitative services for children and youth in New Hampshire will implement consolidated and streamlined administrative functions, thereby increasing efficiency and reducing overall program costs. The ASO would accomplish the following:

- Reduction in administrative costs: The ASO's singular administrative structure will pool financial resources from the following departments/programs: DCYF, DJJS, DCBS; Department of Education Medicaid to Schools; Catastrophic Aid and Court-Ordered Services; thereby reducing overall administrative costs. Shared administrative functions will include eligibility determination, prior authorization, utilization review, discharge planning, case management, quality management, provider certification and/or licensing, claims processing and data management.
- Increased efficiency in administrative claiming: The streamlined administrative process will facilitate more precise claiming of all administrative costs in the single cost allocation plan.
- Streamlining claims processing: All claims will be handled by a single claims process through DHHS, thus eliminating the need for multiple providers to send claims to multiple funding sources.
- Consolidated staffing: Staffing for the management of the shared administrative structure will be pooled from existing staff positions currently within DCYF/ DJJS, the Bureau of Behavioral Health and DOE. The ASO, therefore, will take advantage of the existing knowledge base within DHHS, thus easing the transition to the new system.
- Integration of diverse funding streams: Providers and consumers will be able to develop individualized community-based care plans that rely on multiple funding streams across multiple departments within DHHS. In this manner, the ASO will be able to identify all available funding opportunities and be able to offer consumers the most appropriate and comprehensive level of services available.
- Enhanced technology: The common administrative infrastructure resulting from an ASO will allow for an integration of existing databases to provide for more effective financial planning, ensure connectivity to MMIS, avoid duplicative or contraindicated services and improve budget management.

H. Consumer Empowerment and Responsibility

"Individuals who clearly take a proactive role in their own care should be rewarded accordingly. When people are enabled to make healthy decisions, everyone benefits." (Medicaid Feedback)

"Why would you use your commercial insurance (when) the deductibles, co-pays, etc., are higher than Medicaid if (you are) not required?" (Medicaid Feedback)

A fundamental goal of GraniteCare is to empower consumers and to encourage their involvement in maintaining and improving their health status. The initiatives described below are designed to increase consumer control and involvement in their health care decisions, provide incentives to consumers for making good healthcare choices and to providers for providing high quality care, and implement some cost-sharing measures designed to encourage appropriate utilization of services.

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The plan envisions greater consumer empowerment and responsibility through a combination of four initiatives. These include making more information concerning the quality and price of medical services available to consumers; offering incentives for consumers to protect their health and to deal with their existing healthcare issues proactively; providing consumers with access to funds to enable them to make decisions and direct their own care; and having consumers share in a small percentage of the cost of their care, where appropriate and reasonable.

- Report Cards (see page 26).
- Health Services Accounts (see page 20).
- Incentives: Although the Health Services Accounts will only be covering those whose incomes exceed 133% of the federal poverty level, New Hampshire will create other incentives to encourage clients to take more responsibility and interest in their own health care. Consumers will be rewarded for complying with parts of their individual care plans such as preventive visits and adherence to standards of care for those with chronic health conditions.
- Premiums, Co-pays and Deductibles: New Hampshire believes that some small amount of cost sharing by consumers will lead to greater awareness in decision-making on the part of Medicaid consumers.

I. Restructuring the Delivery of Mental Illness Management Services (MIMS)

Mental Illness Management Services, commonly referred to as "MIMS," has been a Medicaid reimbursable service since the early 1990s under the Rehabilitation Option in the State Medicaid Plan. MIMS are clinical interventions, prescribed by the individual's psychiatrist, as medically necessary services to assist the individual in developing the skills necessary to manage the debilitating symptoms of mental illness. Because these services are delivered in the community, individuals with serious mental illness have had the opportunity to receive clinical supports in settings previously not available to them, for example in a work setting, allowing countless individuals to live more productive lives and achieve recovery from mental illness.

The service has been extremely effective in promoting recovery, and it is not the intent of the department in making this recommendation to remove access to this critical service for consumers, but rather address a number of significant issues by proposing to:

- Revise current administrative rules to define the service according to nationally recognized standards. Specifically, define the service according to the Evidenced Based Practice of "Illness Management and Recovery."
- Establish clear guidelines to specify who is eligible to receive the service, based on objective evaluation criteria, not simply the current process of meeting eligibility under the SMD definition (Severely Mentally Disabled) referenced in RSA 135-C and He-M 401.
- Establish guidelines for the medical necessity of the service, specific criteria that an individual must meet in order to receive the service
- Remove the different service categories listed under MIMS (e.g. Symptom management, crisis intervention, medication intervention) and instead have one service, called "IMR- Illness Management and Recovery," with the current iterations listed instead as objectives on the individualized service plan.

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- Consider expanding the role of Peer Support to play a more active role in the delivery of supportive services in the community, including IMR.
- Rebase the current fee-for-service system to be more aligned with the cost of providing the services. This includes resetting the current MIMS rates and making adjustments to other rates (e.g. Psychiatry) to be more reflective of the actual cost of providing the service.
- Remove the financial incentives inherent in the current reimbursement structure.
- Consider establishing annual, monthly, weekly or even daily service limitations (maximum allowable amounts).
- Reimburse service based on an essentially budget neutral case rate or capitated payment to be all inclusive of MIMS services provided in the month.
- Establish a cost finding methodology for providers to report back to the state, and establish a tighter rate setting methodology based on cost.
- Establish a different funding mechanism for critical services such as Emergency Services, perhaps as an annual all-inclusive grant, to move entirely away from dependence on fee for service since little revenues are generated from the service. This will remove the impact of providing services to the indigent population, and the effect that these services have on the cost of services to Medicaid recipients when establishing and resetting rates.
- Revise RSA 135-C to give the Department of Health and Human Services clear legislative authority to establish alternative frameworks for the mental health delivery system, eligibility criteria and who determines eligibility for services (that may include limitations on services for certain populations), and flexibility for both the Department and the consumer (choice) in determining who is eligible to provide services.
- Revise the statutes accordingly to reflect the intent of the legislature as to who the priority population is and address the issue of optional services.
- Address the issue of Conditional Discharges and tighten the criteria for revocation (returning individuals back to a hospital) for involuntary care based on compliance with the terms of their discharge from the Hospital. The current system allows for potential over-utilization of New Hampshire Hospital resources, for individuals who can have their needs met in other, less restrictive settings.

J. Developmental Disability (DD) Waiting List:

Under this recommendation, the department would focus further attention on funding for the Priority #1 Developmentally Disabled wait list, where decisive action by the Legislature created a considerable amount of progress during the last three biennia. By maximizing the resources provided through legislative appropriations, the New Hampshire Area Agency system and the Department were able to move 504 people off the wait list, at a cost of about $31,000 per person. Consequently, as of July 1 of 2004, the Priority #1 DD wait list stood at 196, the first time it has been under 200 since 1999.

