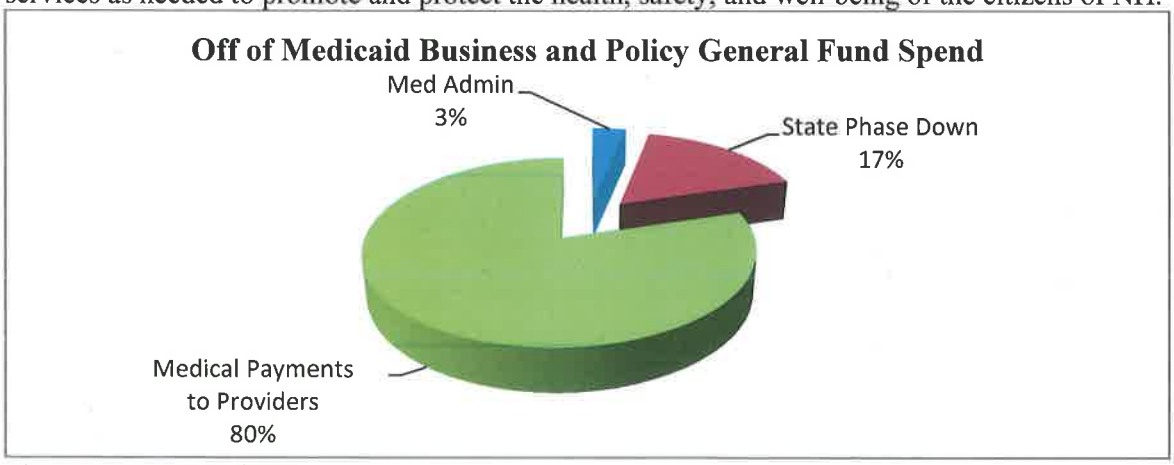
**Department of Health & Human Services**

**Agency 047, Office of Medicaid Business and Policy**

**Senate Presentation**

**Agency Overview:**

The OFFICE OF MEDICAID BUSINESS AND POLICY (OMBP) manages a number of the key program activities under Title XIX Medicaid and Medicaid Expansion group (formerly known as Title XXI Children's Health Insurance Program (CHIP)) in order to meet the non-long-term healthcare needs of Medicaid-eligible pregnant women, infants, children, and individuals with special needs. The Office's responsibilities include maintaining compliance with Title XIX and Medicaid Expansion State Plans and applicable federal and state laws, managing the Medicaid healthcare system, enrollment and payment of hospital, medical and dental providers, medical/dental/pharmacy benefit management, and other activities associated with managing a health insurance product. Through planning and research capacity, OMBP works to identify health care and social service needs and assess the effectiveness of the State's delivery systems in meeting those needs. The services provided assist the client who is receiving or is in need of receiving Medicaid benefits as well as assist in establishing a framework from which government, communities, health care providers, and others can work together. OMBP provides a broad range of services within the statutory guidelines set by the NH Legislature. The Office makes decisions regarding the type, amount, duration, and scope of medical care to be covered by the NH Medicaid program, which are consistent with the goals of access, quality, choice and cost effectiveness. In accordance with New Hampshire statutes, OMBP provides "a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well-being of the citizens of NH.




Figures rounded to $000

| | FY14 Actual | FY15 Adj. Auth. | FY15 Revised | FY16 Gov | FY16 House | FY16 Gov | FY17 House |
|---|---|---|---|---|---|---|---|
| Total Funds | 578,864 | 541,047 | 784,785 | 860,537 | 848,186 | 860,537 | 830,899 |
| General | 113,050 | 49,740 | 171,609 | 206,231 | 200,055 | 206,055 | 182,522 |

| | FY14/15 Biennium Adj Auth | FY16/17 Biennium House |
|---|---|---|
| Total Funds | $1,363,649 | $1,679,085 |

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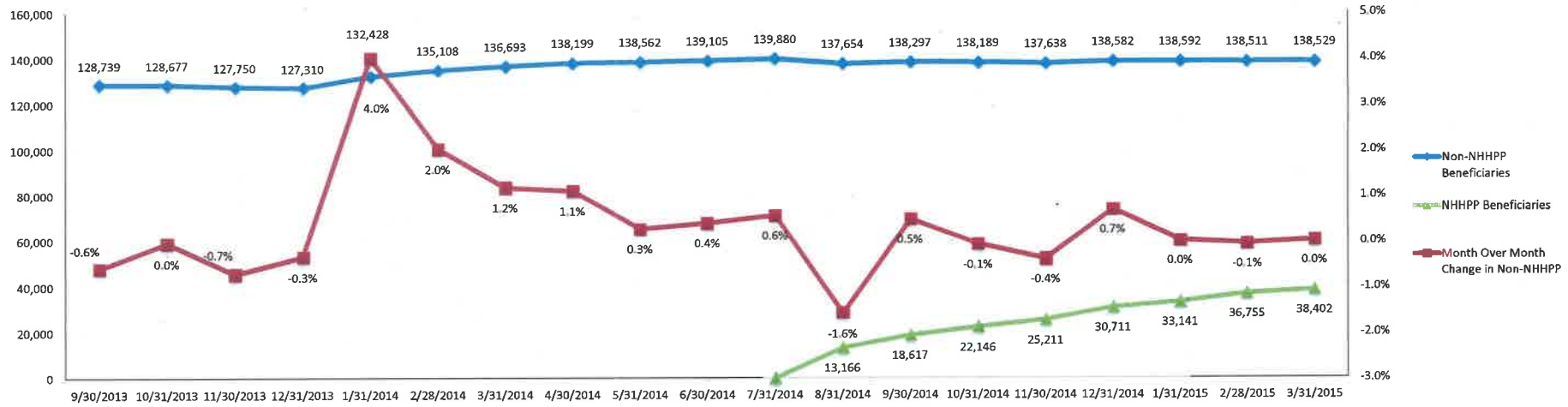
**New Hampshire Medicaid Point in Time Enrollment at End of Month, 9/2013 - 3/2015**

*Note: Excludes refugees and those who only have Medicare savings plan coverage.*

