



Medicaid in NH

(and the GraniteCare proposal)

The NH Health Care “System”
Medicaid in New Hampshire
Medicaid Reform and GraniteCare
The 2nd Safety Net: Cost-Shifting
The 3rd Safety Net: RSA 165

*Our health system research
undertaken with generous
support from*



Doug Hall

Co-Executive Director
NH Center for Public Policy Studies



New Hampshire Center for Public Policy Studies

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are available on the web:

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"...to raise new ideas and improve policy debates through quality information and analysis on issues shaping New Hampshire's future."

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The NH Health Care “System”

- As complex as any ecological system
- Effects are simultaneously causes
- \$7 billion this year, 14% of the Gross State Product
- Affects everyone
- Growing in size by about 10-12% per year
- Does not differ much from national averages or national trends
- Just about 50% is funded with tax dollars
- Costs are highly concentrated in certain individuals
- Not a market system because there is no access to price or quality information, supply generates its own demand, etc.

NHCPPS Health Care Finance Project

Conceptual Flow Chart of Funds in New Hampshire Health Care System

Ultimate Fundors: Level 1

Funders: Level 2

Intermediaries: Level 3

Payments to Providers
Administration
Profits

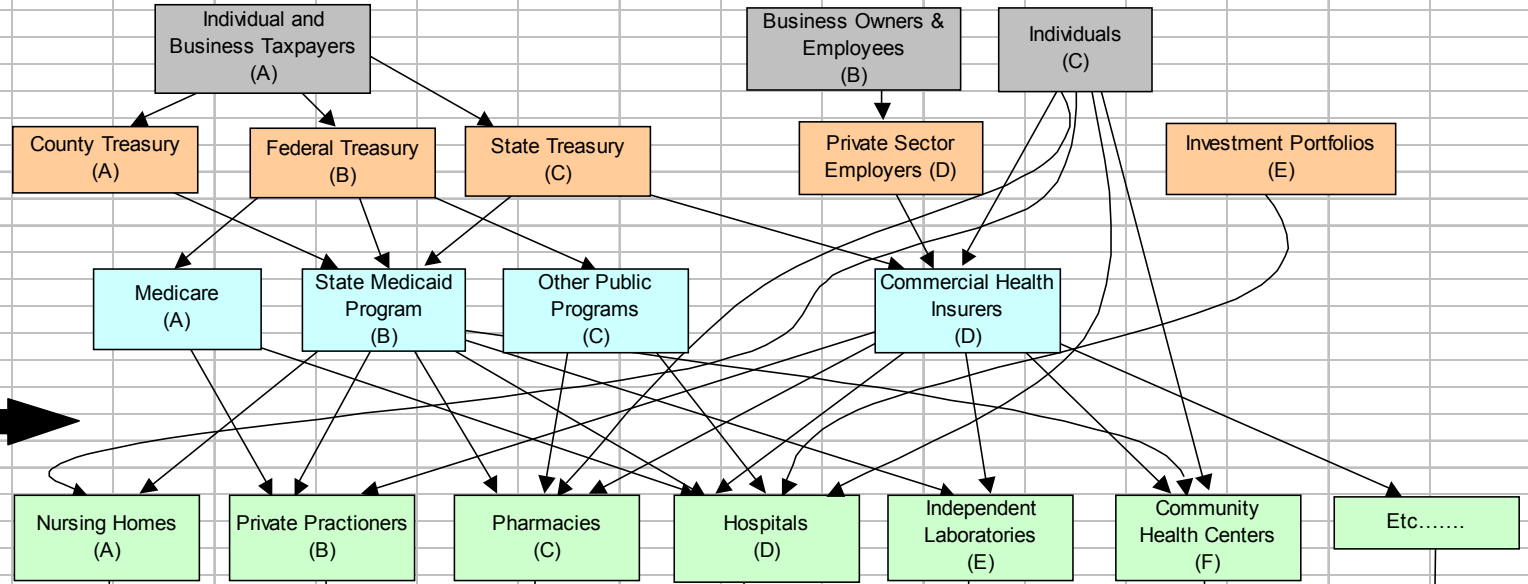
Changes in these lines constitute reimbursement control, not "cost control."

Providers: Level 4

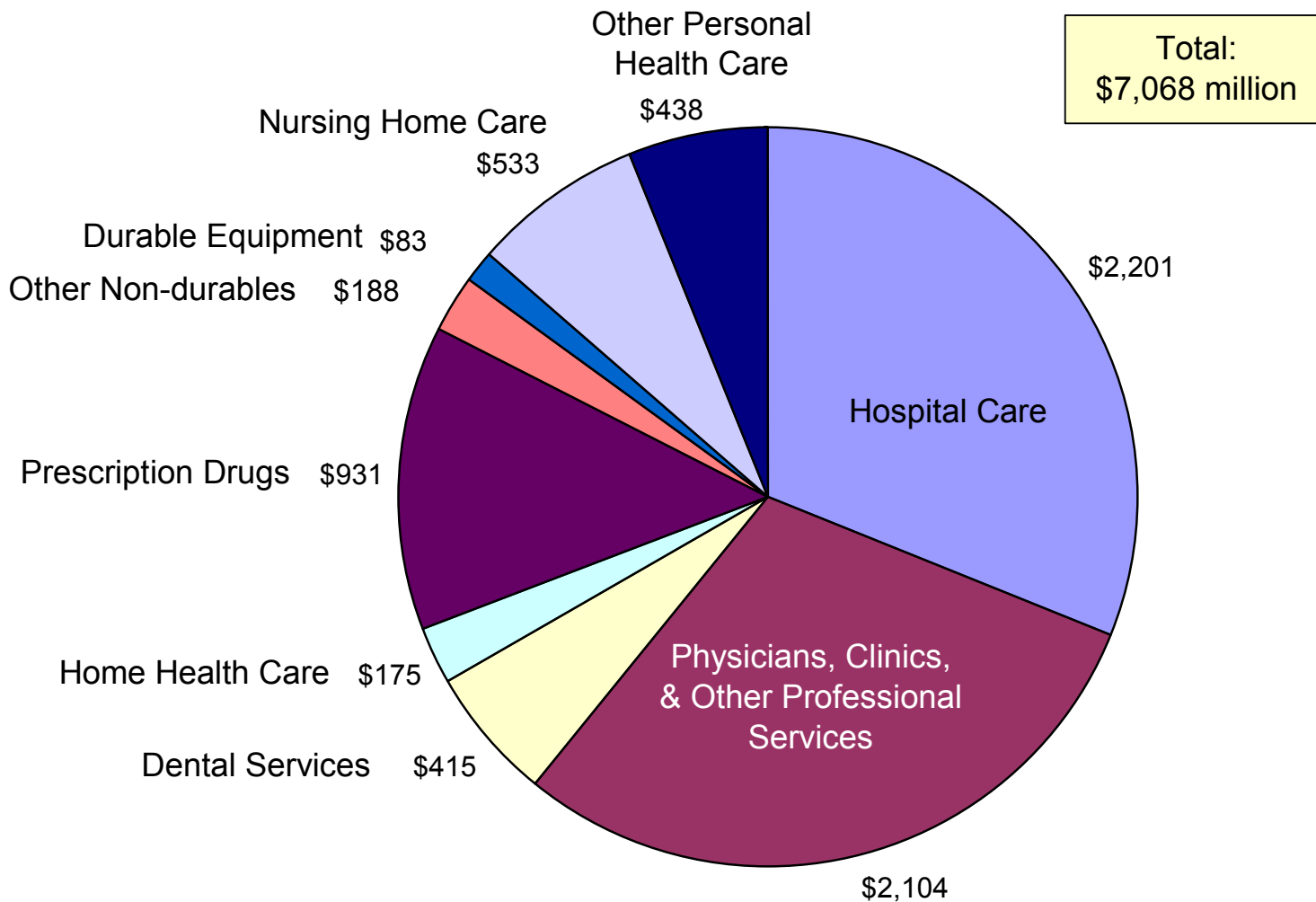
This is the only point at which real "cost control" can take

Provider cost structures: Level 5

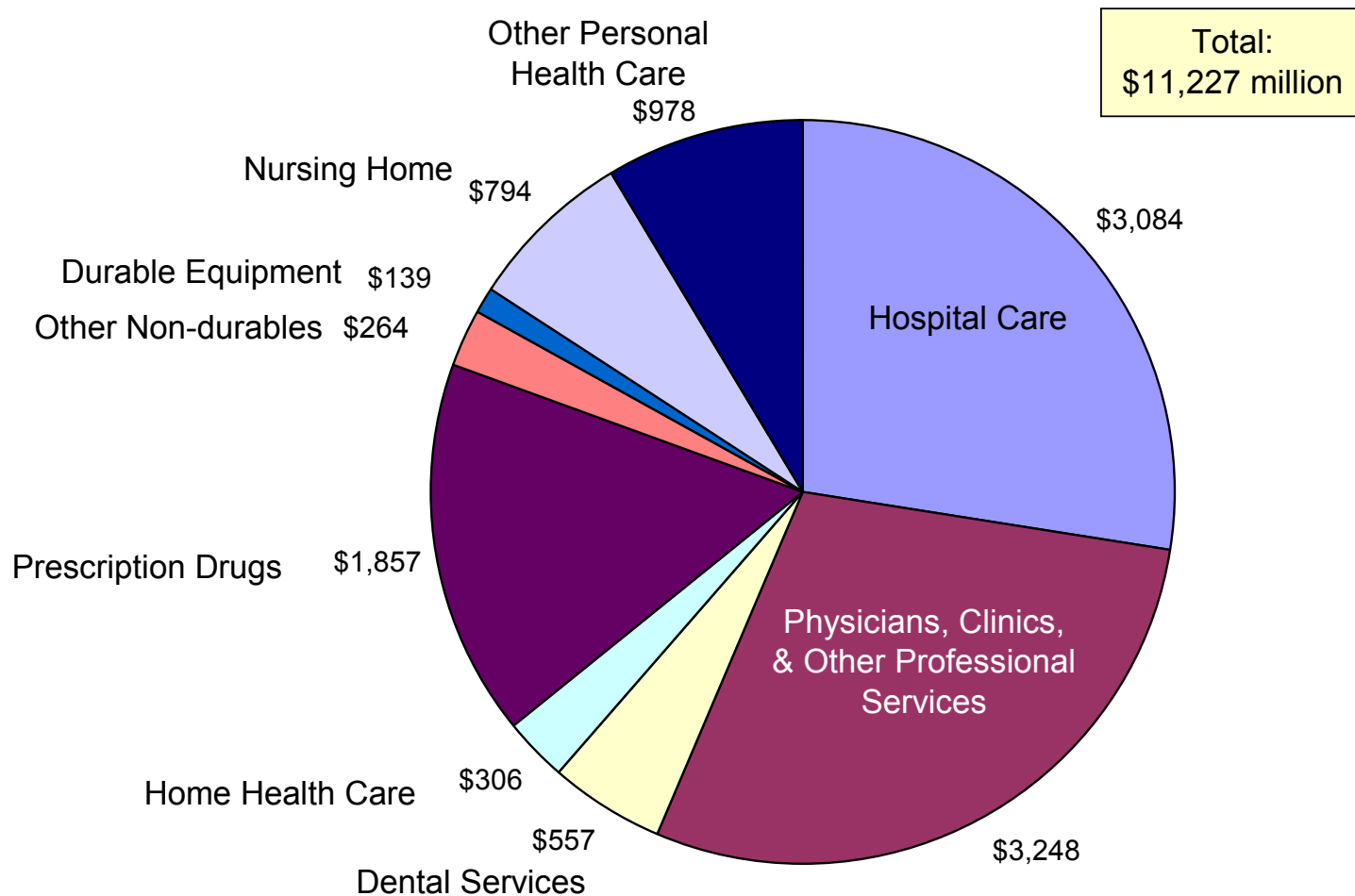
Salaries and wages	\$?	\$?	\$?	\$?	\$?	\$?	\$?
	\$?	\$?	\$?	\$?	\$?	\$?	\$?
In-state	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Fringe benefit Out-of-state	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Consumable non-medical supplies	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Consumable medical supplies	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Cost of Capital (debt service)	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Over-the-counter medications	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Prescription medications	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Malpractice insurance	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Other insurance	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Utilities	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Office equipment	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Clinical equipment	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Profits	\$?	\$?	\$?	\$?	\$?	\$?	\$?
Etc.....	\$?	\$?	\$?	\$?	\$?	\$?	\$?



