Department of Health and Human Services

Budget Summary
State Fiscal Years Ending June 30, 2010 to 2013
House Finance Discussion Document

Prepared February 28, 2011

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Governor's Adjustments to Agency Budget Request (Maintenance & Change)

Rounded to $000

	A	B	C	D	E	F	G	H	I	J
73	ELDERLY									
74	**Bud**	**Org**	**Div**	**Initiative**	**12 Reductions**		**SFY 13 Reductions**			
75	**Ref**	**Code**			**General**	**Total**		**General**	**Total**	
76	1021	5944	BEAS	MQIP 100% (State Retains 25%)	$8,438	$8,438		$8,606	$8,606	
77										
78	1019	5942	BEAS	Reversal of Change Item - Full N.F. Rates	$41,568	$83,136		$42,611	$85,222	
79	1020	5943	BEAS	Reversal of Change Item - Full N.F. Rates - Proshare	$0	($18,246)		$0	($18,612)	
80	1019	5942	BEAS	Reversal of Change Item - Home Health Rates	$167	$334		$180	$360	
81	1019	5942	BEAS	Discontinue Case Management to Mid-Level Care	$514	$1,028		$575	$1,150	
82	1019	5942	BEAS	Redefine/clarify Rule for Personal Care Services	$773	$1,546		$1,400	$2,800	
83	1019	5942	BEAS	Redefine/clarify Rule for Homemaker Services	$66	$132		$120	$240	
84	1019	5942	BEAS	Require Single Dose Medication for H.H.RN Visits	$853	$1,706		$879	$1,758	
85	Var	Var	BEAS	Personnel Services - Permanent	$137	$255		$136	$253	
86	Var	Var	BEAS	Personnel Services - Benefits	$59	$108		$63	$116	
87										
88	1016	2202	BEAS	Eliminate Catastrophic Illness Program	$250	$250		$260	$260	
89	1013	8918	BEAS	Freezes funding N. H. Foster Grandparents Program	$1	$1		$2	$2	
90	1014	8919	BEAS	Freeze funding Retired Senior Volunteer Program	$2	$2		$3	$3	
91	1016	9565	BEAS	Freeze State Funding of Service Link Program	$41	$41		$55	$55	
92	1015	8943	BEAS	Freeze funding ADRD & Caregiver Program	$3	$3		$9	$9	
93	1015	8915	BEAS	Freeze funding Congregrate Housing Supports	$14	$14		$29	$29	
94										
95	1008	7872	BEAS	Rate Reduction-Transportation	$33	$78		$67	$159	
96	1008	7872	BEAS	Rate Reduction-Social Service Contracts	$13	$31		$26	$62	
97	1010	9255	BEAS	Rate Reduction-Contacts - SSBG Program Svcs.	$4	$4		$8	$8	
98	1010	9255	BEAS	Rate Reductions-I.&.R. Contracts	$2	$2		$3	$3	
99	1010	9255	BEAS	Rate Reductions-Meals-Home Delivered	$30	$30		$60	$60	
100	1010	9255	BEAS	Rate Reductions-Adult Group Day Care	$99	$99		$107	$107	
101	1010	9255	BEAS	Rate Reductions-Adult In Home Care	$31	$31		$78	$78	
102	1021	6180	BEAS	Rate Reductions-Assessment+Counseling	$6	$53		$18	$97	
103	1019	5942	BEAS	Rate Reduction-HCBC-CFI-Home Support	$534	$1,068		$918	$1,836	
104	1008	7872	BEAS	Rate Reductions-Meals-Home Del.+Congregate	$56	$134		$112	$268	
105	Var	Var	BEAS	Unrestricted Revenue	$468	$0		$168	$0	
106										
107	998	6170	DFA	Reduction to State Supp grant when live w/family-OAA	$75	$75		$75	$75	
108	998	6170	DFA	Change OAA grant to prospective vs. retrospective	$90	$90		$90	$90	
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048-6173 & 5942 NURSING SERVICES-NURSING FACILITY (504)

CLIENT PROFILE

Nursing Facility Services are provided to individuals of all ages who meet clinical and financial eligibility guidelines in RSA 151-E:3.