| Eligibility Group | 9/30/2013 | 10/31/2013 | 11/30/2013 | 12/31/2013 | 1/31/2014 | 2/28/2014 | 3/31/2014 | 4/30/2014 | 5/31/2014 | 6/30/2014 | 7/31/2014 | 8/31/2014 | 9/30/2014 | 10/31/2014 | 11/30/2014 | 12/31/2014 | 1/31/2015 | 2/28/2015 | 3/31/2015 | Current Month vs. Prior Month | | Current Month vs. 9/30/13 | | Current Month vs. 12/31/13 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1a. Low-Income Children - Non-CHIP (Age 0-18) | 71,267 | 71,098 | 70,530 | 70,136 | 75,553 | 78,212 | 79,826 | 79,443 | 79,197 | 79,302 | 79,345 | 78,887 | 78,942 | 78,641 | 78,047 | 78,435 | 78,035 | 77,897 | 77,918 | 0.0% | 21 | 9.3% | 6,651 | 11.1% | 7,782 |
| 1b. Low-Income Children - CHIP (Age 0-18) | 11,872 | 11,937 | 11,850 | 11,993 | 9,782 | 9,052 | 8,238 | 9,407 | 9,667 | 9,659 | 10,047 | 10,382 | 10,760 | 11,257 | 11,719 | 12,183 | 12,477 | 12,544 | 12,331 | -1.7% | -213 | 3.9% | 459 | 2.8% | 338 |
| 2. Children With Severe Disabilities (Age 0-18) | 1,626 | 1,607 | 1,600 | 1,604 | 1,653 | 1,674 | 1,680 | 1,688 | 1,677 | 1,670 | 1,656 | 1,636 | 1,619 | 1,615 | 1,610 | 1,622 | 1,626 | 1,630 | 1,631 | 0.1% | 1 | 0.3% | 5 | 1.7% | 27 |
| 3. Foster Care & Adoption Subsidy (Age 0-25) | 1,950 | 1,955 | 1,955 | 1,948 | 1,966 | 1,992 | 2,003 | 2,012 | 1,990 | 2,004 | 2,015 | 2,020 | 2,048 | 2,087 | 2,092 | 2,085 | 2,110 | 2,123 | 2,173 | 2.4% | 50 | 11.4% | 223 | 11.6% | 225 |
| 4. Low-Income Non-Disabled Adults (Age 19-64) | 10,566 | 10,463 | 10,446 | 10,324 | 11,604 | 12,210 | 12,955 | 13,357 | 13,627 | 13,976 | 14,274 | 12,898 | 13,287 | 13,130 | 13,069 | 13,212 | 13,531 | 13,598 | 13,595 | 0.0% | -3 | 28.7% | 3,029 | 31.7% | 3,271 |
| 5. Low-Income Pregnant Women (Age 19+) | 2,408 | 2,441 | 2,368 | 2,275 | 2,789 | 2,944 | 3,051 | 3,113 | 3,165 | 3,246 | 3,238 | 2,832 | 2,846 | 2,760 | 2,667 | 2,602 | 2,550 | 2,516 | 2,532 | 0.6% | 16 | 5.1% | 124 | 11.3% | 257 |
| 6. Adults With Disabilities (Age 19-64) | 20,005 | 20,081 | 19,986 | 19,997 | 20,075 | 20,023 | 19,961 | 20,154 | 20,156 | 20,222 | 20,257 | 19,991 | 19,830 | 19,713 | 19,521 | 19,540 | 19,469 | 19,482 | 19,627 | 0.7% | 145 | -1.9% | -378 | -1.9% | -370 |
| 7. Elderly & Elderly With Disabilities (Age 65+) | 8,840 | 8,896 | 8,810 | 8,828 | 8,802 | 8,796 | 8,779 | 8,823 | 8,872 | 8,822 | 8,848 | 8,809 | 8,771 | 8,796 | 8,724 | 8,714 | 8,608 | 8,537 | 8,545 | 0.1% | 8 | -3.3% | -295 | -3.2% | -283 |
| 8. BCCP (Age 19-64) | 205 | 199 | 205 | 205 | 204 | 205 | 200 | 202 | 211 | 204 | 200 | 199 | 194 | 190 | 189 | 189 | 186 | 184 | 177 | -3.8% | -7 | -13.7% | -28 | -13.7% | -28 |
| Non-NHHPP Beneficiaries | 128,739 | 128,677 | 127,750 | 127,310 | 132,428 | 135,108 | 136,693 | 138,199 | 138,562 | 139,105 | 139,880 | 137,654 | 138,297 | 138,189 | 137,638 | 138,582 | 138,592 | 138,511 | 138,529 | 0.0% | 18 | 7.6% | 9,790 | 8.8% | 11,219 |
| Month Over Month Change in Non-NHHPP | -0.6% | 0.0% | -0.7% | -0.3% | 4.0% | 2.0% | 1.2% | 1.1% | 0.3% | 0.4% | 0.6% | -1.6% | 0.5% | -0.1% | -0.4% | 0.7% | 0.0% | -0.1% | 0.0% | | | | | | |
| NHHPP Beneficiaries | | | | | | | | | | | 0 | 13,166 | 18,617 | 22,146 | 25,211 | 30,711 | 33,141 | 36,755 | 38,402 | 4.5% | 1,647 | - | - | - | - |
| Month Over Month Change for NHHPP | - | - | - | - | - | - | - | - | - | - | - | - | 41.4% | 19.0% | 13.8% | 21.8% | 7.9% | 10.9% | 4.5% | - | - | - | - | - | - |
| Grand Total Full Medicaid | 128,739 | 128,677 | 127,750 | 127,310 | 132,428 | 135,108 | 136,693 | 138,199 | 138,562 | 139,105 | 139,880 | 150,820 | 156,914 | 160,335 | 162,849 | 169,293 | 171,733 | 175,266 | 176,931 | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| Limited Family Planning Benefit | | | | | | | | 143 | 833 | 1,832 | 2,328 | 1,914 | 1,780 | 1,736 | 1,620 | 1,559 | 1,405 | 1,354 | 1,384 | | | | | | |
| 1. Low-Income Children (Age 0-18) - Total | 83,139 | 83,035 | 82,380 | 82,129 | 85,335 | 87,264 | 88,064 | 88,850 | 88,864 | 88,961 | 89,392 | 89,269 | 89,702 | 89,898 | 89,766 | 90,618 | 90,512 | 90,441 | 90,249 | -0.2% | -192 | 8.6% | 7,110 | 9.9% | 8,120 |




*Note: Non-NHHPP excludes beneficiaries without full Medicaid coverage who only have Medicare savings plan or family planning coverage and refugees*

*Source: New Heights data in Enterprise Data Warehouse; point in time as of the end of the month*