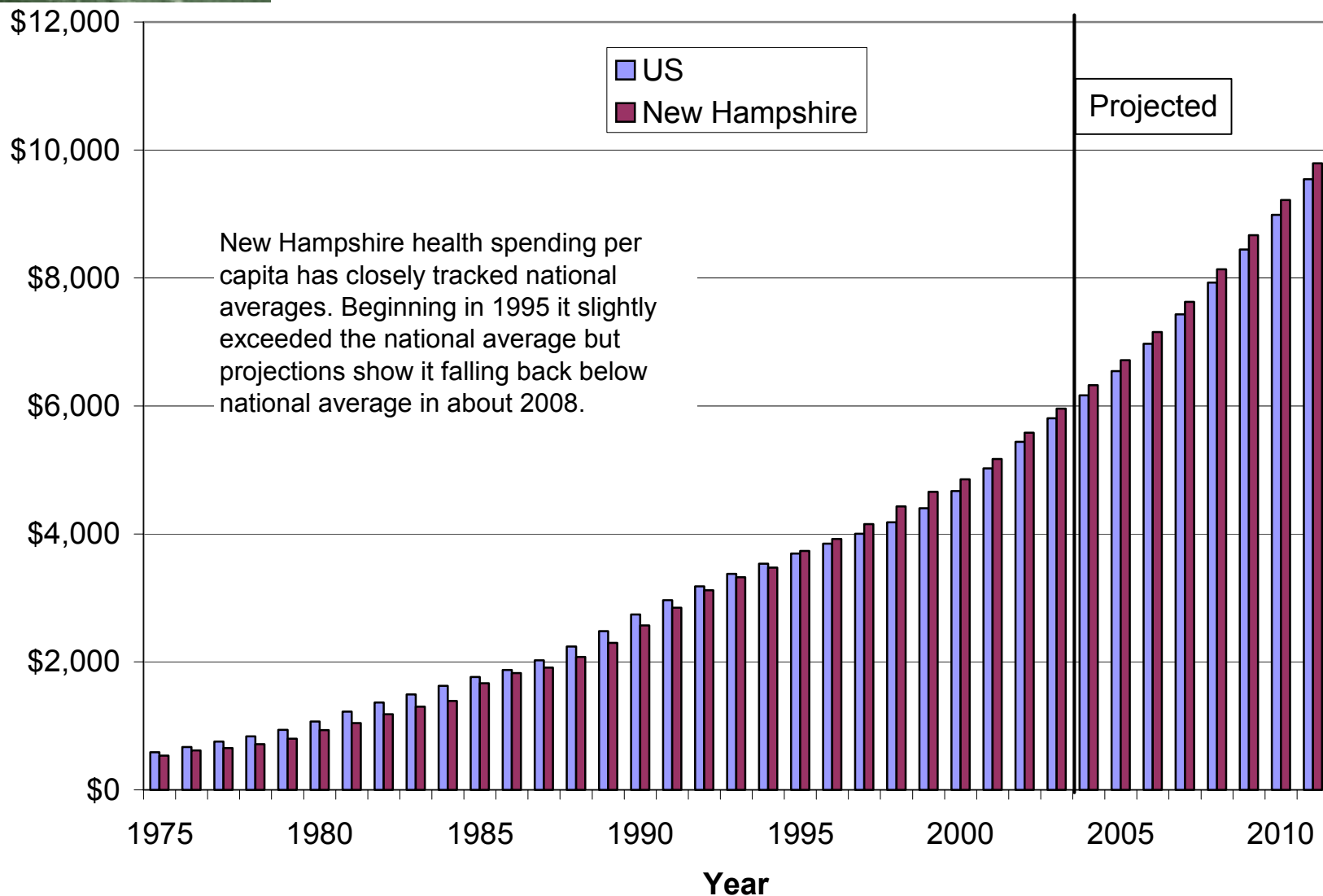
**Estimated Personal Health Care Spending in NH, 2004
 (in \$ million)**



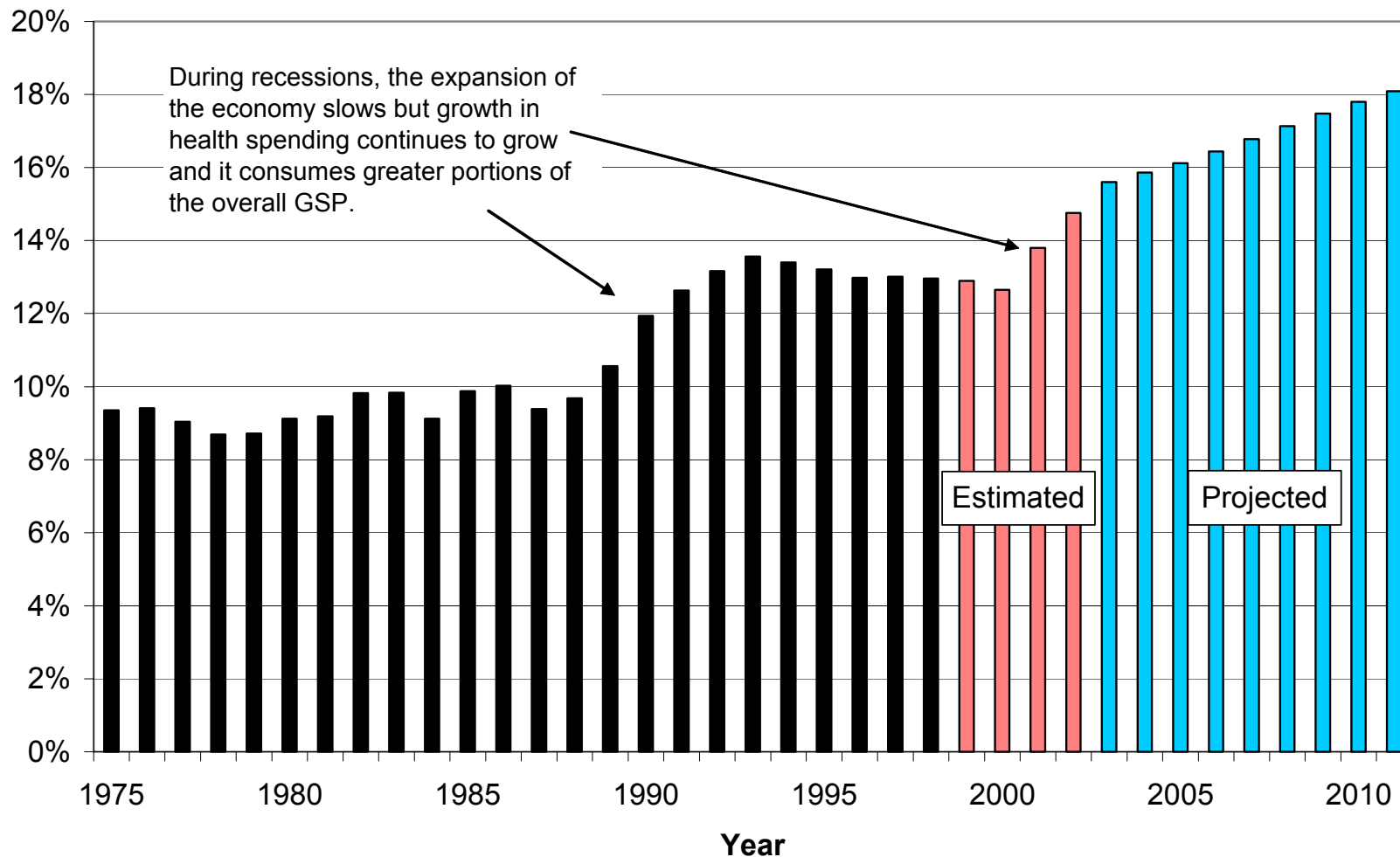
Projected Personal Health Care Expenditure in NH 2011 (in \$ million)