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
TOTAL FUNDS	$182,714	$173,748	$182,435	$186,084	$182,435	$186,084
GENERAL FUNDS	$9,696	$10,678	$38,012	$45,499	$31,355	$37,764
CASELOAD	*4,357*	*4,378*	*4,400*	*4,422*	*4,400*	*4,422*
COST PER CASE-TOTAL	*$41,936*	*$39,678*	*$41,463*	*$42,081*	*$41,463*	*$42,081*

SERVICES PROVIDED

Age 1-17: Nursing facility services provided to children with severe disabilities:

- Temporary Assistance to Needy Families (TANF).
- Aid to the Needy Blind (ANB)

Age 18-64: Nursing facility services are provided to individuals who meet the clinical and financial eligibility guidelines in RSA 151-E:3:

- Aid to the Needy Blind (ANB),
- Aid to the Permanently and Totally Disabled (APTD) or
- Temporary Assistance to Needy Families (TANF)

Age 65 and Over: Nursing facility services are provided to individuals who meet the clinical and financial eligibility guidelines in RSA 151-E:3:

- Aid to the Needy Blind (ANB),
- Temporary Assistance to Needy Families (TANF) or
- Old Age Assistance

IMPACT IF SERVICES LOST

If nursing facility services are eliminated:

1. Department of Health and Human Services would be out of compliance with CMS regulation 42 CFR Part 440, which requires coverage of nursing facility services by every Medicaid Program.
2. Department of Health and Human Services would lose the 50% federal matching funds for services provided to seniors and adults with disabilities who require nursing facility level of care.
3. The loss would have a detrimental impact on the financial viability of these providers as they are funded primarily by the Medicaid Program.
4. Significant disruption would be experienced by frail nursing facility clients and their families, who would be forced to endure transition to another facility or entity.
5. Numerous jobs would be lost due to nursing facilities closing, which would have a negative impact on local economy.
6. There would be increased dependence on local communities, which may not have the resources, to assist individuals in need.

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048-6173 & 5942 HOME & COMMUNITY BASED SERVICES (506 & 529)

CLIENT PROFILE

Home and Community Based Services are provided to individuals aged 18 and older who meet clinical and financial eligibility for nursing facility level of care as defined in RSA 151-E:3, and who choose to receive services in their homes or other community setting when this services costs are less than 50% of average annual cost to provide services in a nursing facility.

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
CLIENT PROFILE						
TOTAL FUNDS	$49,717	$50,790	$54,413	$56,957	$48,933	$49,173
GENERAL FUNDS	$2,634	$3,117	$11,328	$11,390	$10,301	$9,971
CASELOAD	*2,568*	*2,595*	*2,621*	*2,647*	*2,621*	*2,647*
COST PER CASE-TOTAL	*$19,360*	*$19,572*	*$20,760*	*$18,486*	*$18,670*	*$18,577*

SERVICES PROVIDED

Age 18-64: Community Based Services are provided to individuals who meet the clinical and financial eligibility guidelines in RSA 151-E:3:

- Aid to the Needy Blind (ANB),
- Aid to the Permanently and Totally Disabled (APTD) or
- Temporary Assistance to Needy Families (TANF)

Age 65 and Over: Community Based Services are provided to individuals who meet the clinical and financial eligibility guidelines in RSA 151-E:3:

- Aid to the Needy Blind (ANB),
- Temporary Assistance to Needy Families (TANF) or
- Old Age Assistance (OAA)

Home Support Waiver Services: Includes Adult Medical Day, Adult-In Home Care, Respite, Personal Care, Personal Emergency Response System, Home Delivered Meals, Environmental Accessibility Adaptations, Supportive Housing, and Case Management services.

Home Health Waiver Services: Includes Skilled Nursing, Home Health Aide and Homemaker services.

IMPACT IF SERVICES LOST

If Home and Community Based Services are eliminated:

1. Individuals who now receive assistance with their activities of daily living that enable them to remain in their communities instead of requiring institutional care, would not have access to this care.
2. The additional annual expense to care for these individuals would be $71,607,510 in nursing home expenditures.
3. During the month of July 2010, 2,925 Medicaid-eligible individuals participated in Choices For Independence, all of whom are clinically and financially eligible to receive nursing facility services.
4. 60% of the 2,925 Choices For Independence clients (representing 1,755 clients) are aged 65 and over. If these 1,755 Medicaid-eligible individuals moved into nursing facilities due to the unavailability of home-based care, at an annualized average cost of $66,203 (including Medicaid Quality Incentive Payment), rather than Choices For

Independence, at an average annualized cost of $25,401, the additional annual expense would be $71,607,510.