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| | A | B | C | D | E | F | G | H | I |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Agy 047 Off of Medicaid Business and Policy | | | | | | | | |
| 2 | | SFY16 | | | | SFY17 | | | |
| 3 | | Federal | General | Other | Total | Federal | General | Other | Total |
| 4 | **Maintenance Request** | **$490,279,823** | **$281,339,275** | **$239,840,199** | **$1,011,459,297** | **$510,412,368** | **$295,513,381** | **$248,014,376** | **$1,053,940,124** |
| 5 | Cl 041 Audit Set-aside | $58,014 | $0 | $0 | $58,014 | $9,531 | $0 | $0 | $9,531 |
| 6 | Chiropractic services currently covered for NHHPP population only. Change Item to add benefit to standard Medicaid coverage package | $337,500 | $337,500 | $0 | $675,000 | $337,500 | $337,500 | $0 | $675,000 |
| 7 | Substance Use Disorder currently covered for NHHPP population only. Change Item to add benefit to standard Medicaid coverage package. | $8,669,264 | $8,669,264 | $0 | $17,338,528 | $9,193,755 | $9,193,755 | $0 | $18,387,509 |
| 8 | 30.2.6 MCO contracts: Capitation payments are made retrospectively with a two (2 )month delay. Change item to reduce the delay in payment from a two (2) to a one (1) month retrospective delay. | $20,000,000 | $20,000,000 | $0 | $40,000,000 | $0 | $0 | $0 | $0 |
| 9 | **Change Request** | **$29,064,778** | **$29,006,764** | **$0** | **$58,071,542** | **$9,540,786** | **$9,531,255** | **$0** | **$19,072,040** |
| 10 | **Total Agency Request** | **$519,344,601** | **$310,346,039** | **$239,840,199** | **$1,069,530,839** | **$519,953,154** | **$305,044,635** | **$248,014,376** | **$1,073,012,164** |
| 11 | Eliminate Change Items: Chiro; SUD; MCO gap | ($29,064,778) | ($29,006,764) | $0 | ($58,071,542) | ($9,540,786) | ($9,531,255) | $0 | ($19,072,041) |
| 12 | Revised Medicaid Assumptions | ($50,967,698) | ($68,761,738) | $0 | ($119,729,436) | ($76,527,521) | ($97,966,609) | $0 | ($174,494,130) |
| 13 | PDL - Adopt MCO's formularies | ($12,500,000) | ($12,500,000) | $0 | ($25,000,000) | ($12,500,000) | ($12,500,000) | $0 | ($25,000,000) |
| 14 | PDL - Changes Impacting Rx Rebate Revenues | $0 | $10,000,000 | ($10,000,000) | $0 | $0 | $10,000,000 | ($10,000,000) | $0 |
| 15 | Revised State Phase Down caseload assumptions | $0 | ($1,500,000) | $0 | ($1,500,000) | $0 | ($1,500,000) | $0 | ($1,500,000) |
| 16 | Revised Medicaid Admin | ($303,146) | ($303,146) | $0 | ($606,291) | ($318,625) | ($318,625) | $0 | ($637,250) |
| 17 | Cl102 Contracts for Program Services | ($2,043,126) | ($2,043,126) | $0 | ($4,086,251) | ($2,043,126) | ($2,043,126) | $0 | ($4,086,251) |
| 18 | NHHPP State Share | $0 | $0 | $0 | $0 | $0 | $12,000,000 | $0 | $12,000,000 |
| 19 | SUD Benefits to traditional medicaid clients | $0 | $0 | $0 | $0 | $3,300,000 | $3,300,000 | $0 | $6,600,000 |
| 20 | **Governor Recommend** | **$424,465,854** | **$206,231,266** | **$229,840,199** | **$860,537,319** | **$422,323,096** | **$206,485,020** | **$238,014,376** | **$866,822,492** |
| 21 | 7937 Med Admin: reduce contracts related to repeal of NHHPP | $0 | $0 | $0 | $0 | ($1,650,000) | ($1,650,000) | $0 | ($3,300,000) |
| 22 | 7937 Med Admin: Repeal HIPP eff 7/1/15. HB2 section | ($1,600,000) | ($1,600,000) | $0 | ($3,200,000) | ($800,000) | ($800,000) | $0 | ($1,600,000) |
| 23 | 7941 BCC Program: Reinstate the BCC Program upon repeal of NHHPP | $0 | $0 | $0 | $0 | $801,600 | $800,000 | $0 | $1,601,600 |
| 24 | 7948 MCM: Repeal NHHPP 12/31/2016. Reduce costs associated w/state share of benefits | $0 | $0 | $0 | $0 | $0 | ($12,000,000) | $0 | ($12,000,000) |
| 25 | 7948 MCM: Remove SUD Standard Medicaid | $0 | $0 | $0 | $0 | ($3,300,000) | ($3,300,000) | $0 | ($6,600,000) |
| 26 | 7948 MCM: Change medicaid caseload assumption from -1.4% to -2% FY16 and -2.5% FY17 | ($1,950,000) | ($1,950,000) | $0 | ($3,900,000) | ($5,187,000) | ($5,187,000) | $0 | ($10,374,000) |
| 27 | 7948 MCM: Allow MCO's to use own PDL. | ($2,500,000) | ($2,500,000) | $0 | ($5,000,000) | ($2,500,000) | ($2,500,000) | $0 | ($5,000,000) |
| 28 | 7948 MCM: Restore coverage for low income pregnant women contingent on repeal of NHHPP. HB2 | $0 | $0 | $0 | $0 | $800,000 | $800,000 | $0 | $1,600,000 |
| 29 | 7948 MCM: Reduce limit on cost of services for low utilizers of mental health services. HB2 $2k cap vs $4k cap | ($125,366) | ($125,366) | $0 | ($250,732) | ($125,366) | ($125,366) | $0 | ($250,732) |
| 30 | **House Recommend** | **$418,290,488** | **$200,055,900** | **$229,840,199** | **$848,186,587** | **$410,362,330** | **$182,522,654** | **$238,014,376** | **$830,899,360** |