The Department intends to work with the legislature, area agencies and other provider agencies to maintain this positive development and build on the successes of the recent past. The Department will use the multi-dimensional approach of redeploying savings achieved through agency consolidations and securing additional legislative appropriations to prevent the waiting list numbers from building up to previous higher levels. In the meantime, the Department will support those individuals on the wait list who are eligible for other DHHS programs through a variety of services. For example, many individuals on the waiting list who qualify for Medicaid are able to receive a number of services, such as rehabilitative services, physicians'

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services, private duty nursing, and prescription drugs, under the State Plan. Moreover, many of the individuals on the wait list do not go without any area agency services and are typically given some assistance, such as family support, respite, and part-time day services while they wait for more substantial area agency services.

In 2001, the New Hampshire Legislature passed Chapter 270, laws of 2001, which required DHHS to develop a plan to reduce the waiting list and the waiting period to 90 days. The plan, *Renewing The Vision,* was submitted in November of that year to the Legislature and its Developmental Disability Waitlist Fund Allocation Oversight Committee and to the Governor. While not implemented, the Department remains in support of the vision articulated in the plan.

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IV. SUBMITTAL OF COMMENTS

The Department welcomes comments on GraniteCare. Comments may be submitted via E-mail or in writing.

- E-mail comments should be submitted to:

  MedicaidFeedback@dhhs.state.nh.us

- Written comments should be addressed to:

  John A. Stephen, Commissioner
  Attn: Medicaid Feedback
  NH Department of Health and Human Services
  129 Pleasant St
  Concord NH 03301

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A Pending Resolution from the National Governors' Association

COMMUNITY SERVICES AND SUPPORTS RESOLUTION

Commitment To Community-based Long Term Care Services and Support

WHEREAS millions of people with disabilities and older Americans currently need or will need long term services and supports to live in the community and this number is expected to grow at a rapid pace over the next three decades; and

WHEREAS the current long term care system is fragmented, overly medicalized, bureaucratic, expensive with an institutional bias that unnecessarily forces people with disabilities and older Americans in nursing homes and other institutions; and

WHEREAS the Supreme Court in the Olmstead vs. LC & EW decision ruled in 1999 that people have the right to services in the most integrated setting; and

WHEREAS the American public overwhelmingly supports long term care services and supports be provided in their own home and communities; and

WHEREAS the reform of the long term care (services and supports) system must be a cooperative partnership between the federal government, the states and the disability/older community,

THEREFORE BE IT RESOLVED that the National Governors Association, NGA, by a vote of the membership and the Executive Committee supports the following:

A) The current long term services and support system has an institutional bias that must be reformed through a cooperative effort by the federal government, the states and the disability/older community including those who use services; and

B) The long term services and support system must include the principles that home and community services and supports are the first priority and that support services should be provided in the most integrated setting; and

C) No person with a disability or older American should be forced into a nursing home or other institution because of the lack of integrated home and community options; and

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D) People with disabilities and older Americans must have full inclusion in the design, implementation and review of the long term services and support system; and

BE IT FUTHER RESOLVED that the NGA supports the passage and funding of the Medicaid Community Attendant Services and Supports Act, MICASSA (currently S971 - HR 2032) and legislation that include the Money Follows the Person initiative (currently S. 1394 – HR 1811); and

BE IT FURTHER RESOLVED that the NGA work with the individual states to assure that the Supreme Court's Olmstead decision is aggressively implemented and that the measure of this implementation be, in a year, how many people have gotten out of nursing homes and other institutions and how many people have been diverted from nursing homes and other institutions; and

BE IT FURTHUR RESOLVED that the NGA work with the stated to assure that any 1115 waivers submitted by a State should have statewide public hearings before development and submission to HHS, and that the 1115 waiver process should not be used to undercut current community Medicaid services and federal protections; and

BE IT FURTHER RESOLVED that the NGA supports reform of the long term services and support system that does not result in block granting, capitating or otherwise reducing or eliminating funding to the states or the removal of the current national Medicaid protections.

Passed this day____________________February 2005

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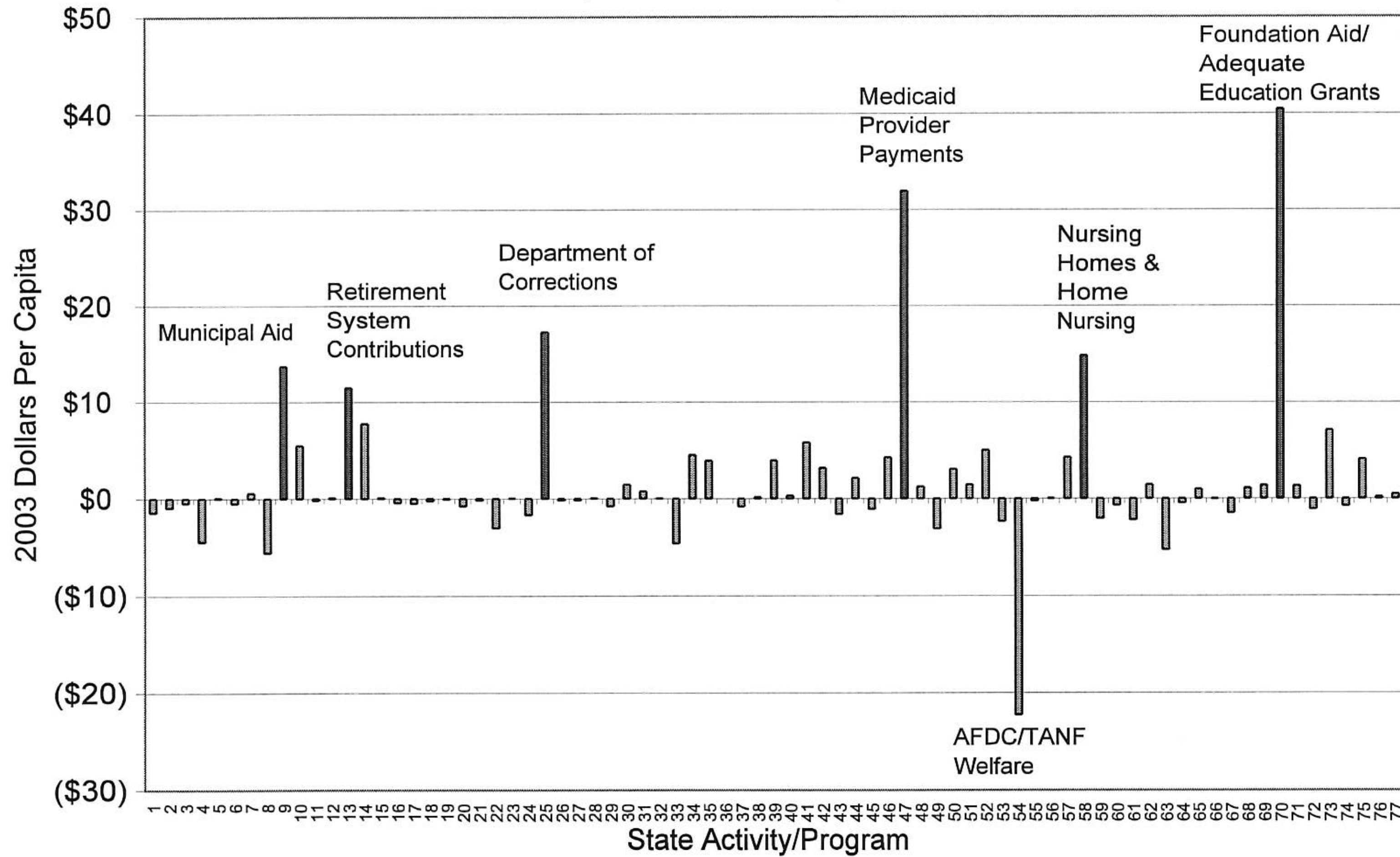