5. This would reduce or eliminate revenue for the agencies that provide these services.
6. Many jobs would be lost by staff of the agencies affected by the elimination of the Home and Community Based Services, which would have a negative impact on the local economy.
7. Any reduction in the amount of time spent by direct service staff with a Choices For Independence participant could result in an increase in caregiver burden, which has been correlated to an increase in nursing home admissions.
8. Participants who spend less time with in-home care workers may become isolated and at risk of self-neglect or physical danger.
9. Department of Health and Human Services would lose the 50% Federal matching funds for these services.

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048-6173 & 5942 MID-LEVEL CARE (505)

CLIENT PROFILE

Mid-Level Care services are provided to individuals who have been found eligible to participate in the Home and Community Based Care program, Choices for Independence, and who have chosen to receive services in a licensed residential care facility instead of a nursing facility. Program participants are aged 18 and older. They must meet clinical and financial eligibility guidelines in RSA 151-E:3, and their care costs must be less than 60% of average annual cost to provide services in a nursing facility.

Rounded to $000	**SFY10 Actual**	**SFY11 Adj Auth**	**SFY12 Maint Req**	**SFY13 Maint Req**	**SFY12 Governor**	**SFY13 Governor**
CLIENT PROFILE						
TOTAL FUNDS	$6,239	$8,818	$7,812	$8,925	$7,812	$8,925
GENERAL FUNDS	$331	$541	$1,626	$1,818	$1,614	$1,810
CASELOAD	*363*	*406*	*455*	*509*	*455*	*509*
COST PER CASE-TOTAL	*$17,187*	*$21,718*	*$17,170*	*$17,534*	*$17,169*	*$17,534*

SERVICES PROVIDED

Mid-Level Care Services are provided on a 24/7 basis by licensed Residential Care facilities for persons eligible for the Home and Community Based Care program, Choices for Independence. The average Medicaid payment per mid-level care resident is approximately 40% of that of the average Medicaid nursing home payment per resident. Such low reimbursement for 24/7 service provided in a licensed setting has slowed both the development and the utilization of this very cost-effective service, and it has discouraged new facilities from enrolling as Medicaid providers.

IMPACT IF SERVICES LOST

If Mid-Level Care Services were eliminated:

1. Eligible residents would not be able to continue to live in these licensed facilities and would be required to move into nursing facilities.
2. This would reduce or eliminate revenue for the licensed facilities that provide mid-level care and many would no longer remain in business.
3. As a result of 2. above, many jobs would be lost by staff of the facilities affected by the elimination of the mid-level care, negatively impacting the local economy.
4. The costs of these eliminated services would shift to county and local governments due to the local welfare laws
5. The department receives numerous inquires from prospective providers potentially interested in enrolling as residential care providers; however, upon hearing of the extraordinarily low rates of reimbursement they are no longer interested.

048-6173 OTHER NURSING SERVICES (509)

CLIENT PROFILE

Other Nursing Homes provides nursing facility services for people eligible for Medicaid under Aid to the needy Blind (ANB), and children at Cedarcrest, the only Intermediate Care Facility for the Mentally Retarded (ICF-MR) facility in New Hampshire.

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
TOTAL FUNDS	$3,787	$4,810	$4,391	$4,479	$4,391	$4,479
GENERAL FUNDS	$1,893	$2,405	$2,195	$2,195	$2,239	$2,239
CASELOAD	*37*	*35*	*39*	*39*	*39*	*39*
COST PER CASE-TOTAL	*$102,351*	*$137,429*	*$112,590*	*$114,846*	*$112,590*	*$114,846*

SERVICES PROVIDED

The other Nursing Home category consists of services provided by Cedarcrest, an Intermediate Care Facility for the Mentally Retarded (ICF-MR) serving children who are severely disabled. This facility has a capacity of 24 children and depends primarily upon Medicaid funds and is the only one of its type on New Hampshire. The reduction would have a detrimental impact on the continuation of services to this extremely vulnerable population. Home and community based services are not adequate to support the special needs of this population. Therefore, the only alternative is placement at out-of-state facilities, which are more costly and would make it more difficult for families to maintain relationships with their children and to prepare for the eventual discharge to the community.