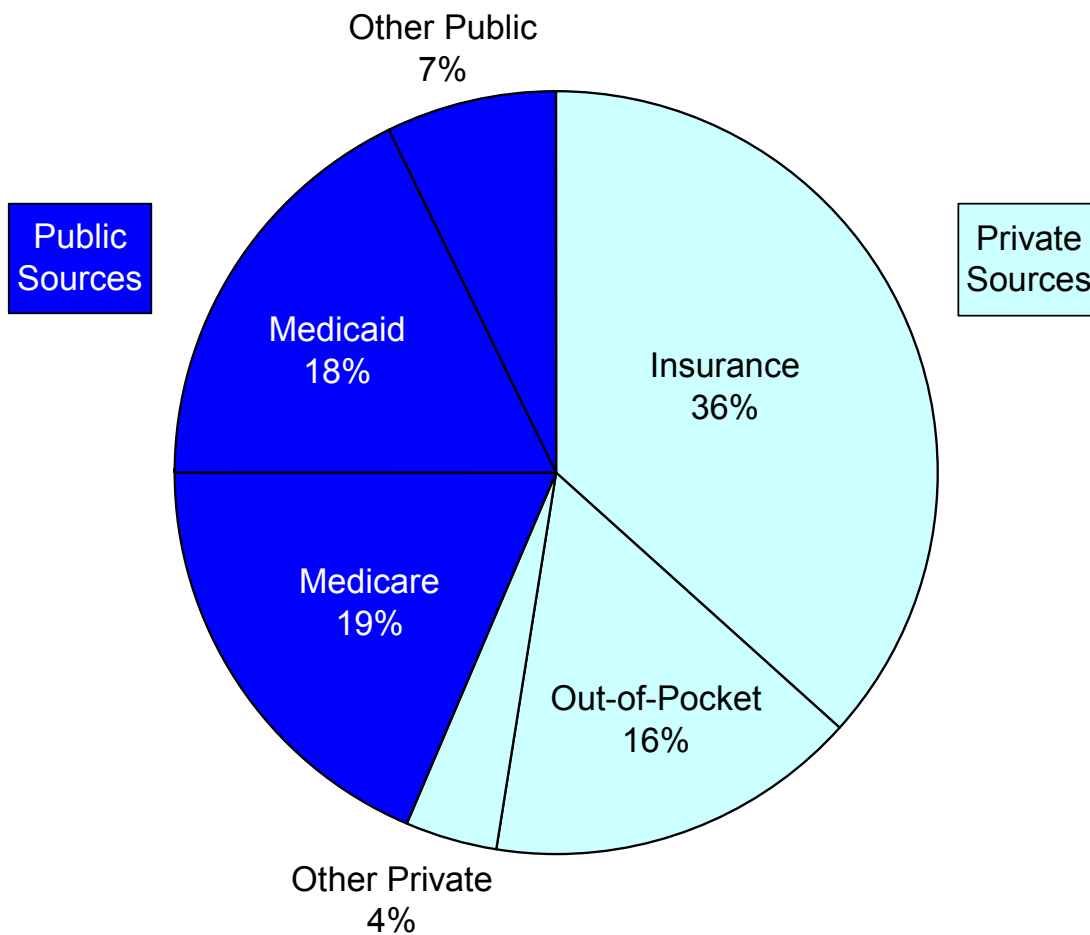
Personal Health Expenditure per Capita



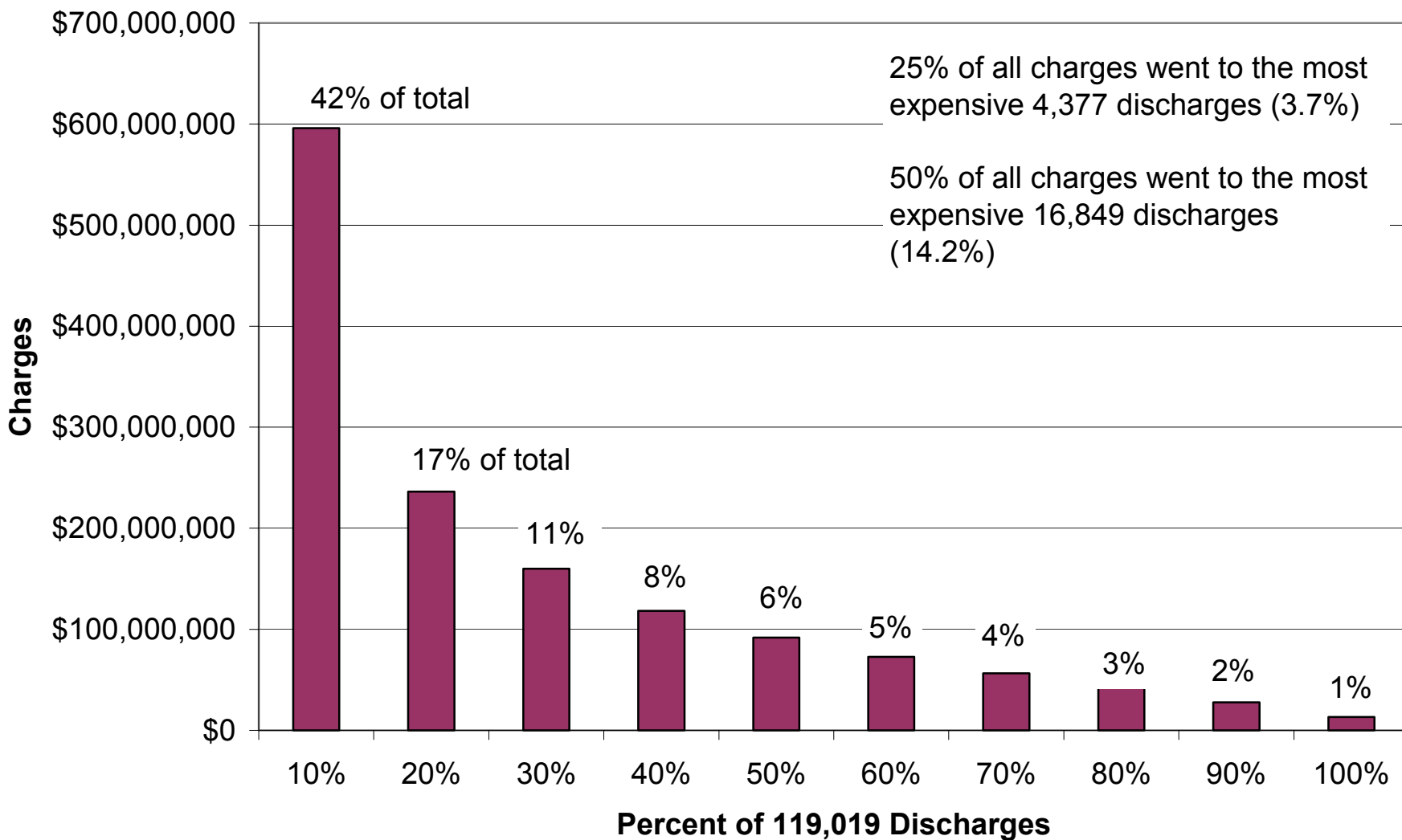
NH Health Expenditure as % of Gross State Product (GSP)



Estimated Source of Funds Personal Health Care in US, 2004



\$1.4 Billion of Inpatient Hospital Charges, 2001



Medicaid in New Hampshire

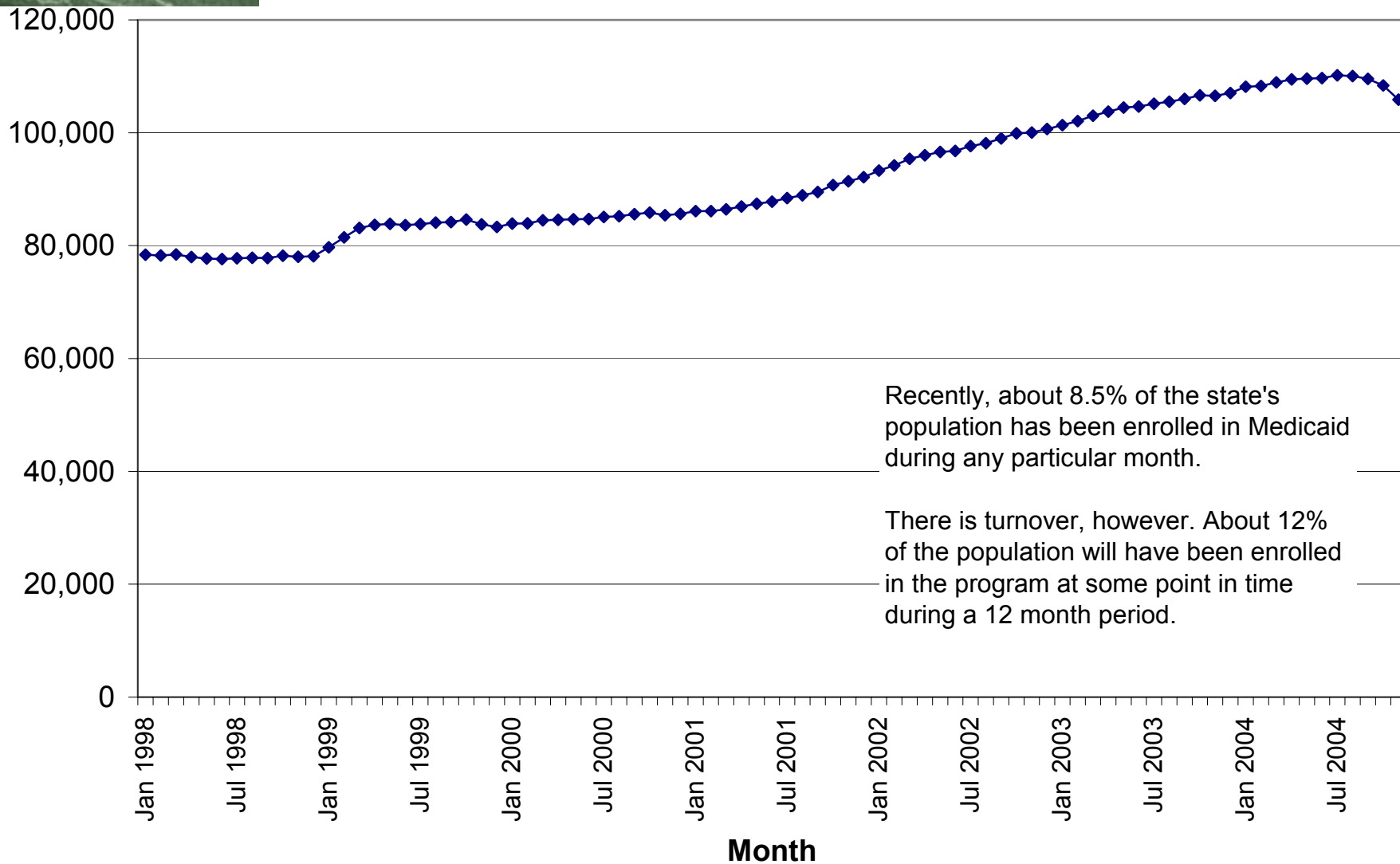
- 50% federal and 50% state funding (generally)
- Total spending in recent 12 months: \$836 million
- In the last 20 years the State shifted what were previously 100% state-paid services to Medicaid in order to obtain 50% federal funds, thus contributing to overall Medicaid growth
 - some special education costs in schools
 - services for the developmentally disabled (think LSS)
 - community mental health services
 - New Hampshire Hospital
 - health care for prisoners (under consideration)*