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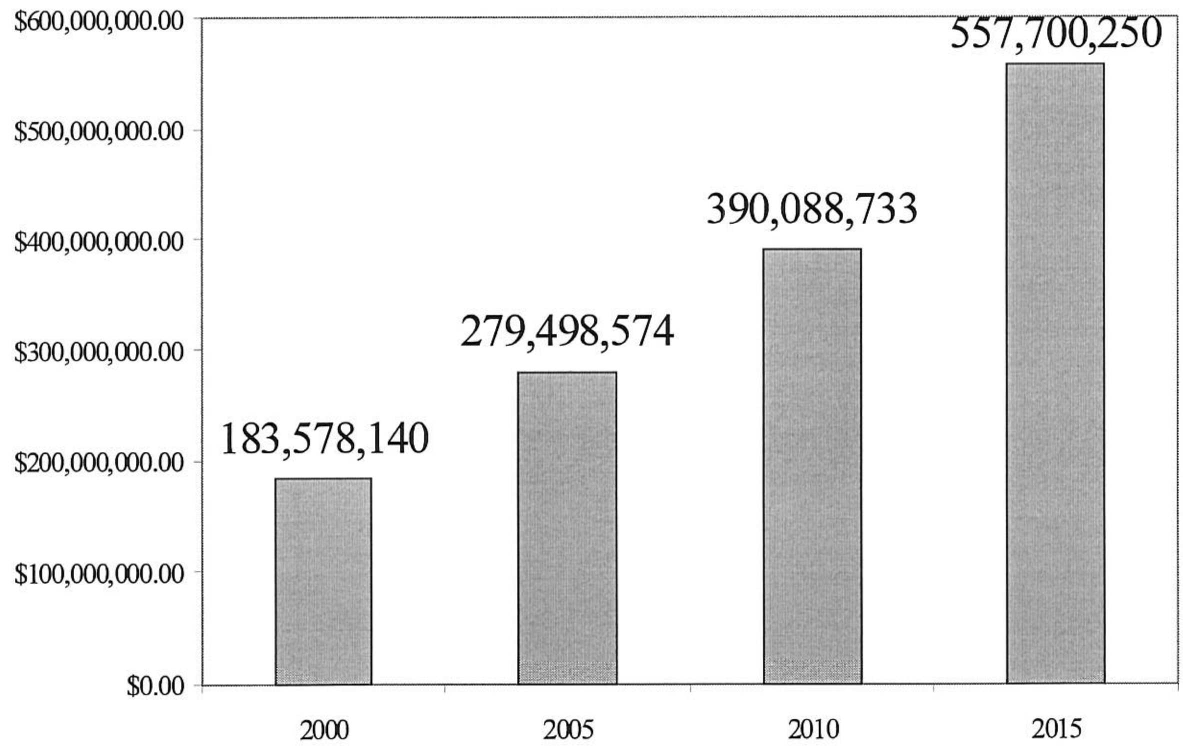
Projected Long Term Care Spending



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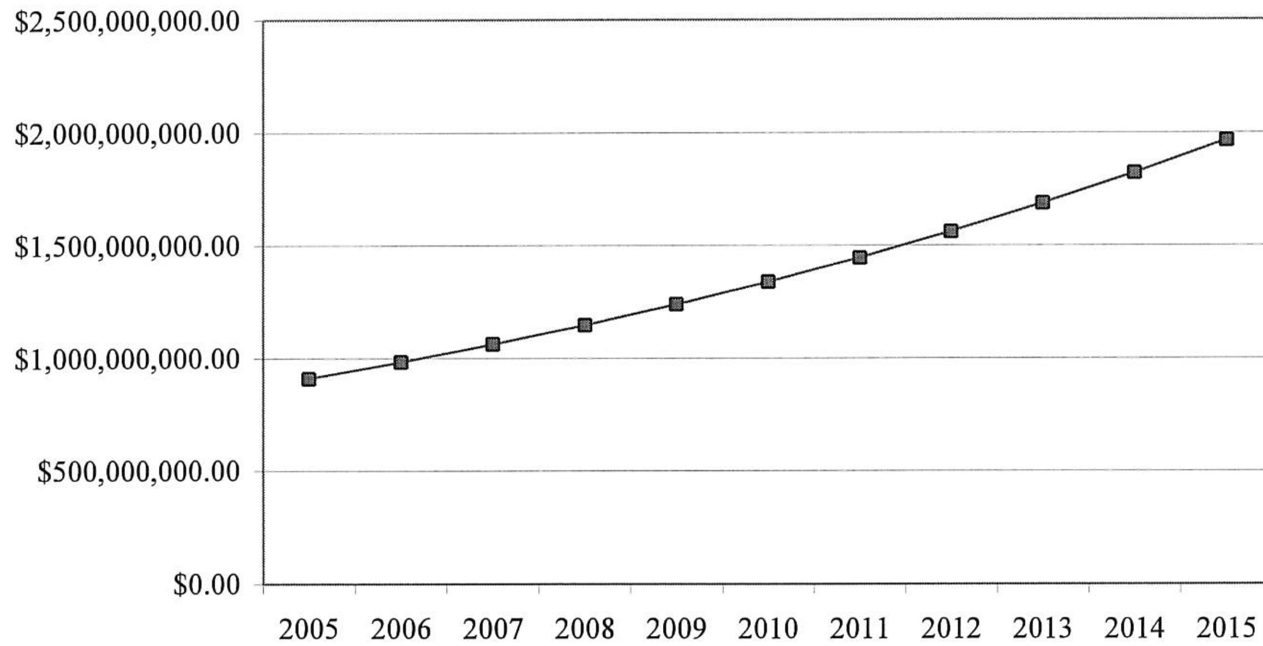
Estimated Trend in Medicaid Spending



2004 POVERTY LEVEL GUIDELINES
ALL STATES (EXCEPT ALASKA AND HAWAII) AND DC

Income Guidelines as Published in the Federal Register on February 13, 2004
Effective Date: February 13, 2004
ANNUAL GUIDELINES