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| | A | B | C | F | G | H | I | J | K | L | M | N | O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Agy 047: OMBP Budget Summary** | | | | | | | | | | | | |
| 2 | Class | Class Title | FY14 Actual | FY15 Revised | $ Diff Revised Reclass FY15/14 Actual | % Diff Revised FY15/14 Actual | FY16 Gov | FY16 House | $ Diff House FY16/15 Reclass | % Diff House FY16/15 Reclass | FY17 Gov | FY17 House | $ Diff House FY17/16 Gov |
| 3 | 010 | Personnel Services - Permanent | 2,117,648 | 2,901,763 | 784,115 | 37% | 2,892,283 | 2,892,283 | (9,480) | 0% | 2,953,585 | 2,953,585 | 61,302 |
| 5 | 012 | Personnel Services - Unclassified | 458,014 | 595,117 | 137,103 | 30% | 615,194 | 615,194 | 20,077 | 3% | 619,760 | 619,760 | 4,566 |
| 6 | 017 | Full Time Temporary | - | - | - | #DIV/0! | - | - | - | #DIV/0! | - | - | - |
| 7 | 018 | Overtime | 26,626 | 50,000 | 23,374 | 88% | 26,626 | 26,626 | (23,374) | -47% | 26,626 | 26,626 | - |
| 8 | 020 | Current Expense | 161,197 | 212,552 | 51,355 | 32% | 160,000 | 160,000 | (52,552) | -25% | 160,000 | 160,000 | - |
| 9 | 022 | Rents & Leases Other than State | - | 6,494 | 6,494 | 100% | - | - | (6,494) | -100% | - | - | - |
| 10 | 026 | Organizational Dues | 8,202 | 9,800 | 1,598 | 19% | 8,400 | 8,400 | (1,400) | -14% | 8,400 | 8,400 | - |
| 11 | 030 | Equipment | 7,224 | 5,410 | (1,814) | -25% | 5,000 | 5,000 | (410) | -8% | 5,000 | 5,000 | - |
| 12 | 039 | Telecommunications | 30,973 | 48,983 | 18,010 | 58% | 46,020 | 46,020 | (2,963) | -6% | 46,020 | 46,020 | - |
| 13 | 040 | Indirect Costs | 15,934 | 54,184 | 38,250 | 240% | 30,161 | 30,161 | (24,023) | -44% | 31,084 | 31,084 | 923 |
| 14 | 041 | Audit Fund Set Aside | 248,301 | 272,202 | 23,901 | 10% | 489,770 | 489,770 | 217,568 | 80% | 510,215 | 511,815 | 22,044 |
| 15 | 042 | Transfer to COLA | 95,632 | 161,627 | 65,995 | 69% | 137,401 | 137,401 | (24,226) | -15% | 141,607 | 141,607 | 4,206 |
| 16 | 049 | Transfer to Other State Agencies | 47,287 | 97,205 | 49,918 | 106% | 50,383 | 50,383 | (46,822) | -48% | 52,530 | 52,530 | 2,147 |
| 17 | 050 | Personal Services - Temporary | 11,262 | 50,850 | 39,588 | 352% | 108,000 | 108,000 | 57,150 | 112% | 108,000 | 108,000 | - |
| 18 | 060 | Benefits | 1,150,252 | 1,779,405 | 629,153 | 55% | 1,598,964 | 1,598,964 | (180,441) | -10% | 1,663,084 | 1,663,084 | 64,120 |
| 19 | 066 | Employee Training | 1,300 | 6,476 | 5,176 | 398% | 5,000 | 5,000 | (1,476) | -23% | 5,000 | 5,000 | - |
| 20 | 070 | In-State Travel | 2,192 | 15,511 | 13,319 | 608% | 2,000 | 2,000 | (13,511) | -87% | 2,000 | 2,000 | - |
| 21 | 080 | Out-of-State Travel | 5,387 | 12,627 | 7,240 | 134% | 6,000 | 6,000 | (6,627) | -52% | 6,000 | 6,000 | - |
| 22 | 100 | Prescription Drug Expenditures | 54,808,184 | - | (54,808,184) | -100% | - | - | - | 0% | - | 164,136 | 164,136 |
| 23 | 101 | **Medical Payments to Providers** | **198,631,326** | **658,824,629** | **460,193,303** | **232%** | **617,102,209** | **607,951,477** | **(50,873,152)** | **-8%** | **611,374,134** | **591,167,227** | **(25,934,982)** |
| 24 | 102 | Contracts for Program Services | 141,833,698 | 11,578,218 | (130,255,480) | -92% | 10,978,475 | 7,778,475 | (3,799,743) | -33% | 10,953,699 | 7,071,738 | (3,906,737) |
| 25 | 503 | State Phase Down | 20,872,691 | 25,297,780 | 4,425,089 | 21% | 34,899,320 | 34,899,320 | 9,601,540 | 38% | 36,407,676 | 36,407,676 | 1,508,356 |
| 27 | 515 | Hosp. Uncomp. Care | 92,020,821 | 52,096,735 | (39,924,086) | -43% | 191,376,112 | 191,376,112 | 139,279,377 | 267% | 189,748,072 | 189,748,072 | (1,628,040) |
| 28 | 517 | NHHPP State Share | | | | | - | - | - | 0% | 12,000,000 | - | - |
| 31 | 565 | Outpatient - Hospital | 66,310,283 | - | (66,310,283) | -100% | - | - | - | 0% | - | - | - |
| 32 | | **Total Expense** | **578,864,435** | **754,077,568** | **175,213,133** | **30%** | **860,537,319** | **848,186,587** | **94,109,019** | **12%** | **866,822,492** | **830,899,360** | **(29,637,959)** |
| 33 | | | | | | | | - | - | | | | |
| 34 | | Federal | 258,378,624 | 377,038,784 | 118,660,160 | 46% | 424,465,854 | 418,290,488 | 41,251,704 | 11% | 422,323,097 | 410,362,331 | (14,103,524) |
| 35 | | Other | 207,435,017 | 215,275,677 | 7,840,660 | 4% | 229,840,199 | 229,840,199 | 14,564,522 | 7% | 238,014,376 | 238,014,376 | 8,174,177 |
| 36 | | General | 113,050,795 | 161,763,107 | 48,712,312 | 43% | 206,231,266 | 200,055,900 | 38,292,793 | 24% | 206,485,020 | 182,522,654 | (23,708,612) |
| 37 | | **Total Revenue** | **578,864,436** | **754,077,568** | **175,213,132** | **30%** | **860,537,319** | **848,186,587** | **94,109,019** | **12%** | **866,822,492** | **830,899,360** | **(29,637,959)** |
| 38 | | | | | | | | | | | | | |
| 39 | | 403978 Federal Funds | 258,378,624 | 377,038,784 | 118,660,160 | 46% | 424,465,854 | 418,290,488 | 41,251,704 | 11% | 422,323,097 | 410,362,331 | (14,103,524) |
| 40 | | 407785/402201 MET Revenue | 180,494,244 | 196,197,553 | 15,703,309 | 9% | 220,506,638 | 220,506,638 | 24,309,085 | 12% | 228,100,854 | 228,100,854 | 7,594,216 |
| 41 | | 406848 MEAD Revenue | 163,042 | 172,187 | 9,145 | 6% | 147,576 | 147,576 | (24,611) | -14% | 135,576 | 135,576 | (12,000) |
| 42 | | 407145 Drug Rebates | 26,429,438 | 18,905,936 | (7,523,502) | -28% | 8,852,985 | 8,852,985 | (10,052,951) | -53% | 9,444,946 | 9,444,946 | 591,961 |
| 43 | | 403626 NHCHIS Funds | 348,293 | - | (348,293) | -100% | 333,000 | 333,000 | 333,000 | 0% | 333,000 | 333,000 | - |
| 44 | | General | 113,050,795 | 161,763,107 | 48,712,312 | 43% | 206,231,266 | 200,055,900 | 38,292,793 | 24% | 206,485,020 | 182,522,654 | (23,708,612) |
| 45 | | **Total Revenue by Rev Source** | **578,864,436** | **754,077,567** | **175,213,131** | **30%** | **860,537,319** | **848,186,587** | **94,109,020** | **12%** | **866,822,492** | **830,899,360** | **(29,637,959)** |

## Medicaid Managed Care – Medical Budget Assumptions and Changes: Original BASE-LINE

- During the Governor and House Sessions Milliman's Actuary Base-Line was $331 pmpm (composite rate) which was the rate effective 1/1/15
- All budget assumptions were reductions off of the $331 pmpm.
- Milliman enrollment and case mix were based off of 2012 data.

- Taken into account all Governor and House budget reductions, the final Medicaid budget for MCM assumed the following:
  - Caseloads would drop -2% effective 7/1/15 (SFY 16) and drop -2.5% 7/1/16 (SFY17).
  - Current caseloads trending at 138,500 (non-NHHPP).
  - Mandatory enrollment effective 7/1/15 would mean only 5,000 or about 3.5% at any given time would be transitioning and remain in FFS.
  - Aggressive savings would be seen from PDL changes, reducing administrative loads, shortening the enrollment period to 30days from 90days, and step 2 savings from provider/MCO negotiated rates.
  - After all reductions, House final budget assumed an aggressive range of $320-325 pmpm

# Medicaid Managed Care – Medical Budget Assumptions and Changes: Current Trends

Milliman continues to refresh rates and on 4/14/15 the Department received the first draft of rates and assumptions for rates effective 7/1/15 (SFY16)

*What we have learned:*

1. Data has been refreshed with enrollment and case mix as of November 2014 (from 2012).
2. As a result the new draft BASE-LINE (composite rate) is $343 pmpm (compared to $331).
3. This $12 variance in pmpm has a significant impact when you factor in a Medicaid population (non- NHHPP) of about 138,500 clients.
4. The main driver of the variance ($11 of the $12 increase) is from the BBH add-on. What the new data tells us is that more individuals are receiving the BBH add-on then projected.
5. The Final House budget assumed we would pay the PMPM on a reduced caseload beginning 7/1/15, which means that the reduction would need to be seen on 4/1/15 due to the 3 month lag in MCO payments. As of 4/17/15, we have not yet seen any drop in caseloads.