Medicaid brings federal funds to community mental health and developmental services

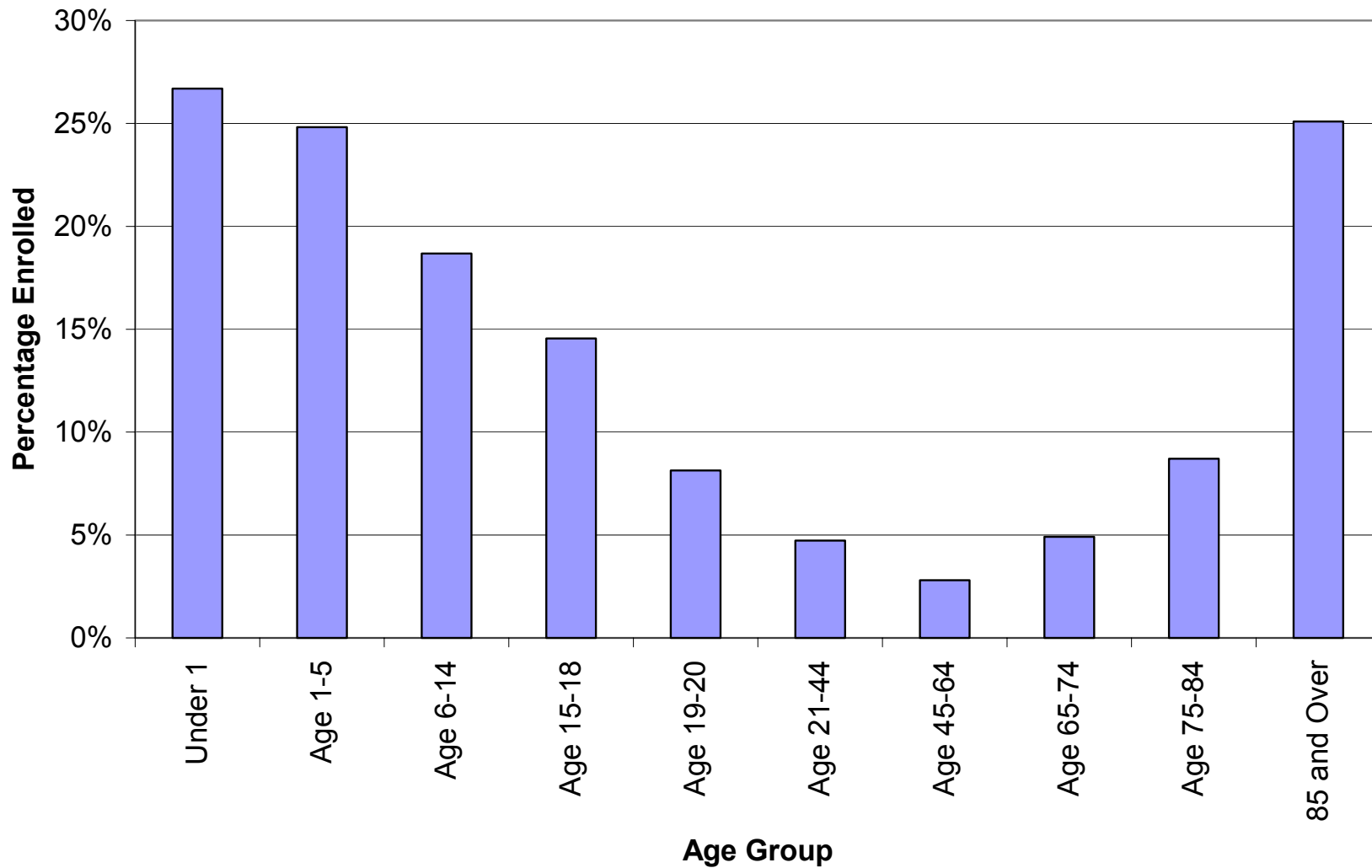
Community Mental Health Services	1985	1990	1995	2000	2005
General Funds	\$12,091,227	\$31,407,777	\$37,630,589	\$40,094,084	\$44,033,100
Federal Funds	\$0	\$0	\$11,625,891	\$29,671,428	\$39,491,833
Other	\$0	\$0	\$0	\$0	\$0
Total	\$12,091,227	\$31,407,777	\$49,256,480	\$69,765,512	\$83,524,933
% Federal	0%	0%	24%	43%	47%
Community Developmental Services	1985	1990	1995	2000	2005
General Funds	\$20,047,990	\$39,049,190	\$19,901,752	\$60,350,570	\$74,540,055
Federal Funds	\$0	\$0	\$8,575,706	\$53,374,304	\$71,455,478
Other	\$0	\$0	\$0	\$27,000	\$77,004
Total	\$20,047,990	\$39,049,190	\$28,477,458	\$113,751,874	\$146,072,537
% Federal	0%	0%	30%	47%	49%

Source: Primary PAUs for these services in NH state budgets; in some years additional PAUs provided other services with varying mix of funds.