FAMILY SIZE	100% POVERTY*	120%	133%	150%	170%	175%	185%	190%	200%	250%	300%
1	9,310.00	11,172.00	12,382.30	13,965.00	15,827.00	16,292.50	17,223.50	17,689.00	18,620.00	23,275.00	27,930.00
2	12,490.00	14,988.00	16,611.70	18,735.00	21,233.00	21,857.50	23,106.50	23,731.00	24,980.00	31,225.00	37,470.00
3	15,670.00	18,804.00	20,841.10	23,505.00	26,639.00	27,422.50	28,989.50	29,773.00	31,340.00	39,175.00	47,010.00
4	18,850.00	22,620.00	25,070.50	28,275.00	32,045.00	32,987.50	34,872.50	34,872.50	37,700.00	47,125.00	56,550.00
5	22,030.00	26,436.00	29,299.90	33,045.00	37,451.00	38,552.50	40,755.50	41,857.00	44,060.00	55,075.00	66,090.00
6	25,210.00	30,252.00	33,529.30	37,815.00	42,857.00	44,117.50	46,638.50	47,899.00	50,420.00	63,025.00	75,630.00
7	28,390.00	34,068.00	37,758.70	42,585.00	48,263.00	49,682.50	52,521.50	53,941.00	56,780.00	70,975.00	85,170.00
8	31,570.00	37,884.00	41,988.10	47,355.00	53,669.00	55,247.50	58,404.50	59,983.00	63,140.00	78,925.00	94,710.00

*For family units of more than 8 members, add $3,180 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	100% POVERTY	120%	133%	150%	170%	175%	185%	190%	200%	250%	300%
1	775.83	931.00	1,031.86	1,163.75	1,318.92	1,357.71	1,435.29	1,474.08	1,551.67	1,939.58	2,327.50
2	1,040.83	1,249.00	1,384.31	1,561.25	1,769.42	1,821.46	1,925.54	1,977.58	2,081.67	2,602.08	3,122.50
3	1,305.83	1,567.00	1,736.76	1,958.75	2,219.92	2,285.21	2,415.79	2,481.08	2,611.67	3,264.58	3,917.50
4	1,570.83	1,885.00	2,089.21	2,356.25	2,670.42	2,748.96	2,906.04	2,984.58	3,141.67	3,927.08	4,712.50
5	1,835.83	2,203.00	2,441.66	2,753.75	3,120.92	3,212.71	3,396.29	3,488.08	3,671.67	4,589.58	5,507.50
6	2,100.83	2,521.00	2,794.11	3,151.25	3,571.42	3,676.46	3,886.54	3,991.58	4,201.67	5,252.08	6,302.50
7	2,365.83	2,839.00	3,146.56	3,548.75	4,021.92	4,140.21	4,376.79	4,495.08	4,731.67	5,914.58	7,097.50
8	2,630.83	3,157.00	3,499.01	3,946.25	4,472.42	4,603.96	4,867.04	4,998.58	5,261.67	6,577.08	7,892.50

Ref: Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.

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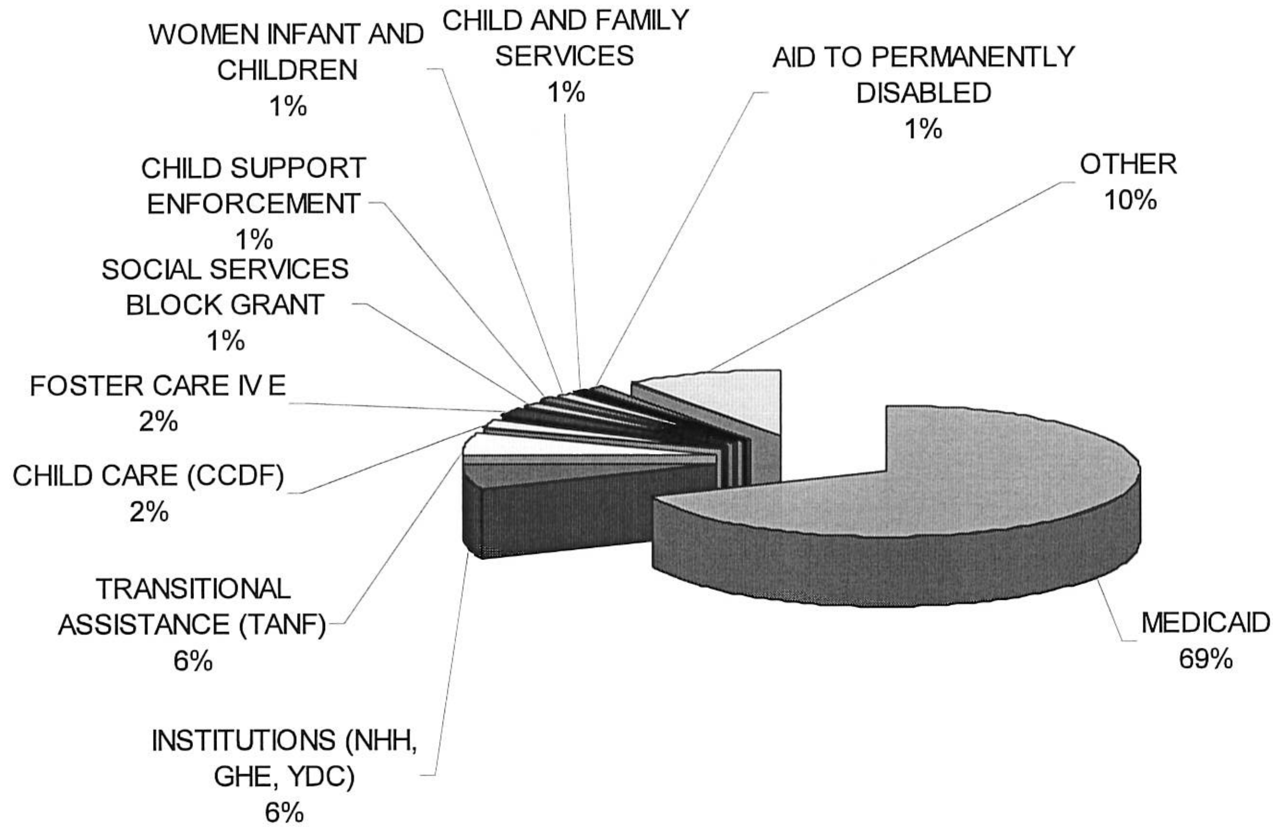
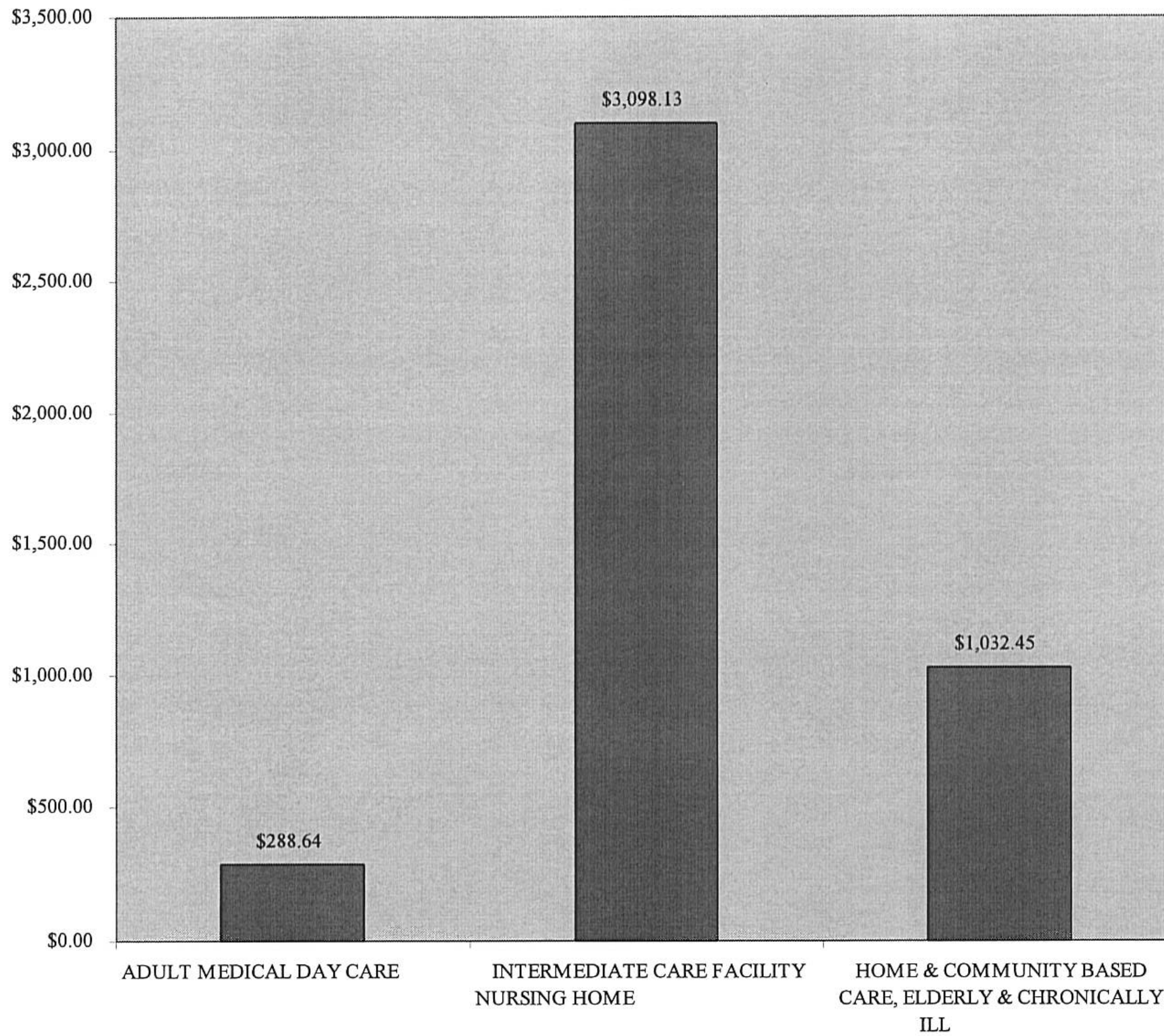
Medicaid Expenditures by Programs/Services