# General Fund Impact on the Latest Actuary and Enrollment Data

| | A | B | C | D |
|---|---|---|---|---|
| 1 | DHHS | | | |
| 2 | MCM- Revised Data Budget Assumptions as of 4/20/15 | | | |
| 3 | **Best case options: Latest PMPM can be dropped by 2%** | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | senario 1 - Caseloads drop 2% | senario 2 - Caseloads drop 1% | senario 3 - no change in caseloads |
| 7 | | sfy 16 | sfy 16 | sfy 16 |
| 8 | pmpm current per Milliman 4/14/15 | $ 343 | $ 343 | $ 343 |
| 9 | WHAT IF RATE CAN DROP 2% | $ 336 | $ 336 | $ 336 |
| 10 | | | | |
| 11 | clients non NHHPP as of 3/31/15 | 138,500 | 138,500 | 138,500 |
| 12 | caseload reduction | 135,730 | 137,115 | 138,500 |
| 13 | MCM Estimated Caseloads (assumes 5,000 stay in ffs) | 130,730 | 132,115 | 133,500 |
| 14 | | | | |
| 15 | estimated monthly cap | $ 43,943,582 | $ 44,409,136 | $ 44,874,690 |
| 16 | annual mcm | $ 527,322,986 | $ 532,909,633 | $ 538,496,280 |
| 17 | | | | |
| 19 | annual FFS (Dental, Part A&B, and services for 5,000 clients/month for transition, churn and exempt poplulations) | $ 96,000,000 | $ 96,000,000 | $ 96,000,000 |
| 20 | | | | |
| 21 | Total Estimate for SFY16 | $ 623,322,986 | $ 628,909,633 | $ 634,496,280 |
| 22 | | | | |
| 23 | House Budget | $ 605,208,767 | $ 605,208,767 | $ 605,208,767 |
| 24 | | | | |
| 25 | (shortfall) over | $ (18,114,219) | $ (23,700,866) | $ (29,287,513) |
| 26 | GF shortfall | (9,057,110) | (11,850,433) | (14,643,757) |
| 27 | Rounded (this row is shown on next slide) | -9.1 | -11.8 | -14.6 |

# GF Shortfall Scenarios for changes in PMPM and Caseloads

If PMPM is -2% below current baseline and caseloads drop -2%, GF shortfall for SFY16 is $9.1 million as compared to the final House recommended budget.

If PMPM is finalized at 2% higher than current baseline and caseloads stay flat, GF shortfall for SFY16 is $26.3 million.

| | A | B | C | D |
|---|---|---|---|---|
| 1 | Department of Health and Human Services | | | |
| 2 | **GF shortfall as compared to Final House Budget** | | Dollars in Millions | |
| 3 | | | | |
| 4 | Assumes baseline is Milliman's latest draft at $343 pmpm composite rate (1) | Caseloads drop 2% | Caseloads drop 1% | Caseloads drop 0% |
| 5 | | | | |
| 6 | If pmpm is -2% less than Baseline | $ (9.1) | $ (11.8) | $ (14.6) |
| 7 | If pmpm is Baseline | $ (15.1) | $ (17.9) | $ (20.8) |
| 8 | If pmpm is +2% than Baseline | $ (20.5) | $ (23.4) | $ (26.3) |
| 9 | | | | |
| 10 | | | | |
| 11 | note (1): Per Milliman the latest draft rate was adjusted for Nov 2014 enrollment mix vs 2012 enrollment mix | | | |

This row was illustrated in detail on previous slide

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Supplemental Information by Major Accounting Units

**047-7943 Uncompensated Care**
Cl 102 Contracts for Program Services
Cl 515 Hospital Uncompensated Care Pool

PURPOSE

Under the terms of Laws of 2014, Ch. 158, *"there is established in the state treasury an uncompensated care and Medicaid fund which shall consist of the moneys collected pursuant to RSA 84-A, as amended by Laws of 2014, Ch. 158. Investment earnings of the fund shall be credited to the fund. Moneys paid into the fund shall be exempt from any state budget reductions, and the commissioner is authorized to expend these funds, together with matching federal funds, as follows: The commissioner shall provide reimbursement for uncompensated care costs in accordance with the approved schedule of payments through either Medicaid rate adjustments or disproportionate share hospital payment adjustments, or a combination thereof, provided however that no hospital shall receive any such reimbursement for uncompensated care costs unless it is a qualified hospital. Funds available under this section shall also be used to make provider payments and to support Medicaid services and programs administered by the department in amounts directed by the budget in each year of the biennium.*

Under the provisions of the Laws of 2014,Ch. 158, and the NH Medicaid Title XIX Medicaid State Plan, the Department of Health and Human Services is authorized and directed to make disproportionate share hospital (DSH) payments to all qualifying hospitals to reimburse certain uncompensated care costs incurred by those hospitals (therefore, also known as "UCC" payments). The first group of qualified hospitals are New Hampshire's hospitals with critical access designation that also participate in NH's Medicaid care management program and that meet all federal qualifying criteria specified under the provisions of 42 U.S.C. section 1396r-4 and any relevant federal regulations promulgated thereunder. The amount of such reimbursement shall be 75 percent of the uncompensated care costs incurred and consistent with the amounts budgeted in each year of the biennium, based on available funding. Another group of hospitals qualified to receive DSH payments are New Hampshire hospitals without critical access designation that participate in NH's Medicaid care management program and that meet all federal criteria specified under the provisions of 42 U.S.C. section 1396r-4 and any relevant federal regulations promulgated thereunder. The amount of such payments shall be 50% of the uncompensated care costs incurred and consistent with the amounts budgeted in each year of the biennium, based on available funding.

In fiscal years 2016 and 2017, the above-described DSH payments for New Hampshire hospitals with or without critical access shall not exceed a cap of $224,000,000 and in fiscal years 2018 and 2019, the New Hampshire hospitals shall not be paid more than a cap of $241,900,000 in disproportionate share hospital payments.