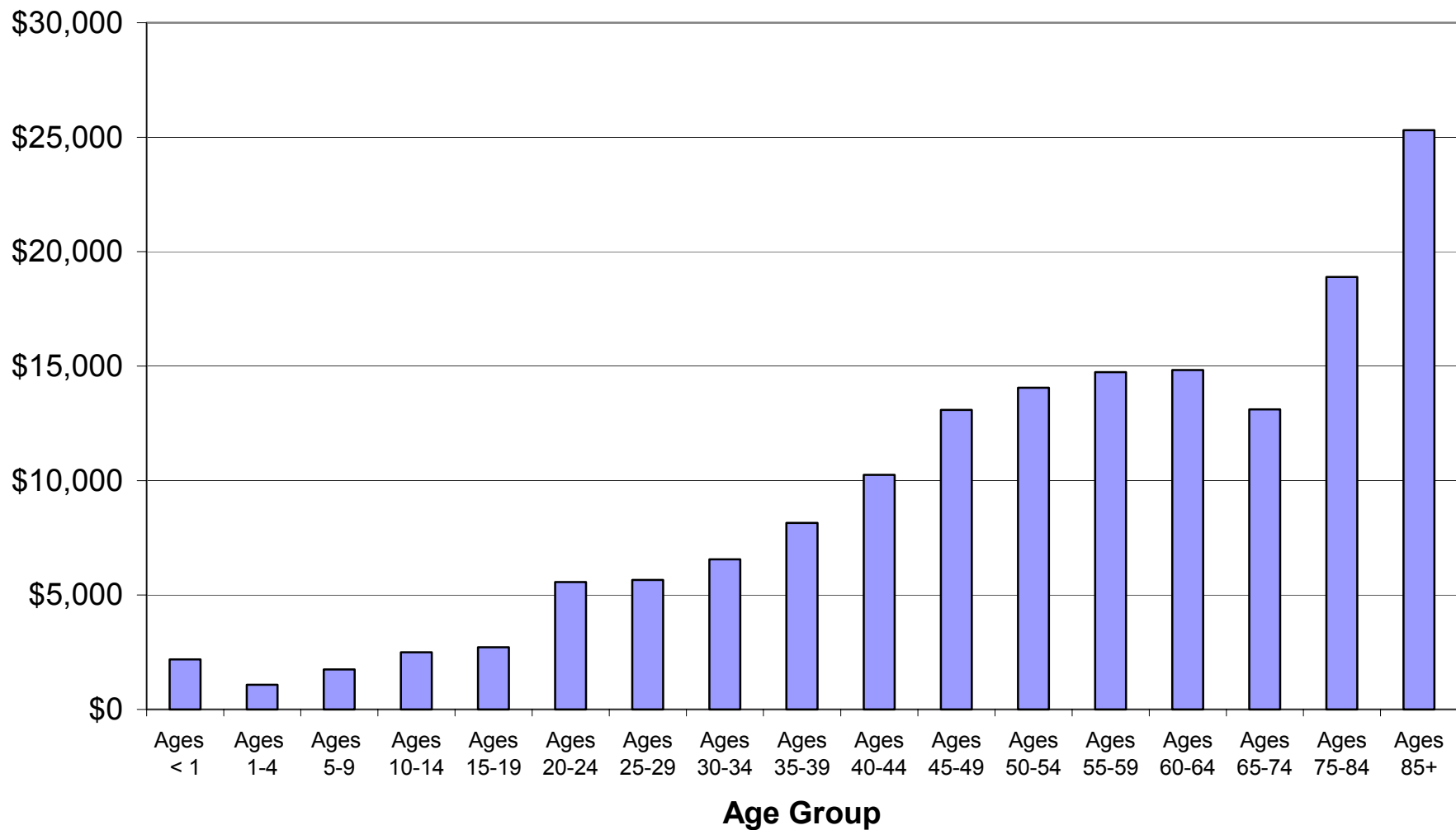
Medicaid Persons



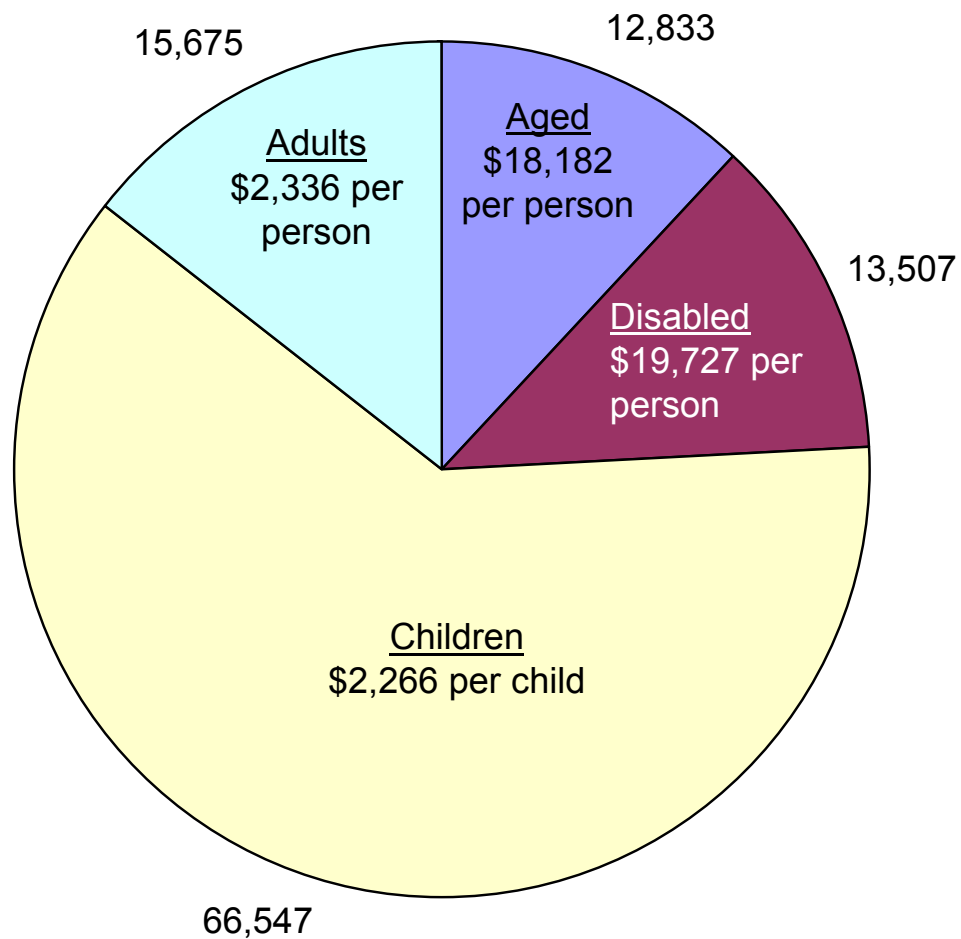
2001 NH Medicaid Enrollees as % of NH Population by Age Group



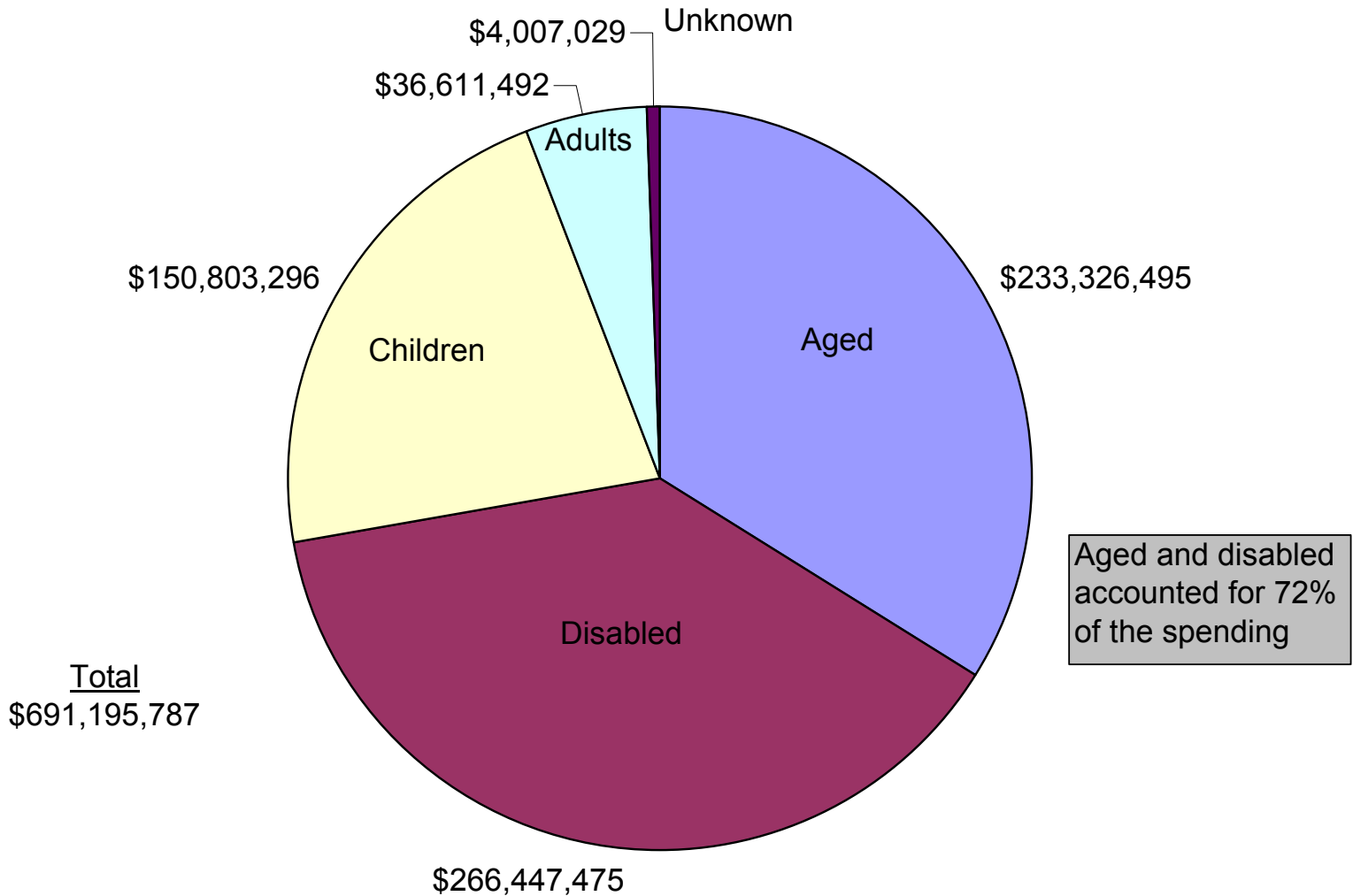
Spending per Medicaid Person per Year (December 2003-November 2004)



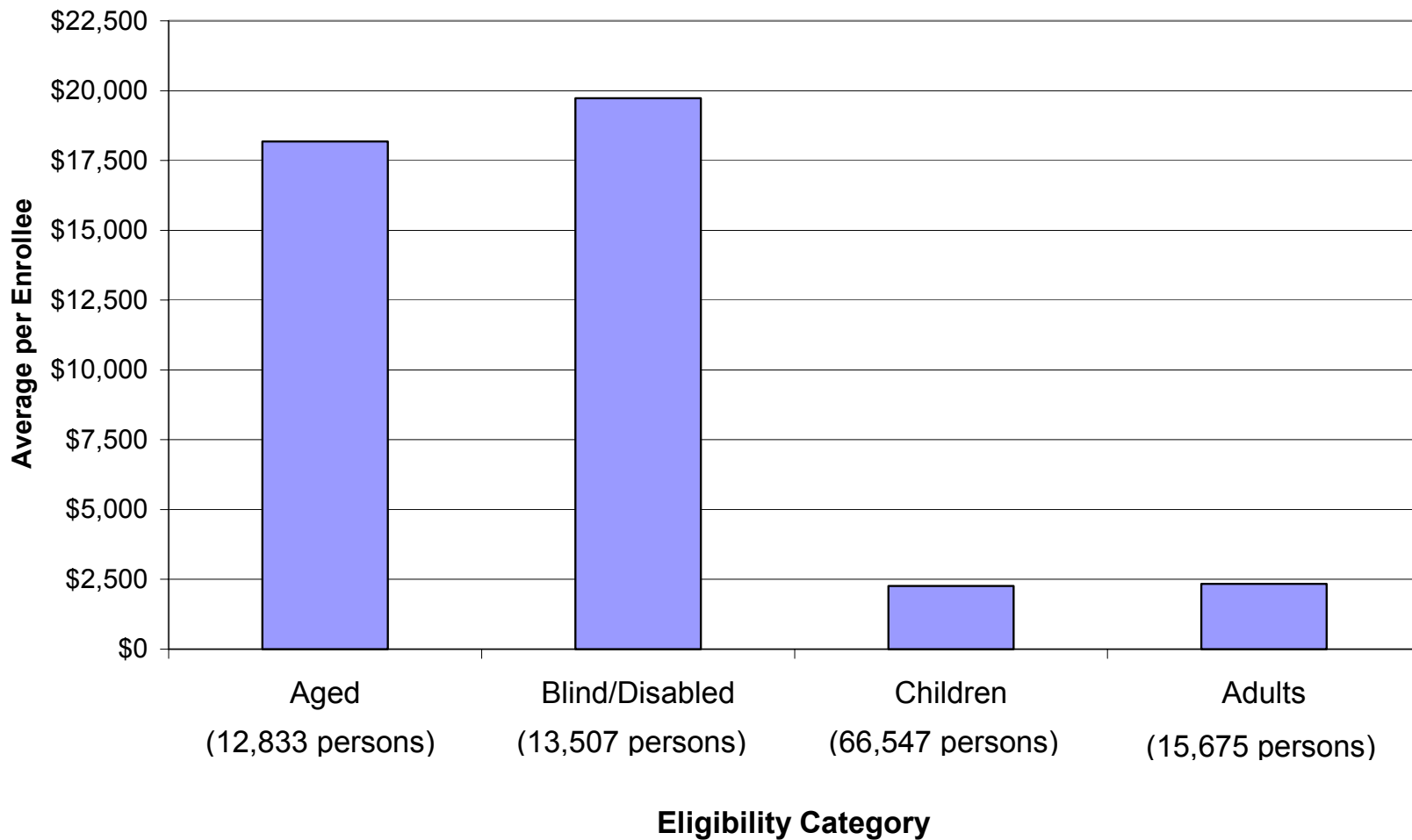
2001 NH Medicaid Enrollees by Eligibility Category