IMPACT IF SERVICES LOST

1. DHHS would be out of compliance with CMS regulation 42 CFR Part 440, which requires coverage of nursing facility services by every Medicaid program.
2. DHHS would lose the 50% federal matching funds for services provided to seniors, adults and children with disabilities who require nursing facility level of care.
3. The loss would have a detrimental impact on the financial viability of these providers, as they are funded primarily by the Medicaid Program.
4. Lost jobs due to nursing facilities closing will negatively impact the economy of local communities.
5. Increased dependence on communities to assist individuals in need.

048-6180 LTC ASSESSMENT & COUNSELING (ALL)

CLIENT PROFILE

A substantial portion of these funds are allocated to the ServiceLink Resource Center program, a locally based information and assistance resource for long-term care and community services for the elderly and for adults with disabilities. ServiceLink is the single point of entry for Medicaid funded long-term care for seniors and adults with disabilities. Funds are also used to reimburse providers whose nurses are trained to complete the Medical Eligibility Determination (MED) assessment instrument for Medicaid-covered long-term care.

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
TOTAL FUNDS	$1,391	$1,777	$1,790	$1,816	$1,778	$1,780
GENERAL FUNDS	$690	$888	$895	$908	$889	$890

SERVICES PROVIDED

Services provided under this heading include a number of activities related to the clinical eligibility determination process for Medicaid-funded long-term care, including both nursing home care and home and community based services. It funds a portion of the ServiceLink Resource Center operation that provides long term care counseling to nursing home applicants mandated under RSA 151-E, the salaries of the Bureau of Elderly and Adult Services Long-Term Care Nurses, and reimbursement for trained community nurses who complete the Medical Eligibility assessment required to establish an individual's clinical eligibility for long term care.

IMPACT IF SERVICES LOST

1. DHHS would lose the 50% federal matching funds that enable ServiceLink to provide the information and assistance resource for long-term care and services for elderly and disabled adults.
2. Individuals and families would no longer have the supported decision model that ServiceLink provides to help them consider all of their options for care when that care is needed, not just nursing home care.
3. Over time, the medical eligibility process has become standardized, with uniform procedures and process flows. The lack of uniformity that would result if funding for the registered nurses were eliminated would result in eligibility errors that would have a financial impact for the State and would increase admission to Nursing Facilities.

048-8915 CONGREGATE HOUSING (ALL)

CLIENT PROFILE

Congregate Housing Program services are provided at nine public housing sites that provide supportive services to frail elderly and incapacitated adults who reside there.

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
TOTAL FUNDS	$764	$736	$751	$766	$737	$737
GENERAL FUNDS	$764	$736	$751	$766	$737	$737

SERVICES PROVIDED

Congregate Housing Program Supportive services include transportation to scheduled medical appointments, meals, personal assistance, housekeeping, and service coordination. Individuals who reside at these locations are unable to maintain their independence without the supportive services provided.

IMPACT IF SERVICES LOST

If Congregate Housing Program services were eliminated:

1. Department of Health and Human Services would be in violation of RSA 161-F:39 and 24 CFR700.
2. Rate cuts and/or contracted unit cuts would result in providers being unable to continue providing services due to the loss of the state as a funding partner.
3. Individuals who lose access to these services would be at great risk of decline.
4. Without these services, some individuals would deteriorate to the point where more costly nursing facility care would become necessary.

048-9255 SOCIAL SERVICES BLOCK GRANT (ALL)

CLIENT PROFILE

Social Services Block Grant Services are provided to individuals 18 years of age and older. There is an income eligibility limit currently at $1,116 per month per person. The services are provided by contracted agencies and other vendors throughout the State. Services are means-tested. Eligibility must be redetermined annually. These services have traditionally served low-income individuals who do not meet Medicaid financial eligibility but who cannot pay privately for their services. Many are at or near clinical eligibility for nursing home care.

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
TOTAL FUNDS	$10,097	$10,842	$11,058	$11,279	$10,738	$10,785
GENERAL FUNDS	$5,493	$5,617	$5,833	$6,054	$5,679	$5,816

SERVICES PROVIDED

The Social Service Block Grant provides the following services:

1. Adult In Home Care,
2. Homemaker,
3. Adult Day Services,
4. Emergency Support Services, authorized by Bureau of Elderly and Adult Services District Offices, and
5. Home Delivered Meals.