FINANCIAL HISTORY

*Cost Figures Rounded to $000*

| | SFY14 | SFY15 | SFY16 Gov | SFY16 House | SFY17 Gov | SFY17 House |
|---|---|---|---|---|---|---|
| Cl041 Audit Set Aside | 37 | 26.34 | 100 | 100 | 104 | 104 |
| Cl102 Contracts | 106 | 616 | 325 | 325 | 408 | 408 |
| Cl515 UCC | 92,021 | 52,097 | 191,376 | 191,376 | 189,748 | 206,748 |
| Total Expense | 92,164 | 52,739 | 191,801 | 191,801 | 190,259 | 207,259 |
| | | | | | | |
| Federal Funds | 45,650 | 26,430 | 95,951 | 95,951 | 95,181 | 95,181 |
| MET Rev | 26,603 | 26,220 | 95,850 | 95,850 | 95,078 | 95,078 |
| General Funds | 19,912 | 88 | - | - | - | - |
| Total Funds | 92,164 | 52,739 | 191,801 | 191,801 | 190,259 | 190,259 |

**Department of Health & Human Services**

**Agency 047, Office of Medicaid Business and Policy**

**Senate Presentation**

**Narratives:**

## 047-7939 State Phase Down – HB Page 637:
## Cl503 State Phase Down

PURPOSE

State Phase Down Contribution is a payment made by the state to the Federal government to defray a portion of the Medicare prescription drug expenditure for full-benefit dual eligible clients whose Medicaid drug coverage is assumed by Medicare Part D. The State Phase Down Contribution is the amount paid by the State to refund Medicare the general fund portion of drug expenditures for the dual eligible population for whom Medicare pays their prescription drug costs. CMS calculates a per member per month rate based on actual cost of dual eligible prescription costs.

CLIENT PROFILE

Medicaid Clients with Medicare coverage are deemed to be eligible for Part D subsidy. An individual is eligible for Part D if he or she is entitled to Medicare benefits under Part A or enrolled in Medicare Part B (42 CFR 423.30). This includes: Medicare/Medicaid Full Benefit Dual eligible, Qualified Medicare beneficiary (QMB), Specialized Low Income Medicare beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI), Qualified Individual, (QI). Current average monthly caseload is 19,440

FINANCIAL HISTORY

*Cost Figures Rounded to $000*

**Caseloads (Clients Served):**

| | FY14 | FY15 | FY16 | FY16 | FY17 | FY17 |
|---|---|---|---|---|---|---|
| | Actual | Budget | Gov | House | Gov | House |
| Number | 18,080 | 19,718 | 19,011 | 19,011 | 20,817 | 20,817 |
| Ave. Cost/Case | $1,764 | $1,858 | $1,836 | $1,836 | $1,821 | $1,821 |

**Caseload Assumptions:**

- The increase in the SPDC premium amount was estimated using the National Health Expenditure Annual Percent change by Type of Expenditure for 2006-2021 that was released in Jan 2014.
- Enrollment based on a 3 year average change growth.

- SFY14/15, OMBP and BEAS funding for State Phase Down were budgeted separately but were combined in SFY16/17 and are budgeted in this one appropriation.

FUNDING SOURCE:

100% General funds

SERVICES PROVIDED:
Payments for State Phased-down contribution (SPDC) are made on a monthly basis to defray the monthly Medicare costs for prescription drugs. Rate per client is $148.67 for CY 2015.

| | Rate Per Individual | BEAS 6173 Enrollment | OMBP 7939 Enrollment |
|---|---|---|---|
| SFY2014 | $146.62 | 73,941 | 143,014 |
| SFY2015 | $148.67 | 81,774 | 154,808 |
| SFY2016 Gov and House | $154.16 | (80,246) | 217,058 |
| SFY2017 Gov and House | $159.85 | (85,068) | 212,671 |

*Cost Figures Rounded to $000*

| AGY | AU | FY14 | FY15 Proj | FY16 Gov | FY16 House | FY17 Gov | FY17 House |
|---|---|---|---|---|---|---|---|
| BEAS 048 | 6173 | $11,025 | $12,101 | ($13,215) | ($12,418) | ($12,418) | ($13,215) |
| OMBP 047 | 7939 | $20,872 | $23,105 | $34,899 | $34,899 | $34,899 | $36,407 |
| | Total | $31,898 | $35,207 | $34,899 | $34,899 | $34,899 | $36,407 |

SERVICE DELIVERY SYSTEM: Monthly payment to the federal government

EXPECTED OUTCOMES: The intent of the State Phase Down program is to make a monthly payment to the federal government to defray a portion of the Medicare drug expenditures for full-benefit dual eligible individuals whose Medicaid drug coverage is assumed by Medicare Part D.

**047-7945 Electronic Health Records (E.H.R) Incentive Payments – HB Page 639**

PURPOSE

The Electronic Health records Incentive payment program was enacted as the healthcare component of the American Recovery and Reinvestment Act of 2009 (ARRA) to create technical infrastructure to facilitate intra-state, interstate, and national exchange of health information. An Electronic Health Record (EHR) provides health-related information for an individual that includes patient demographic and clinical health information such as medical histories. It also provides clinical decision support and query information relevant to health care quality and that facilitates the exchange of health information.

States provide incentive payments to eligible Medicare and Medicaid professionals and hospitals to promote the adoption and meaningful use of certified EHRs. Professionals are defined as physicians, pediatricians, nurse-practitioners, certified nurse mid-wives, dentists and physician assistants.

CLIENT PROFILE

Eligible Medicaid providers must be one of the following specified types:

* Physicians

* Dentists

* Certified Nurse Midwives

* Nurse Practitioners

* Physician Assistants at FQHCs/RHCs led by a PA

* Acute Care Hospitals

And must meet the following criteria:

*Enrolled in New Hampshire Medicaid

*Licensed to practice in New Hampshire

*Not sanctioned or otherwise deemed ineligible to receive payments from New Hampshire Medicaid

Must meet Medicaid patient volume thresholds:

*Eligible professionals (including pediatricians): 30% for a full payment

*Pediatricians: can meet 20-29% for a 2/3 payment

*Eligible hospitals: 10%

*Must attest that EHR technology has been adopted, implemented, or upgraded.

FINANCIAL HISTORY

*Cost Figures Rounded to $000*

| | FY14 | FY15 | FY16 | FY16 | FY17 | FY17 |
|---|---|---|---|---|---|---|
| | Actual | Budget | Gov | House | Gov | House |
| Total Expense | $6,004 | $6,969 | $3,575 | $3,575 | $2,855 | $2,855 |

FUNDING SOURCE

CMS reimburses states 100 percent for eligible provider incentive payments as authorized under section 4201 of the American Reinvestment and Recovery Act and 90 percent to support the development and administration of the Medicaid Electronic Health Record (EHR) Incentive Program

EXPECTED OUTCOMES: To provide incentive payments to eligible Medicare and Medicaid professionals and hospitals to promote the adoption and meaningful use of certified EHRs that will help to facilitate the exchange of health information.

An EHR is an electronic record of health□related information for an individual that includes patient demographic and clinical health information such as medical histories and has the capacity to provide clinical decision support, support physician order entry, capture and query information relevant to health care quality, and exchange health information with, and integrate information from other sources.