2-83



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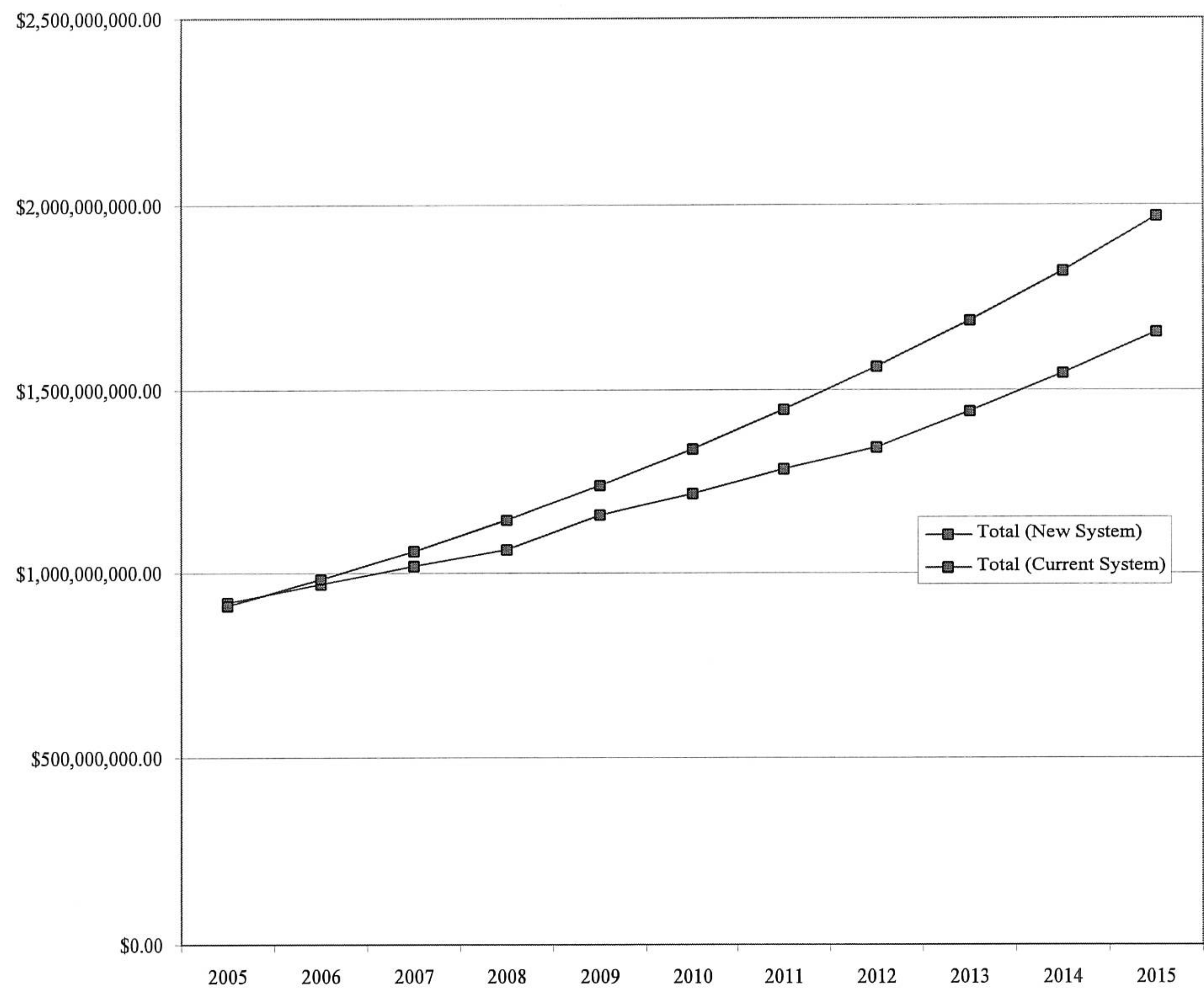