IMPACT IF SERVICES LOST

If the Social Service Block Grant is eliminated:

1. These reductions/elimination would reduce the provision of these contracted services to community residents and have a negative impact on their health and safety.
2. Rate cuts and/or contracted unit cuts could result in providers deciding not to continue providing services if reimbursement is deemed to be inadequate and/or the number of units is not sustainable for that particular program.
3. Individuals who would not have access to these services may suffer poor nutrition or become isolated due to not receiving assistance in their homes or attending group day programs.
4. In addition, some individuals would deteriorate to the point where more expensive nursing home care becomes their only viable option. It can be assumed that the Medicaid long term care caseload will increase as these individuals gradually spend down to eligibility levels.
5. In general, persons receiving these services are more isolated and having home delivered meals provides a safety net inasmuch as contact with the meals provider allows someone to check on their safety.

048 - 5943 Proshare (514)
048 – 5944 Medicaid Quality Incentive Payment (516)

CLIENT PROFILE
Proportionate Share payments (Proshare) are made to county nursing homes only. Medicaid Quality Incentive Payment (MQIP) is the quarterly payment of supplemental rates to all Medicaid nursing homes. Nursing Facility Services are provided to clients of all ages who meet clinical and financial eligibility guidelines in RSA 151-E:3.

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
Proshare						
TOTAL FUNDS	$9,814	$26,301	$18,236	$18,600	$23,231	$23,695
GENERAL FUNDS	$0	$0	$0	$0	$0	$0
Medicaid Quality Incentive Payment						
TOTAL FUNDS	$87,860	$84,472	$67,501	$68,851	$50,626	$51,638
GENERAL FUNDS	$0	$0	$0	$0	$0	$0

SERVICES PROVIDED
Proportionate Share (Proshare) payments are made to county nursing homes in accordance with federal regulations. The dollar value for Proportionate Share is calculated annually based upon ten months of actual data and two months of estimates to determine the difference by county facility between the Medicare and Medicaid rates. If Medicaid rates are lowered, that widens the gap and increases what the counties receive in Proshare. However, the counties would only receive half of this variance in federal funding, as the other half would be considered the county match.

Medicaid Quality Incentive Payment (MQIP) is the quarterly payment of supplemental rates to all Medicaid nursing homes. This payment is based upon paid Medicaid bed days using federal dollars matched to the State funds raised through the Nursing Facility Quality Assessment (NFQA) tax, which is a 5.5% assessment fee on net patient service revenue that can be increased to the Federal level of 6.0% on October 1, 2011. This payment is designed to bridge the gap between New Hampshire Medicaid acuity based payment rates and fully reimbursing nursing facilities at the full cost, at or near the Federal upper payment limit.

IMPACT IF SERVICES LOST
If both the Proportionate Share (Proshare) payments and the Medicaid Quality Incentive Payment (MQIP) are lost:

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1. Nursing facilities would be dramatically impacted by this reduction/elimination.
2. The reduction/elimination would have a detrimental impact on the financial viability of these providers as they are funded primarily by the Medicaid Program.
3. The original SFY2012 and SFY2013, budget projections were based upon an increase in caseload of 0.5% per year. This rate reduction will, therefore, mean a lower reimbursement per resident for a time frame with increased Medicaid occupancy.
4. Nursing facilities also received supplemental funds from American Recovery and Reinvestment Act (ARRA) of approximately $18 million per year during SFY2010 and SFY2011. American Recovery and Reinvestment Act (ARRA) funding is scheduled to end on June 30, 2011.

If only Medicaid Quality Incentive Payments are lost:

1. Additional Federal dollars will not be leveraged for nursing facility cost support.
2. This additional financial burden to non-county facilities would result in providers of nursing facility services closing, causing increased unemployment and an adverse impact on local economies, as well as a reduction in service availability to the citizens of New Hampshire who require this care.
3. Proportionate Share (Proshare) payments to the counties would be increased

If only Proportionate Share (Proshare) payments are lost:

1. There will be a detrimental impact on the financial viability of these county providers as they are funded primarily by the Medicaid Program.