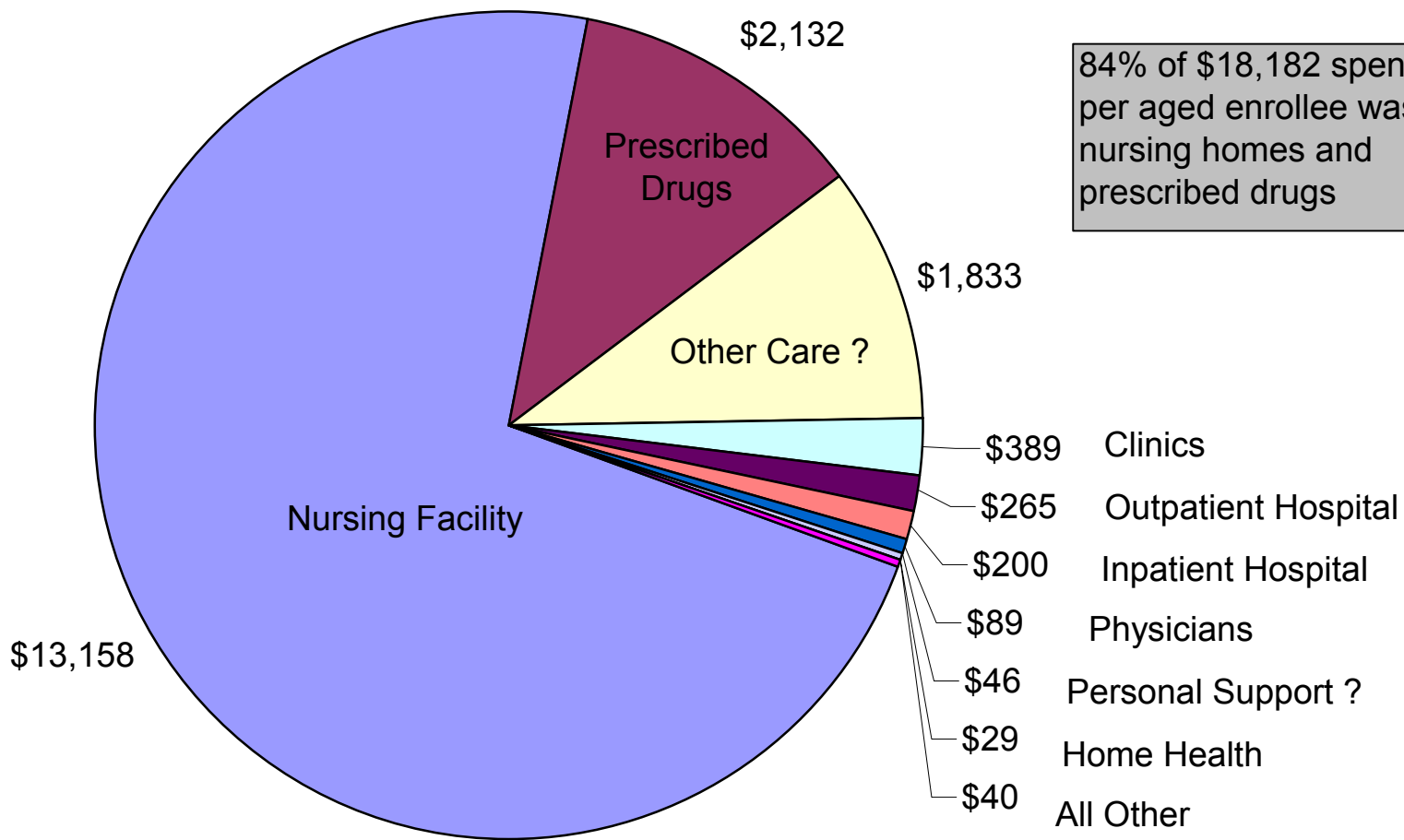
NH Medicaid Spending by Eligibility Category, FFY 2001



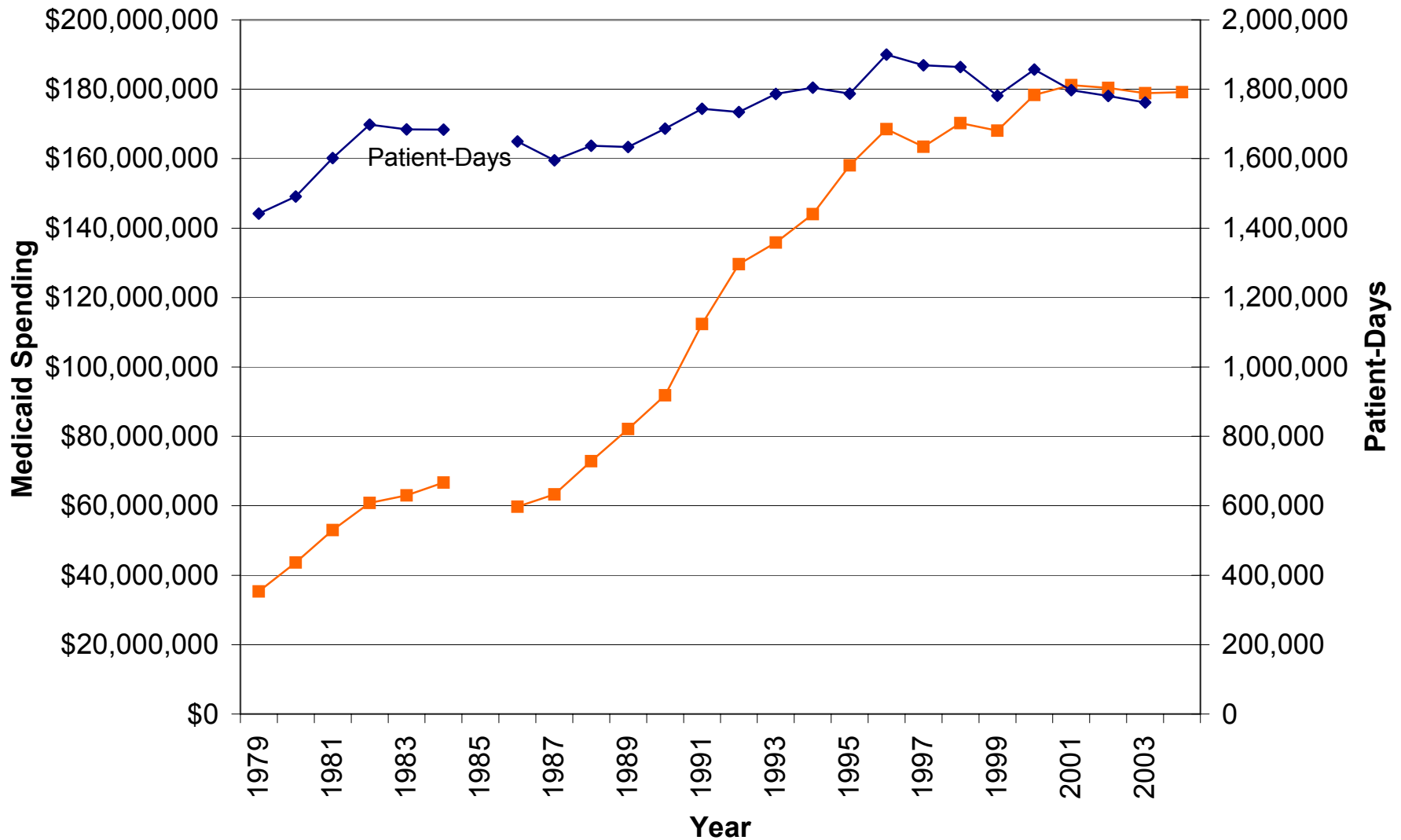
NH Medicaid Spending per Enrollee by Eligibility Category, FFY 2001



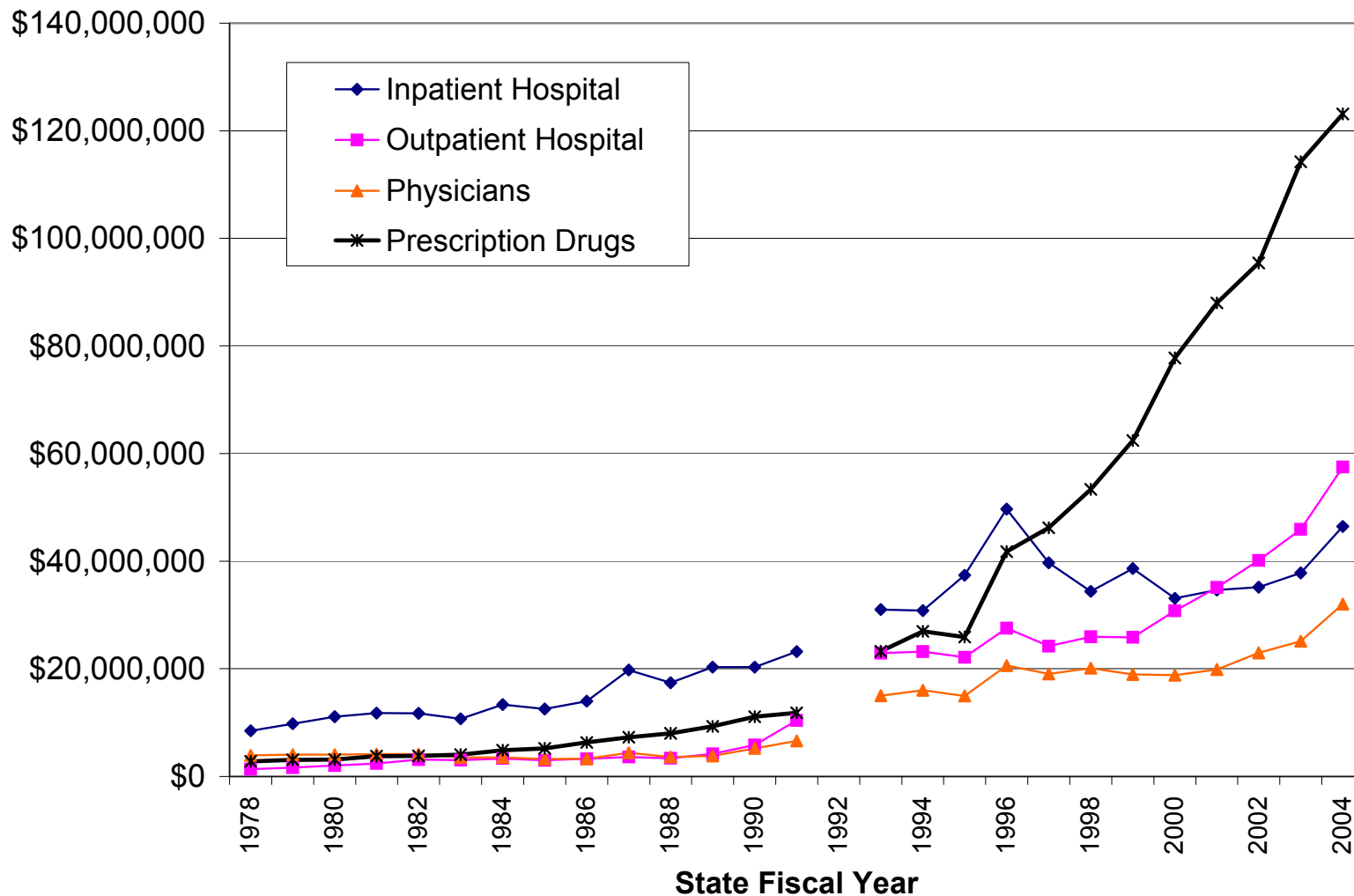
2001 NH Medicaid Spending per Aged Enrollee