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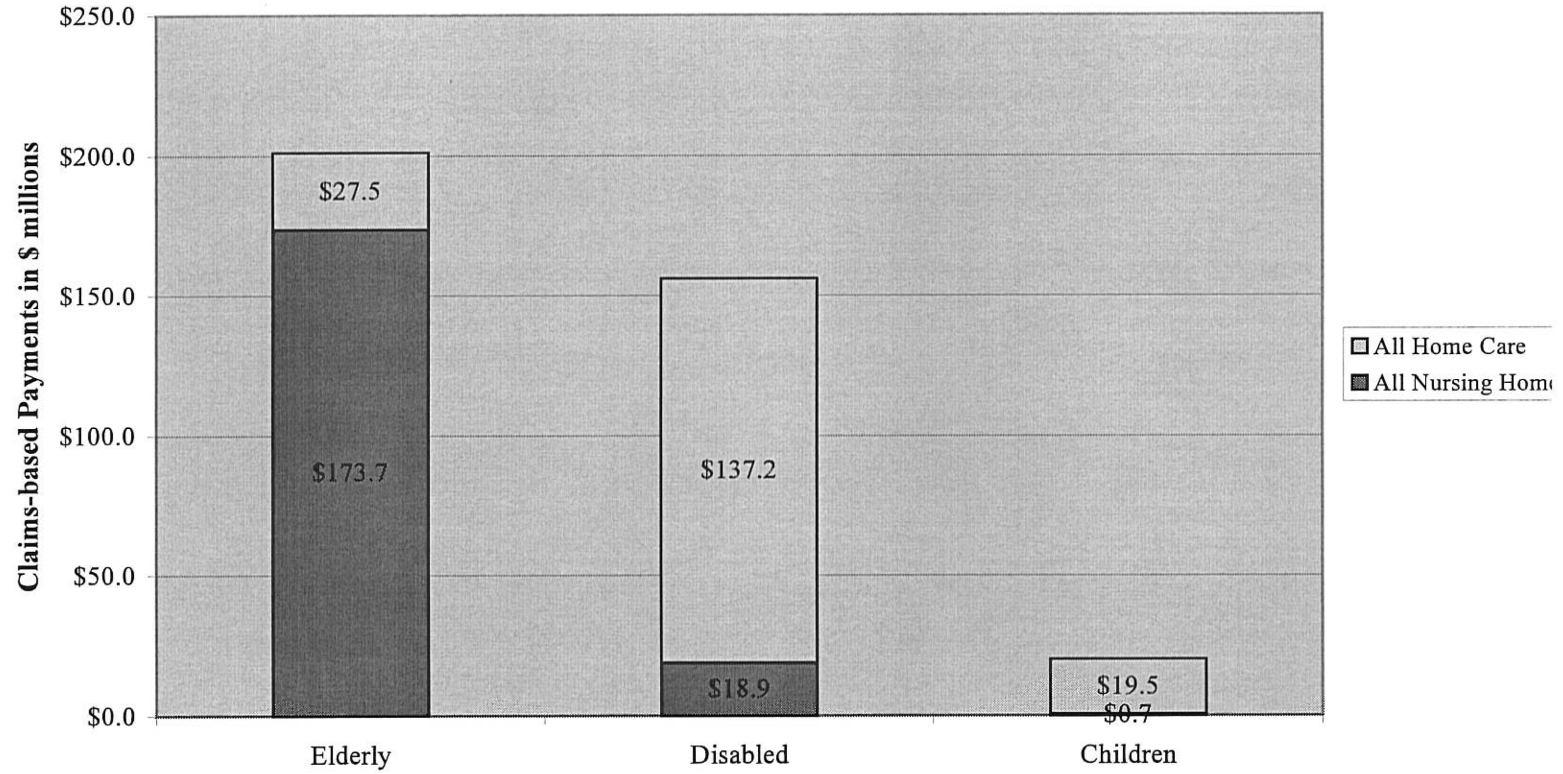

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EPSDT Prevention Guidelines

Prevention guidelines for EPSDT (Early Periodic Screening, Diagnosis and Treatment) are based on the Foundation for Healthy Communities Prevention Guidelines and the Institute for Clinical Systems Improvement (ICSI). Routine Prenatal Care Guidelines

Age 0-1:

7 office visits
1 dentist visit
17 vaccinations
1 lead screening test
1 anemia screening test

Ages 2:

1 office visit
1 lead screening test
8 vaccinations (age 2 only)
1 dentist visit

Age 3-18:

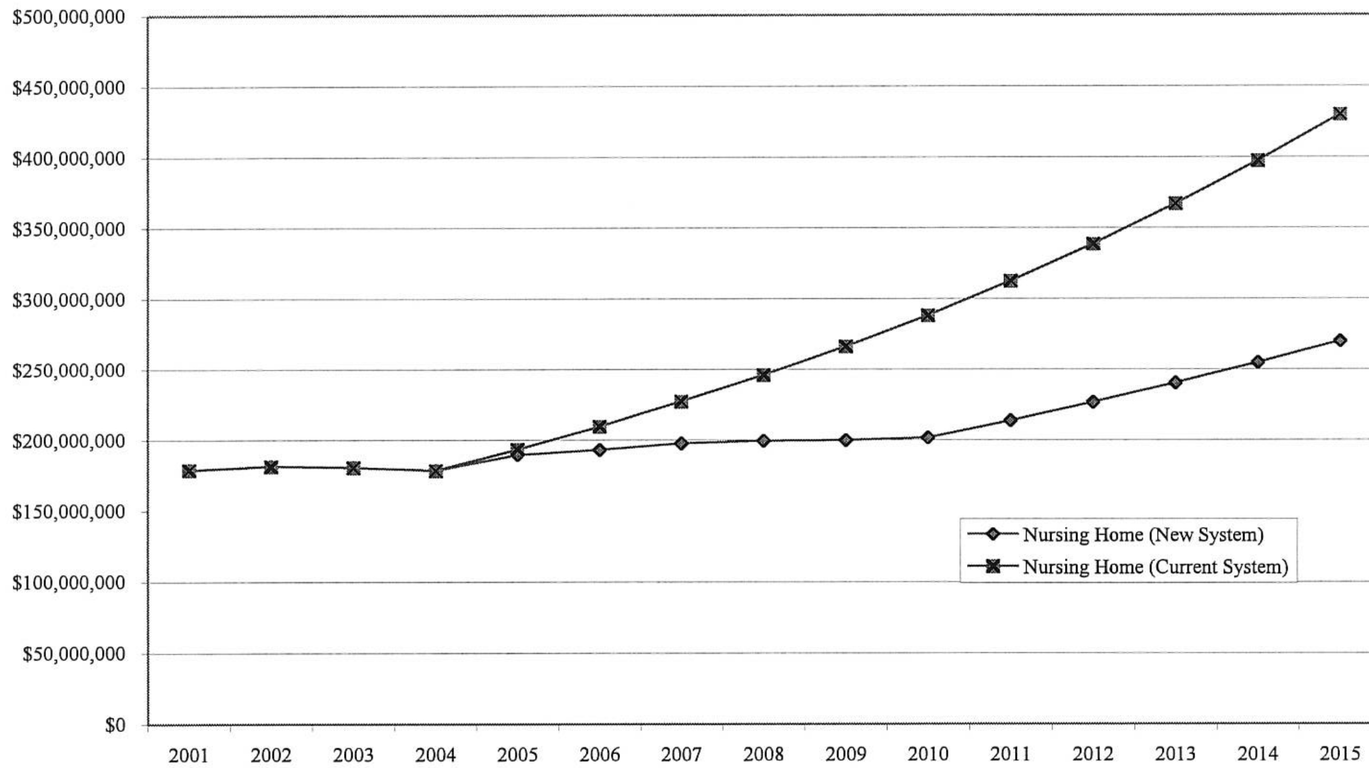
1 office visit
5 vaccinations (age 4 only)
2 dentist visits with fluoride treatment
dental sealants (age 7 and 14 only)