**047-7948 Medicaid Care Management – HB Page 639**

PURPOSE Fee-For-Service Medicaid: Cl101 Medicaid Payments to Providers

Medicaid is the joint federal and state program that offers health coverage to low income individuals in the state. The vast majority of beneficiaries are low income children. Medicaid is also a health care safety net for disabled individuals of all ages and for seniors, providing coverage of services that are either limited or excluded in commercial insurance or Medicare. The menu of covered services in Medicaid is a combination of mandated and optional services that are preventive, diagnostic and treatment oriented. The fee-for-service Medicaid program is the back bone of Medicaid. It has been the traditional model of administration since inception. It refers to the process by which providers (doctors and hospitals for example) are paid when they provide care to Medicaid beneficiaries. Fee-for-service utilizes some tools to manage utilization of care for appropriateness and medical necessity. Fee-for-service models are often criticized for rewarding volume over quality or for being fragmented. Over SFY14/15 the fee-for-service platform has dwindled with the launch of Medicaid Care Management (MCM). At the current time, fee-for-service remains intact as the delivery system only for individuals not yet included in MCM and for services not yet included in MCM. While fee-for-service volume will continue to be reduced over SFY15-16, it will never go away completely.

PURPOSE Medicaid Care Management: Cl102 Contracts for Program Services

In response to legislative policy direction in 2011 (SB 147), DHHS implemented Medicaid Care Management on December 1, 2013. Though the managed care model of Medicaid administration, the state intends to achieve numerous quality, health outcome and budget predictability goals. Through this model, DHHS contracts with managed care organizations that are paid a capitated rate per-member-per-month to assure that beneficiaries receive high quality care at the right time in right venue, to reimburse providers who render that care, and to improve the overall health status of beneficiaries whenever possible. Medicaid Care Management currently includes most acute care services covered by NH Medicaid and will phase in some long term care supports and services over the coming biennium. Similarly, some beneficiaries who elected not to participate in MCM will be mandated to participate in the program in 2015. The inclusion of additional services will serve to advance the ability of the MCOs to manage 'the whole person' in a less fragmented way.

**Covered Populations Matrix**

| Members | Step 1 | Step 2 | Excluded/ FFS |
|---|---|---|---|
| OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals*1 | X | | |
| Foster Care - With Member Opt Out | X | | |
| Foster Care - Mandatory Enrollment (w/CMS waiver) | | X | |
| HC-CSD (Katie Becket) - With Member Opt Out | X | | |
| CHIP (transition to Medicaid expansion) | X | | |
| TPL (non-Medicare) except members with VA benefits | X | | |
| Auto eligible and assigned newborns | X | | |
| Breast and Cervical Cancer Program (BCCP) | X | | |
| Medicare Duals - With Member Opt Out | X | | |
| Medicare Duals - Mandatory Enrollment (w/CMS waiver) | | X | |
| Members with VA Benefits | | | X |
| Family Planning Only Benefit (in development) | | | X |
| Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns) | | | X |
| Spend-down | | | X |
| QMB/SLMB Only (no Medicaid) | | | X |
| Native Americans and Native Alaskans w/ member opt out2 | X | | |

FUNDING SOURCE 50% federal funds / Agency Income: Medicaid Enhancement Tax revenue (funds from the uncompensated care fund to support medical provider payments); Rx Rebate Agency Income (Medicaid Drug Rebate Program is a partnership between CMS, State Medicaid Agencies, and participating drug manufacturers that helps to offset the Federal and State costs of prescription drugs dispensed to Medicaid patients; MEAD premiums / General funds

| *Cost Figures Rounded to $000* | FY16 | FY16 | FY17 | FY17 |
|---|---|---|---|---|
| Source of Funds | Gov | House | Gov | House |
| Federal | $316,264 | $311,688 | $315,634 | $305,322 |
| MET Rev | $124,656 | $124,656 | $133,023 | $133,023 |
| MEAD Rev | $147 | $147 | $135 | $135 |
| Drug Rebates | $8,852 | $8,852 | $9,444 | $9,444 |
| General | $164,438 | $159,863 | $163,199 | $140,887 |
| Total | $614,359 | $605,208 | $621,437 | $588,813 |

SERVICE DELIVERY SYSTEM:

Services delivered by enrolled Medicaid providers.

EXPECTED OUTCOMES

Along with providing health care coverage, NH Medicaid must assure that Medicaid recipients have access to appropriate quality health care services.

With the advent of Medicaid Care Management DHHS has developed a robust quality assurance program to produce information from Medicaid and related data to support the development and oversight of policy and programs while leading quality assurance and improvement activities. The program consists comprehensive set of measures reported by the Care Management health plans, a system to manage are publicly report on those measures, monthly performance reporting, a managed care quality strategy, the services of a third party external quality review organization (EQRO), and staff to manage the program.

The measures provided by the health plans are made up of NH specific measures as well national the standard measure sets: 1) Health Care Effectiveness Data and Information set (HEDIS) specifications to assist NH Medicaid in monitoring satisfaction, access, quality and outcomes of care and provide comparisons to national and regional HEDIS averages for Medicaid managed care programs compiled by the National Committee for Quality Assurance (NCQA) and 2) the Centers For Medicare and Medicaid Services Child and Adult Medicaid Core Sets. By using standardized, national data, consistency in data collection, analytic methodology and reporting is achieved to allow for robust comparisons and monitoring of trends.

Examples of the types of measures tracked include:

- Satisfaction with health plan, care, and access;
- Child and adult access to preventive and primary care services;
- Use to prenatal care;
- Access to immunizations and disease screenings;
- Potentially avoidable emergency department & inpatient hospital use;
- Effective treatment of chronic conditions;
- Use of behavioral health services;
- Care management process measures (e.g., call center, appeals, utilization management).

In addition to assuring the quality of the health plans and of the program as a whole, the goals of tracking such measures includes the adoption and modification of programmatic and financial policies that support the achievement of the highest degree of health possible through primary prevention of a disease and secondary prevention of complications related to a disease as well as maximizing the value of each dollar spent within the context of current policies.

**Children's Expanded Medicaid (formerly CHIP)**

PURPOSE

To meet the non-long-term healthcare needs of Medicaid-eligible children for children 0 to 18 years of age in families with income up to 318% FPL as outlined in the NH Medicaid State Plan. The State Plan serves as the contract between the federal government and the state, which allows the state to receive federal matching funds. This eligibility category is subject to the maintenance of effort requirement as found in the Affordable Care Act (ACA) federal legislation as it pertains to Medicaid and CHIP eligibility for children in effect until October 1, 2019.

CLIENT PROFILE

The federal Balanced Budget Act of 1997 created a health insurance program called the State Children's Health Insurance Program (SCHIP), now known as the Children's Health Insurance Program (CHIP) under an amendment to the federal Social Security Act – Title XXI. The program allows a state with an approved CHIP State Plan to offer health insurance for children under the age of 19, whose family income exceeds the Medicaid financial criteria (in NH >196% FPL). In return, the federal government provides an enhanced federal matching rate of 65%.

The ACA required states to use a uniform methodology for determining income eligibility for Medicaid and CHIP – the Modified Adjusted Gross Income or MAGI methodology. The MAGI regulations at 42 CFR 435.603 implements section 1902(e)(14) of the Social Security Act. These regulations specify how to determine household income and composition. Under the new MAGI-based standard, approximately the same number of people should be eligible as would have been eligible under the old standard. However, there may be some differences in which people will qualify - or not qualify - depending on how they might have fared under the old system (that used deductions and income disregards). Based on the MAGI methodology, NH's CHIP program income standards are >196% FPL – 318% FPL.