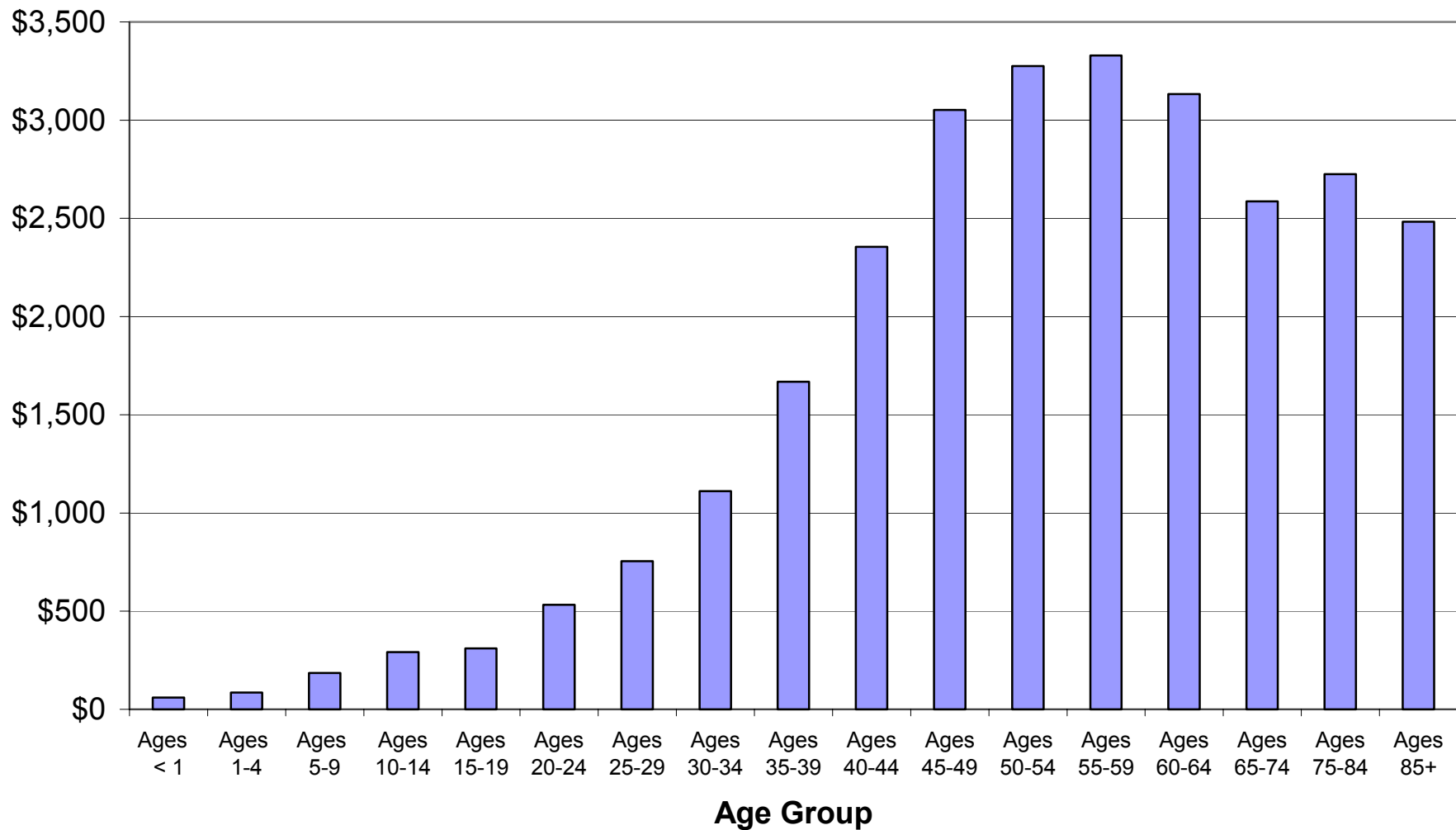
NH Medicaid Spending for Nursing Home Services



NH Medicaid Provider Payments: 4 Large Components



Drug Spending per Medicaid Person per Year
 (December 2003-November 2004)



Medicaid Reform

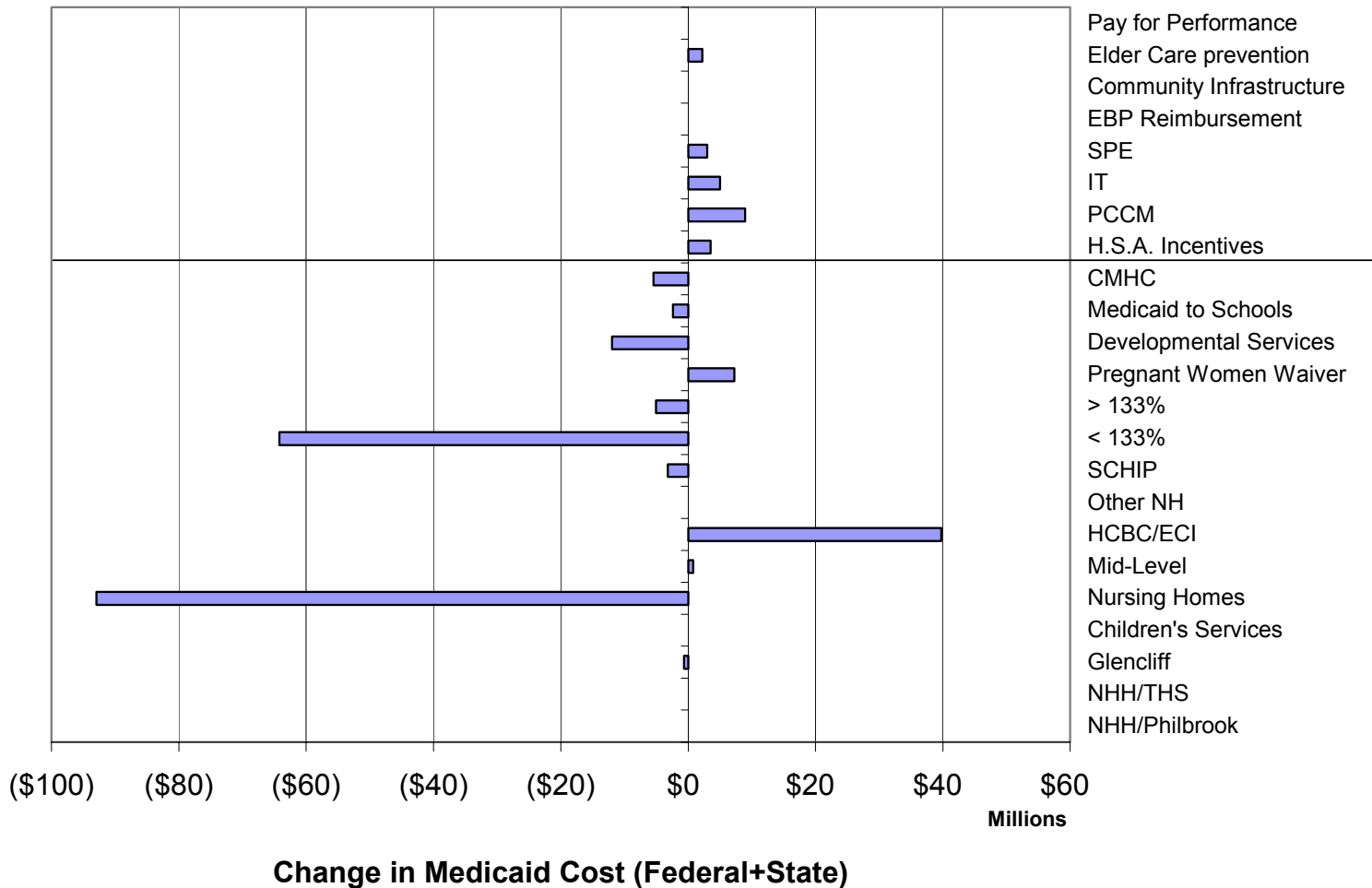
- NH not alone; all states and federal government are currently involved in rethinking the program
- What is the needed and appropriate mix of home and institutional services for elderly and disabled populations?
- Are there ways to limit/control expenditures while increasing the quality and timeliness of Medicaid health care services?
- What payment rates are necessary to ensure that health care institutions and practitioners are willing and able to provide services to the Medicaid population?
- Can meaningful incentives be established to ensure that inefficient or unnecessary use of health care resources does not occur?
- Does society need to make basic triage decisions about who will receive health care?

The GraniteCare Proposal for Medicaid Reform

- Expanding home care services and reducing existing nursing home services
- Single point of entry (SPE) for developmentally disabled, mentally ill, and elderly
- Managed care and individual budgets for health care services across the board
- Health Services Account (HSAs) for low income families/children
- US Department of Health and Human Services must waive existing federal regulations (at least in part)
- New Hampshire as a policy laboratory for the feds

The GraniteCare Proposal for Medicaid Reform

DHHS Projected Change in Medicaid Spending in 2010 with Waiver



Component of GraniteCare Plan

The GraniteCare Proposal for Medicaid Reform

- Large scale system change, behavior change, attitude change
- Commitment from feds not yet certain
- Details of many components not yet worked out
- Federal and state share of any savings not agreed upon
- Little or no net financial impact in FY 2005, 2006, or 2007



The Center's Current Position on GraniteCare

- In September we published a report attempting to correct the use of bad data regarding the status of long-term care in NH.
- We forced DHHS to release Medicaid data and management reports through the state's right-to-know law, RSA 91-A. We posted a small set of their management reports on our website.
- We have not endorsed or rejected any of the proposals or components of the plan.
- We submitted 68+ questions to NH DH&HS seeking more detailed explanations and data regarding the proposal. We have published their responses on our website.
- We suggest DHHS project annual cost/person increases at 6.5% instead of 4.2% and have published a paper .
- We do not believe the state should proceed with any policy change until needed explanations and supporting data are available and well understood.
- We believe that all public policy should be debated in an environment rich with information; we believe that anecdotes, ideologies, hunches, and personal loyalties do not make an appropriate foundation for important public policy.