045-6170 OAA APTD GRANTS

CLIENT PROFILE

This category of cash assistance is available to residents who are 65 years of age or older. Eligibility for this category of assistance depends upon income, resources and living arrangement. Individuals determined eligible for cash assistance are also automatically eligible for Medicaid

Rounded $000	SFY10 Actual	SFY11 Adj Auth	SFY12 Maint Req	SFY13 Maint Req	SFY12 Governor	SFY13 Governor
TOTAL FUNDS	$2,939	$2,697	$3,116	$3,179	$2,763	$2,846
GENERAL FUNDS	$2,816	$2,697	$3,116	$3,179	$2,763	$2,846
CASELOAD	1,383	1,347	1,479	1,509	1,394	1,398
COST PER CASE-TOTAL	*$2,125*	*$2,002*	*$2,107*	*$2,107*	*$1,982*	*$2,036*

SERVICES PROVIDED

Cash Assistance

IMPACT IF SERVICES LOST

Four impacts are potential.

1) Because the Old Age Assistance (OAA) cash program is mandated by the Social Security Act, New Hampshire would lose 100% of federal Medicaid funding.
2) Costs would be downshifted to municipal cities and towns. Statute requires cities and towns to provide basic assistance;
3) To the extent that towns are relieved of their statutory burden, churches and charities are the remaining safety nets.
4) A reduction to the safety net would mean significant financial deprivation for basic living expenses (rent, clothing, etc) for New Hampshire low-income elderly.

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048-6173 MEDICAL SERVICES FOR ELDERLY

CLIENT PROFILE

Disabled adults under age 65 are enrolled in Medicaid through the Aid to the Permanently and Totally Disabled (APTD) Program. To qualify, clients must have Home and Community Based Care – Elderly/chronically ill special disability determination and a medical assessment from either a community or nursing home, or a nursing home placement level of care.

Cost Figures Rounded to $000

APTD Fund Code J Provider Payments	**SFY10 Actual**	**SFY11 Adj Auth**	**SFY12 Maint Req**	**SFY13 Maint Req**	**SFY12 Governor**	**SFY13 Governor**
TOTAL FUNDS	$21,038	$19,638	$23,002	$25,649	$22,834	$25,207
GENERAL FUNDS	$10,519	$9,819	$11,501	$12,825	$11,417	$12,604
CASELOAD	1,752	1,783	1,851	1,904	1,809	1,827
COST PER CASE-TOTAL FUNDS (Not Rounded)	$12,008	$11,016	$12,428	$13,471	$12,620	$13,793
APTD Fund Code J Pharmacy	**SFY10 Actual**	**SFY11 Adj Auth**	**SFY12 Maint Req**	**SFY13 Maint Req**	**SFY12 Governor**	**SFY13 Governor**
TOTAL FUNDS	$2,284	$3,013	$2,639	$2,750	$2,639	$2,750
GENERAL FUNDS	$1,142	$1,507	$1,319	$1,375	$1,319	$1,375
CASELOAD	1,752	1,783	1,851	1,904	1,809	1,827
COST PER CASE-TOTAL FUNDS (Not Rounded)	$1,304	$1,690	$1,426	$1,444	$1,458	$1,505

SERVICES PROVIDED

Mandate	Patients	Top Categories of Service
Fed	1,240	OUTPATIENT HOSPITAL GENERAL
Fed	59	SNF NURSING HOME ATYPICAL CARE
Fed	346	SKILL NURSING FAC NURSING HOME
Fed	484	INPATIENT HOSPITAL GENERAL
Fed	1,467	PHYSICIANS SERVICES
Fed	775	FEDERALLY MANDATED SERVICES
State	124	PERSONAL CARE
State	14	STATE MANDATED SERVICES
Opt	519	WHEELCHAIR VAN
Opt	925	FURNISHED MED SUP OR DME
Opt	7	PRIVATE DUTY NURSING
Opt	1,027	OPTIONAL SERVICES
Opt	1,184	DISPENSE PRESCRIBED DRUGS
	1,752	SFY 2010 Unique Count of Patients in Group

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SERVICES PROVIDED

Below is a table of optional Medicaid State Plan services. The list includes drugs, which are considered optional Medicaid Services by CMS, but are considered elementary to primary and preventive healthcare by NH Medicaid.