Pregnant women:

11 prenatal office visits
Lab tests:

Hemoglobin; Rulla/rubeola; aricella; RPR; Urine culturep; Hepatitis B surface AgHIV; Chromosome/neural tube defect (NTD) screening; Culture for group B streptococcus; and ABO/Rh/Ab (RhoGAM)

5 vaccinations (Tetanus-diphtheria [Td] booster, MMR, Varicella, Hepatitis B, Influenza)



Change in Rate of Growth in Nursing Home Expenditures (Granite Care)
$500,000,000
$450,000,000
$400,000,000
$350,000,000
$300,000,000
$250,000,000
$200,000,000
$150,000,000
$100,000,000
$50,000,000
$0
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Nursing Home (New System)
Nursing Home (Current System)

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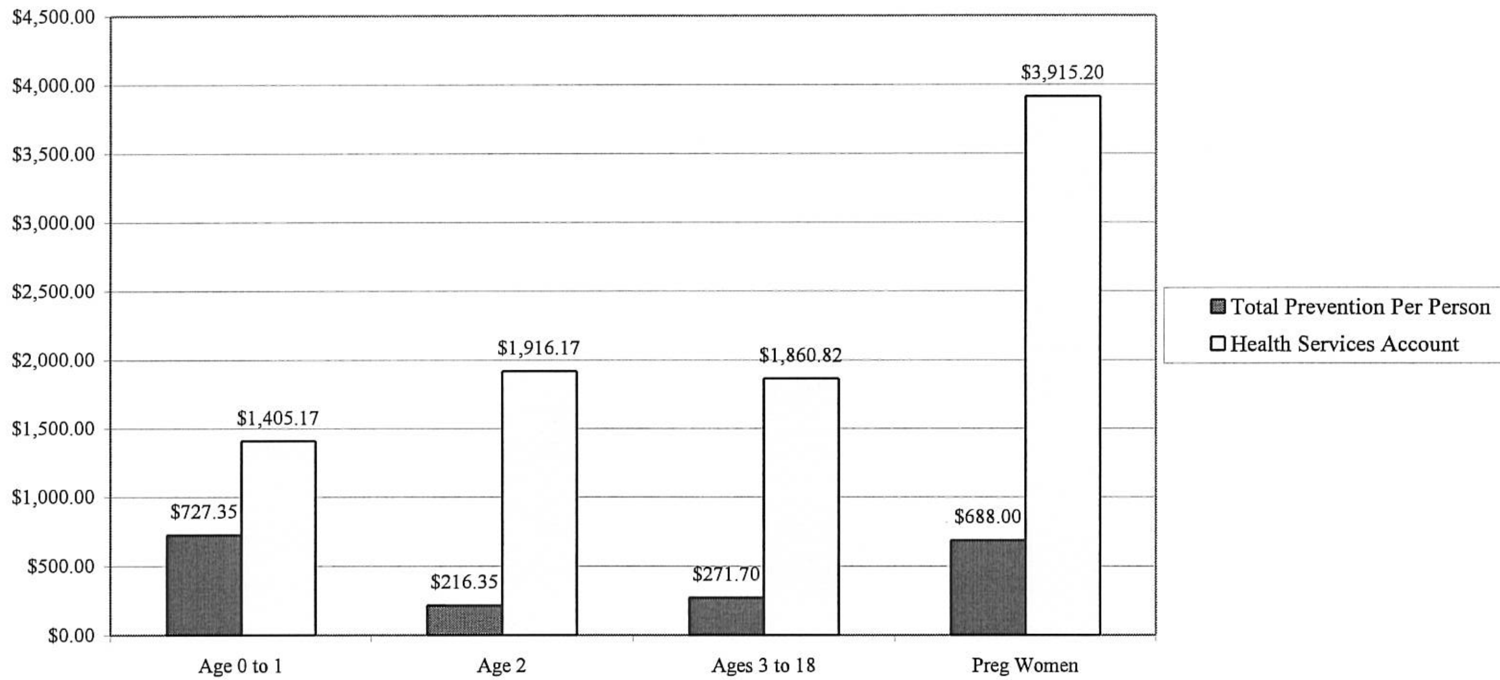

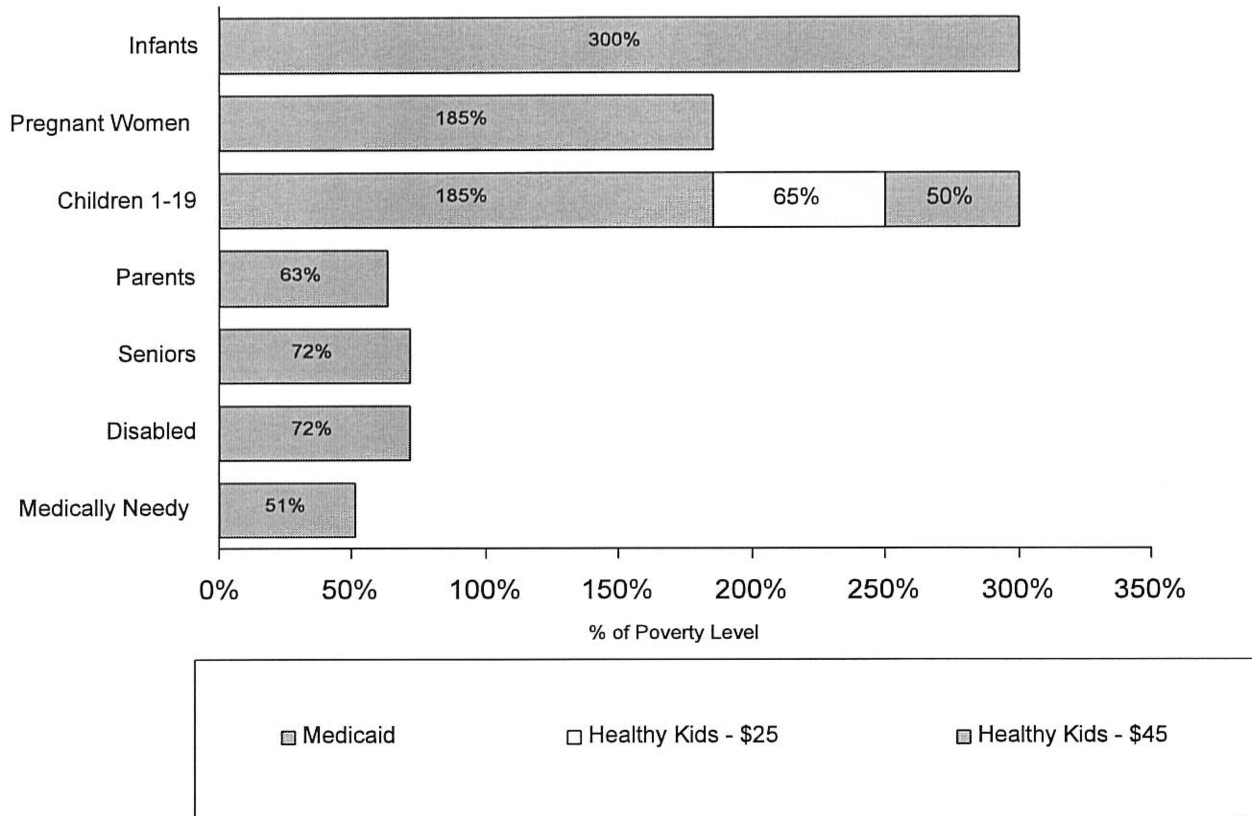
Who is Eligible for Medicaid in New Hampshire?
Infants
Pregnant Women
Children 1-19
Parents
Seniors
Disabled
Medically Needy
300%
185%
185%
65%
50%
63%
72%
72%
51%
0%
50%
100%
150%
200%
250%
300%
350%
% of Poverty Level
Medicaid
Healthy Kids - $25
Healthy Kids - $45