Effective July 1, 2012, New Hampshire converted its "combined" program into a single Medicaid program covering children 0 through 18 years of age in families with income up to 300% FPL (this was prior to the MAGI standard of 318%). At this time, there is no other public health or state only insurance program for children in New Hampshire. The maximum monthly net income for a household size of 4 at 196% FPL is $3,896 and at 318% FPL it is $6,321. Caseload 12,228 children

FUNDING SOURCE

CHIP funding is currently authorized through September 30, 2015, proposed reauthorization of the program includes an increase from 65% to 88% federal through September 30, 2019, potentially offsetting state general fund requirements. If the CHIP program is not reauthorized New Hampshire will draw down the remaining CHIP allotment authorized through FFY 2015.

SERVICES PROVIDED

In July 2012, the CHIP enrollees joined their "traditional" Medicaid counterparts in Fee-for-Service (FFS) NH Medicaid. On December 1, 2013, NH Medicaid moved to a managed care delivery system – Medicaid Care Management (MCM). CHIP participants – just as other Medicaid children - receive their health care services through MCM. MCM uses two Health Plans and recipients get the same benefits and services as they did under "traditional" Medicaid (with the exception of children's dental care, which is delivered in the FFS system).

New Hampshire continues to utilize a single application, regardless of whether the individual qualifies through Title XIX (Medicaid) or Title XXI (CHIP). The appropriate FMAP is applied, but there is no other visible differentiation between children who qualify under Title XXI and those who qualify under Title XIX. Children covered under this program model receive all Medicaid covered services including Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) services.

SERVICE DELIVERY SYSTEM
Services delivered by enrolled Medicaid providers.

EXPECTED OUTCOMES

See NH Medicaid Care Management section discussion of the monitoring system for measures pertaining to access, quality and outcomes of care. The NH Medicaid Care Management Program includes a comprehensive set of measures.

**NH Health Protection Program: Caseloads (Clients Served):**

New Hampshire Health Protection Program provides funding for coverage for uninsured, low-income citizens with income up to 133 percent of the federal poverty level (FPL)

**Caseload Assumptions:**

- Caseload options based on Premium Assistance Program Demonstration Waiver
- PMPM eff 8/15/2014 - 12/31/2015; eff 1/1/16 PMPM based on Premium Asst Program Demonstration Waiver
- Medically Frail PMPM = Disabled Adult Age 45-64 eff 1/2015 - 6/2015
- 95% Federal match eff 1/1/17
- SFY17 Governor's Budget 047 7948000 Cl 517 NHHPP State Share $12M HB Page 639
- SFY17 House Budget removed funding for NHHPP State Share $12M

*Cost Figures Rounded to $000*

**45k Caseload + 5k Medically Frail**

| | SFY16 Proj | | | SFY17 Proj | | |
|---|---|---|---|---|---|---|
| | Federal | General | Total | Federal | General | Total |
| 0% Rate Increase | $465,334 | $0 | $465,334 | $430,979 | $11,051 | $442,030 |
| 2% Rate Increase | $466,670 | $0 | $466,670 | $437,210 | $11,211 | $448,421 |
| 5% Rate Increase | $468,675 | $0 | $468,675 | $446,654 | $11,453 | $458,106 |

**50k Caseload + 5k Medically Frail**

| | SFY16 Proj | | | SFY17 Proj | | |
|---|---|---|---|---|---|---|
| | Federal | General | Total | Federal | General | Total |
| 0% Rate Increase | $508,936 | $0 | $508,936 | $470,967 | $12,076 | $483,043 |
| 2% Rate Increase | $510,272 | $0 | $510,272 | $477,597 | $12,246 | $489,843 |
| 5% Rate Increase | $512,276 | $0 | $512,276 | $487,640 | $12,504 | $500,144 |

**Nursing Services: Non-County Participation**

**Accounting Unit 4815-6173**

PURPOSE: This Accounting Unit includes Medicaid services funded by BEAS without County funding participation. BEAS manages the Skilled Nursing Facility (SNF); SNF Swing Beds; and SNF-Atypical Payments to providers in the Medical Payments to Providers class line. The Other Nursing Homes category consists of Intermediate Care Facility – Intellectual Disabled facility and Aid to the Needy Blind (ANB).

Prior to SFY16, the medical payments to providers; prescription drug expenses; outpatient hospital; and state phase down, as they relate directly to Medicaid State Plan Services, managed by the Office of Medicaid Business and Policy (OMBP), was part of the Accounting Unit. For SFY16/17, all of these expenditures will be in the OMBP accounting unit.

CLIENT PROFILE:

Medicaid Payments to Providers or Provider Payments for Skilled Nursing Facility (SNF); SNF Swing Beds; and SNF-Atypical are State Plan services provided to BEAS clients that fall outside of the services reimbursed under Nursing Services Org 4815-5942. To qualify, the individual must be Medicaid eligible & enrolled at nursing home level of care.

The Other Nursing Homes category provides nursing facility services for children at Cedar crest, the only Intermediate Care Facility for the Intellectually Disabled (ICF-ID) facility in New Hampshire, as well as services for people eligible for Medicaid under Aid to the Needy Blind (ANB). The Cedar crest facility is for 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.

Disabled adults under age 65 are enrolled in Medicaid through the Aid to the Permanently and Totally Disabled (APTD) Program. Clients must first be found eligible for this eligibility category by DHHS, based on medical information about their disability. A subsequent clinical assessment is completed by a nurse and evaluated by BEAS to determine if the person meets the long-term care clinical eligibility criteria defined in RSA 151-E.

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.

| | FY14 | FY15 | FY16 | FY16 | FY17 | FY17 |
|---|---|---|---|---|---|---|
| | Actual | Budget | Gov | House | Gov | House |
| Number | 2,697 | 2,776 | 2,804 | 2,804 | 2,832 | 2,832 |
| Ave. Cost/Case | $6,490 | $8,184 | $6,555 | $6,555 | $6,815 | $6,815 |
| Total Funds | $17,504 | $22,718 | $18,379 | $18,379 | $19,298 | $19,298 |
| General Funds | $8,752 | $11,359 | $9,190 | $9,190 | $9,649 | $9,649 |

FUNDING SOURCE: This accounting unit is funded by Medicaid (50%); Agency Income (1%); and, General Funds (49%). The Agency Income consists of Nursing Facility Quality Assessment (NFQA) for ICF-ID (formerly ICF-MR) facilities, which is approximately $210K.

SERVICES PROVIDED:

These services are required under Title XIX of the Social Security Act and RSA 151-E.

Medical Payment to Providers includes Skilled Nursing Facility (SNF); SNF Swing Beds; and SNF-Atypical nursing home level of care. Crotched Mountain is the largest facility paid in this category. Other Nursing Homes provide nursing facility services for people eligible for Medicaid under Aid to the needy Blind (ANB), and children at Cedar crest, an ICF-ID facility.

SERVICE DELIVERY SYSTEM:

Approximately 2,700 clients receive these services through Medicaid enrolled providers of services, statewide. The highest categories of service utilization for this population are Skilled Nursing Facility, SNF-Atypical, and Cedar crest.

EXPECTED OUTCOMES:

These long term services and supports serve a unique population that is unavailable with any of the other Medicaid nursing facility providers in the State of New Hampshire.