Category of Service Description	Comment on Current Utilization Controls
Drugs	Over-The-Counter (OTC) drug restrictions; dose optimization program requires a Prior Authorization (PA) for the two tablet dosage form, thus encouraging the prescriber to use an "optimized" dosage form; Maximum Allowable Cost (MAC): A program which sets a MAC price for over 4,000 drugs; preferred drug list
Durable Medical equipment and supplies	Prior Authorized, ability to reduce affected by mandatory Medicaid requirements to cover supplies used in home.
Private Duty Nursing	Requires prior authorization per He-W 540.
Personal Care Services	Requires care plan reviewed every 60 days per He-W 552.
Wheelchair van	Limited to 24 trips per year to medical related appointments per He-W 573.
Ambulance Services	Requires medical necessity (emergency)
Psychology	Service limited to 12 visits annually, ability to reduce may be affected by mental health parity requirements in Troubled Assets Relief Program (TARP)
Adult Medical Day Care	Currently requires presence of chronic illness and imminent danger of institutionalization.
Eyeglasses	Currently competitively procured, requires medical necessity. Eyeglass frames purchased under this agreement are guaranteed against breakage for two years from date of purchase.
Medical Services Clinic (Methadone Clinics)	Budget reduced per HB 2, 2009, Rates reduced by 33% in Step 2.

IMPACT IF SERVICES LOST

Approximately 1,750+ eligible clients would lose Medicaid coverage. Highest categories of service utilization for this population are physician services, outpatient hospital and drugs.

048-6173 MEDICAL SERVICES FOR ELDERLY

CLIENT PROFILE

Elderly adults are enrolled in Medicaid through the Old Age Assistance program. Client must have Home and Community Based Care – Elderly/chronically ill special eligibility from either community or nursing home, or nursing home placement level of care.

Cost Figures Rounded to $000

Elderly Fund Code J Provider Payments	**SFY10 Actual**	**SFY11 Adj Auth**	**SFY12 Maint Req**	**SFY13 Maint Req**	**SFY12 Governor**	**SFY13 Governor**
TOTAL FUNDS	$12,324	$13,088	$15,509	$17,299	$15,295	$16,739
GENERAL FUNDS	$6,162	$6,544	$7,754	$8,649	$7,648	$8,369
CASELOAD	7,585	7,718	8,013	8,243	7,834	7,912
COST PER CASE-TOTAL FUNDS (Not Rounded)	$1,625	$1,696	$1,935	$2,099	$1,953	$2,116
Elderly Fund Code J Pharmacy	**SFY10 Actual**	**SFY11 Adj Auth**	**SFY12 Maint Req**	**SFY13 Maint Req**	**SFY12 Governor**	**SFY13 Governor**
TOTAL FUNDS	$829	$1,094	$958	$998	$958	$998
GENERAL FUNDS	$415	$547	$479	$499	$479	$499
CASELOAD	7,585	7,718	8,013	8,243	7,834	7,912
COST PER CASE-TOTAL FUNDS (Not Rounded)	$109	$142	$120	$121	$122	$126

SERVICES PROVIDED

Mandate	Patients	Top Categories of Service
Fed	3,540	OUTPATIENT HOSPITAL GENERAL
Fed	2,612	SKILL NURSING FAC NURSING HOME
Fed	4	SNF NURSING HOME ATYPICAL CARE
Fed	1,364	INPATIENT HOSPITAL GENERAL
Fed	5,057	PHYSICIANS SERVICES
Fed	2,261	FEDERALLY MANDATED SERVICES
State	25	PERSONAL CARE
State	42	STATE MANDATED SERVICES
Opt	2,084	WHEELCHAIR VAN
Opt	1,774	FURNISHED MED SUP OR DME
Opt	79	ADULT MEDICAL DAY CARE
Opt	3,516	OPTIONAL SERVICES
Opt	5,335	DISPENSE PRESCRIBED DRUGS
	7,585	SFY 2010 Unique Count of Patients in Group

ELDERLY

SERVICES PROVIDED

Below is a table of optional Medicaid State Plan services provided. The list includes drugs, which are considered optional Medicaid Services by CMS, but are considered elementary to primary and preventive healthcare by NH Medicaid.