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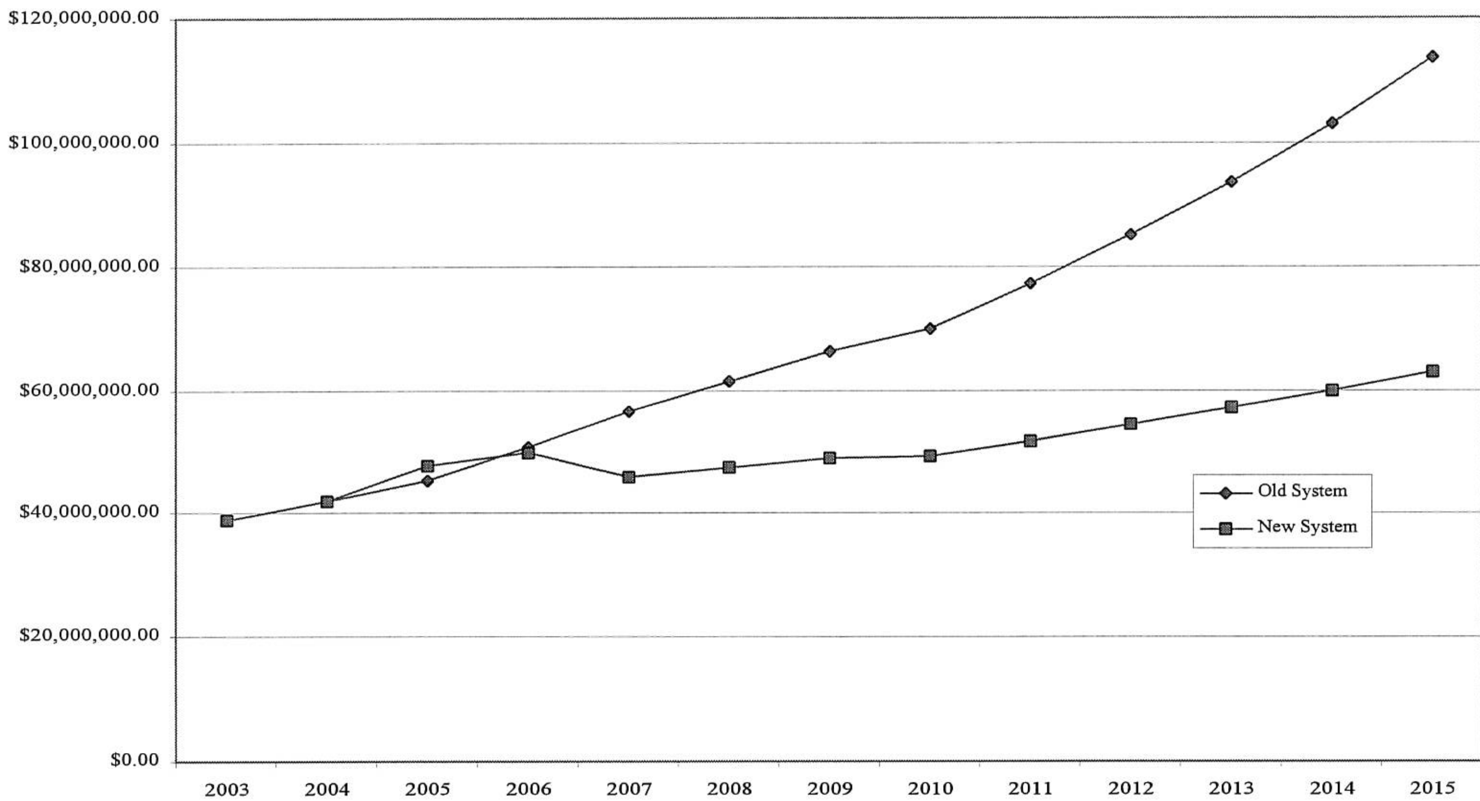
Medicaid Benefits: Federal and State Mandates

FEDERAL MANADATES	STATE MANDATES
Intermediate Care Facility (ICF) Nursing Home	Home and Community Based Care, Developmentally Impaired
Outpatient hospital, General	Home and Community Based Care, Elderly and Chronically Ill
Inpatient Hospital, General	Clinic Services (School Services)
Physicians Services	Personal Care Services
Home Health Services	
Rural Health Clinic	
Skilled Nursing Facility (SNF) Nursing Home	
Dental Services	
SNF Nursing Home Atypical Care	
ICF Nursing Home Atypical Care	
Laboratory (Pathology)	
I/P Hospital Swing Beds, SNF	
I/P Hospital Swing Beds, ICF	
Family Planning Services	
Advanced Registered nurse Practitioner	
X-Ray Services	

Medicaid Benefits: Optional Services

Dispense Prescribed Drugs	Optometric Services - Eyeglasses
Mental Health Centers	Ambulance Services
Private Non-Medical Institutional Services (Children)	Adult Medical Day Care
Health Maintenance Organizations (HMOs)	Crisis Intervention
Furnished Medical Supplies/Durable Medical Equipment	Physical Therapy
Private Duty Nursing	Clinical Services (Without School Services)
Day Habilitation Centers	Medical Services - Clinics
Psychology Services	Intensive Home and Community Services
Wheelchair Van Services	Podiatrist Services
Placement Services	Occupational Therapy
ICF Services for the Mentally Retarded	Chiropractic Services
Inpatient Psychiatric Facility Services (Under Age 22)	Speech Therapy
Home Based Therapy	Audiology Services
Child Health Support Services	Outpatient Hospital Services - Mental



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