Category of Service Description	Comment on Current Utilization Controls
Drugs	Over-The-Counter (OTC) drug restrictions; dose optimization program requires a Prior Authorization (PA) for the two tablet dosage form, thus encouraging the prescriber to use an "optimized" dosage form; Maximum Allowable Cost (MAC): A program which sets a MAC price for over 4,000 drugs; preferred drug list
Durable Medical equipment and supplies	Prior Authorized, ability to reduce affected by mandatory Medicaid requirements to cover supplies used in home.
Private Duty Nursing	Requires prior authorization per He-W 540.
Personal Care Services	Requires care plan reviewed every 60 days per He-W 552.
Wheelchair van	Limited to 24 trips per year to medical related appointments per He-W 573.
Ambulance Services	Requires medical necessity (emergency)
Psychology	Service limited to 12 visits annually, ability to reduce may be affected by mental health parity requirements in Troubled Assets Relief Program (TARP)
Adult Medical Day Care	Currently requires presence of chronic illness and imminent danger of institutionalization.
Eyeglasses	Currently competitively procured, requires medical necessity. Eyeglass frames purchased under this agreement are guaranteed against breakage for two years from date of purchase.
Medical Services Clinic (Methadone Clinics)	Budget reduced per HB 2, 2009, Rates reduced by 33% in Step 2.

IMPACT IF SERVICES LOST

Approximately 7,500+ eligible clients would lose Medicaid coverage. Highest categories of service utilization for this population are drugs, physician services and other optional services.

095-6147 OMBP Provider Payments

CLIENT PROFILE

Elderly adults are enrolled in Medicaid through the Old Age Assistance Program, Other Qualified Medicare beneficiary (QMB) Program or Specialized Low Income Medicare beneficiary (SLMB) Program. The current caseload is 5,300.

Cost Figures Rounded to $000

Elderly Provider Payments	**SFY10 Actual**	**SFY11 Adj Auth**	**SFY12 Maint Req**	**SFY13 Maint Req**	**SFY12 Governor**	**SFY13 Governor**
TOTAL FUNDS	$11,065	$12,362	$13,214	$14,668	$12,107	$12,260
GENERAL FUNDS	$5,533	$6,181	$6,607	$7,334	$6,053	$6,130
CASELOAD	5,230	5,322	5,525	5,684	5,401	5,455
COST PER CASE-TOTAL FUNDS (Not Rounded)	$2,116	$2,323	$2,392	$2,581	$2,241	$2,247
Elderly Pharmacy	**SFY10 Actual**	**SFY11 Adj Auth**	**SFY12 Maint Req**	**SFY13 Maint Req**	**SFY12 Governor**	**SFY13 Governor**
TOTAL FUNDS	$2,109	$2,502	$2,316	$2,443	$2,295	$2,421
GENERAL FUNDS	$1,055	$1,251	$1,158	$1,221	$1,147	$1,210
CASELOAD	5,230	5,322	5,525	5,684	5,401	5,455
COST PER CASE-TOTAL FUNDS (Not Rounded)	$403	$470	$419	$430	$425	$444

SERVICES PROVIDED

Mandate	**Patients**	**Top Categories of Service**
Fed	3,423	OUTPATIENT HOSPITAL GENERAL
Fed	714	SKILL NURSING FAC NURSING HOME
Fed	945	INPATIENT HOSPITAL GENERAL
Fed	4,199	PHYSICIANS SERVICES
Fed	1,599	OTHER FED MANDATE
State	9	OTHER STATE MANDATE
Opt	1,447	MEDICAL SUPPLIES AND DME
Opt	2,136	OTHER OPTIONAL
Opt	2,150	DISPENSE PRESCRIBED DRUGS
	5,230	SFY 2010 Unique Count of Patients in Group

SERVICES PROVIDED

Below is a table of optional Medicaid State Plan services. The list includes drugs, which are considered optional Medicaid Services by CMS, but are considered elementary to primary and preventive healthcare by NH Medicaid.

ELDERLY

Category of Service Description	Comment on Current Utilization Controls
Drugs	Over-The-Counter (OTC) drug restrictions; dose optimization program requires a Prior Authorization (PA) for the two tablet dosage form, thus encouraging the prescriber to use an "optimized" dosage form; Maximum Allowable Cost (MAC): A program which sets a MAC price for over 4,000 drugs; preferred drug list
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IMPACT IF SERVICES LOST

This eligibility category is subject to maintenance of effort requirement as found in the PPACA federal legislation as it relates to eligibility. Highest categories of service utilization for this population are physician services, outpatient hospital services, and drugs. Medicaid optional benefits can be eliminated for this eligibility group however DHHS does not recommend elimination of pharmacy benefit.