Aspects of GraniteCare

1. There is some degree of consensus on these basic ideas:

- Utilization of home-based and intermediate levels of care where they are appropriate
- Uniform assessment tool for evaluating long-term care service needs
- Medical “home” for all Medicaid recipients
- Disease management, especially for high cost cases
- Emphasis on prevention
- Reducing/eliminating inappropriate use of high cost services
- Utilization of “best practices” where they can be identified

Aspects of GraniteCare

2. Policy-makers should question these:

- Target of 30% reduction in nursing home beds and associated cost savings
- Use of 4.2% medical cost inflation factor
- Use of ratio of institutional to all long-term care as only and best measure to compare NH to other states
- Advisability of state setting “individual budgets” for health care as a method of re-introducing managed care into Medicaid
- Wholesale use of NH as a testbed for HSAs for poverty population
- Ability to expand certain services at current Medicaid payment rates and willingness of providers to accept new responsibilities at proposed rates

Aspects of GraniteCare

3. Policy-makers should seek the following before proceeding:

- Simulation of proposed new nursing home entry criteria on recent 12 months of Medicaid nursing home admissions to determine to what reduction in population is actually possible.
- Detailed data on cost of “medically unnecessary” care and the characteristics of populations obtaining such care under Medicaid during recent 12 months.
- Clear definition and distinction between “case management, “care coordination,” and “care management” and roles of associated individuals/institutions
- Involvement in all program planning of persons with direct hands-on experience providing health care for each population
- Clarity from CMS regarding whether any extra federal funds will need to be repaid if the state does not meet spending reduction promises
- Clarity whether any aspect of the plan (especially “individual budgets”) will remove or restrict current entitlement to “medically necessary” services,



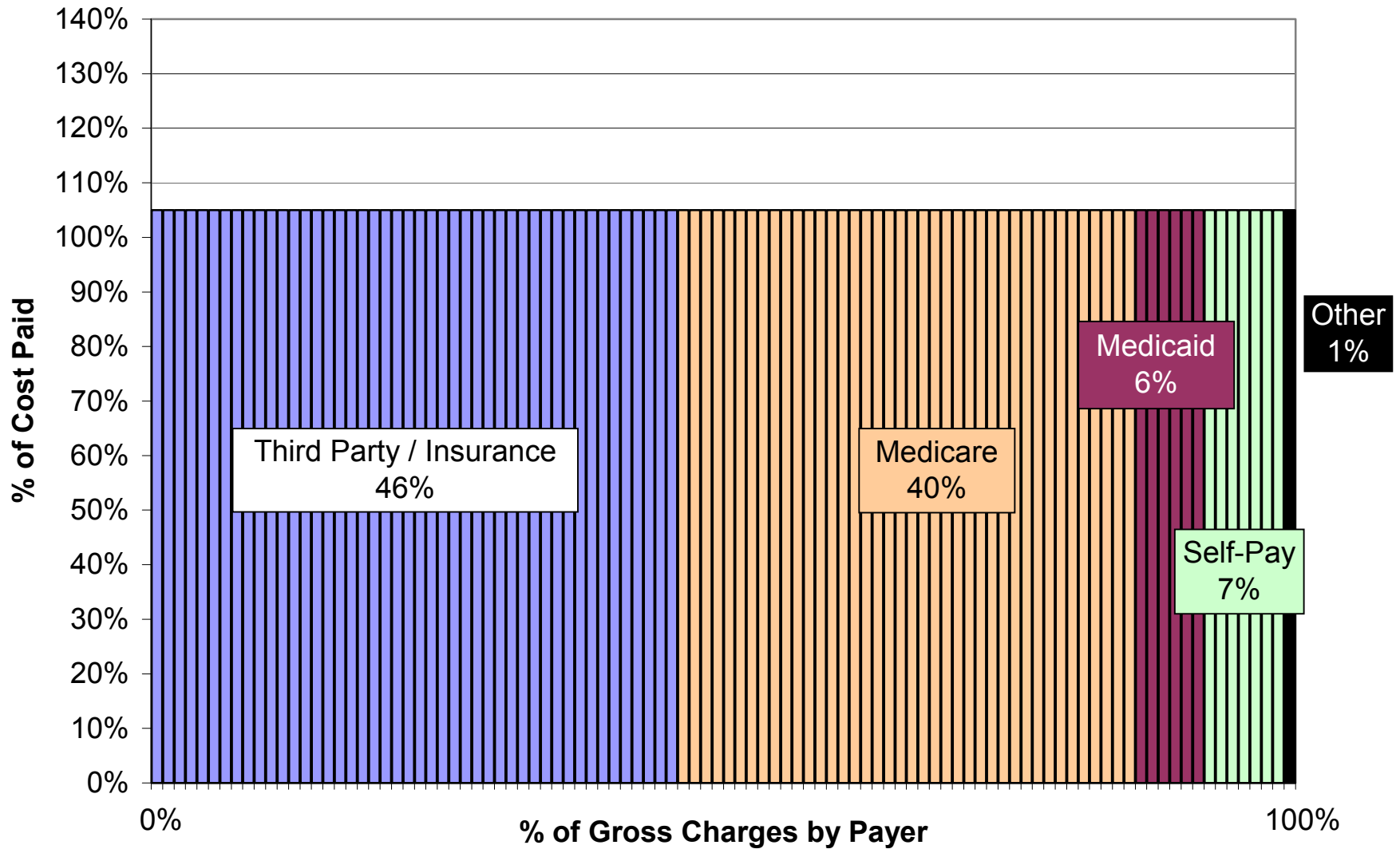
The Center's Role

- Prepare and issue papers on particular concerns
- Ask questions and publish answers
- Analyze new plans and revisions to plans
- Respond to requests for presentation of analysis by legislative committees, community groups, news media and executive branch
- Urge incorporation of experienced stakeholders in detailed planning
- If necessary, force information public through additional right-to-know requests
- Advocate sufficient staff resources at DHHS to understand Medicaid demographics, service, spending, and health trends and to manage and plan the expenditure of \$70 million/month

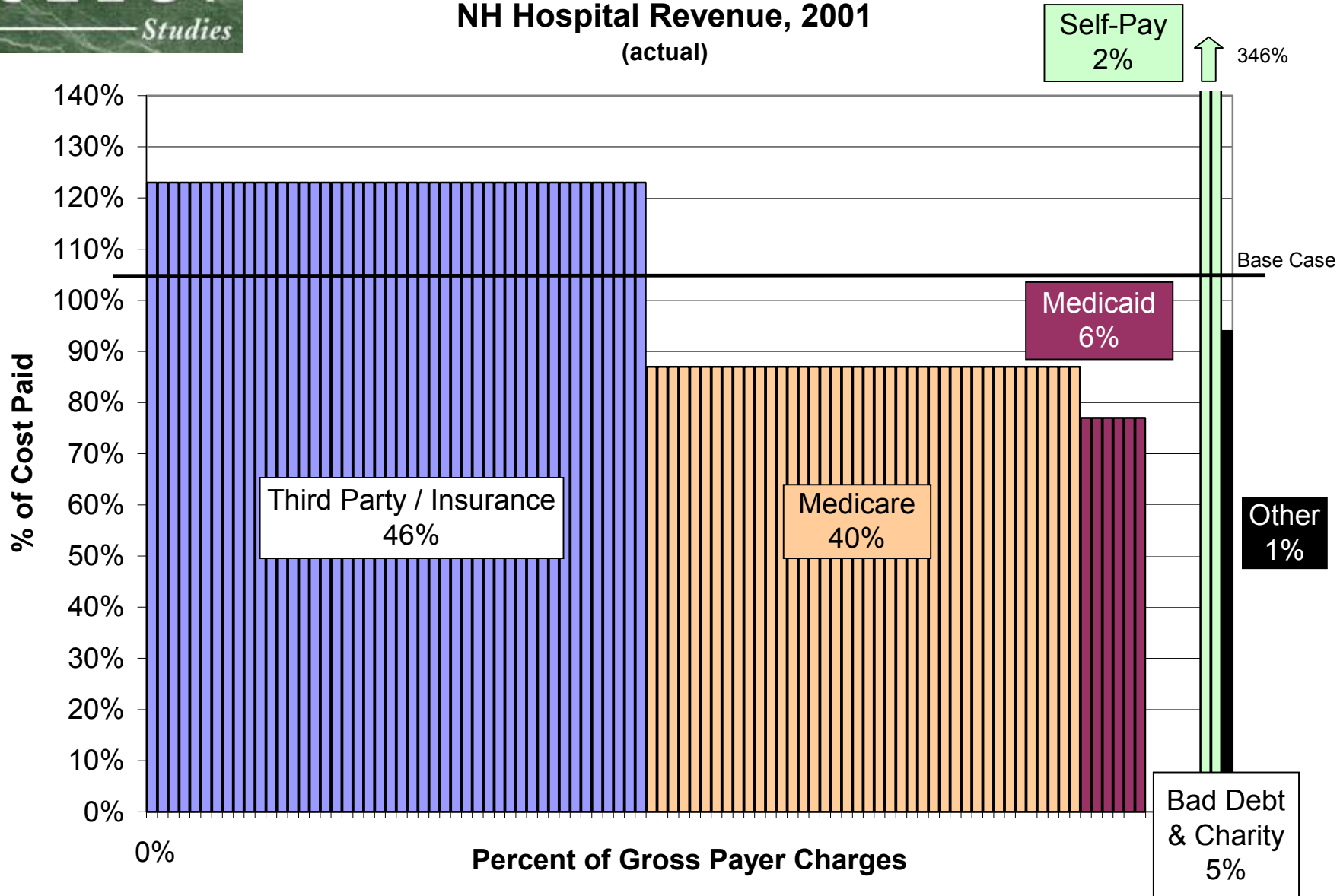
The 2nd Safety Net: Cost-Shifting

- The allocation of unpaid costs of care delivered to one patient population through above-cost revenue collected from other patient populations.
- For hospitals, nursing facilities and physicians, the historical cause of cost shifting has been below-cost reimbursement rates paid by public programs and uncompensated care losses due to charity care and bad debt.

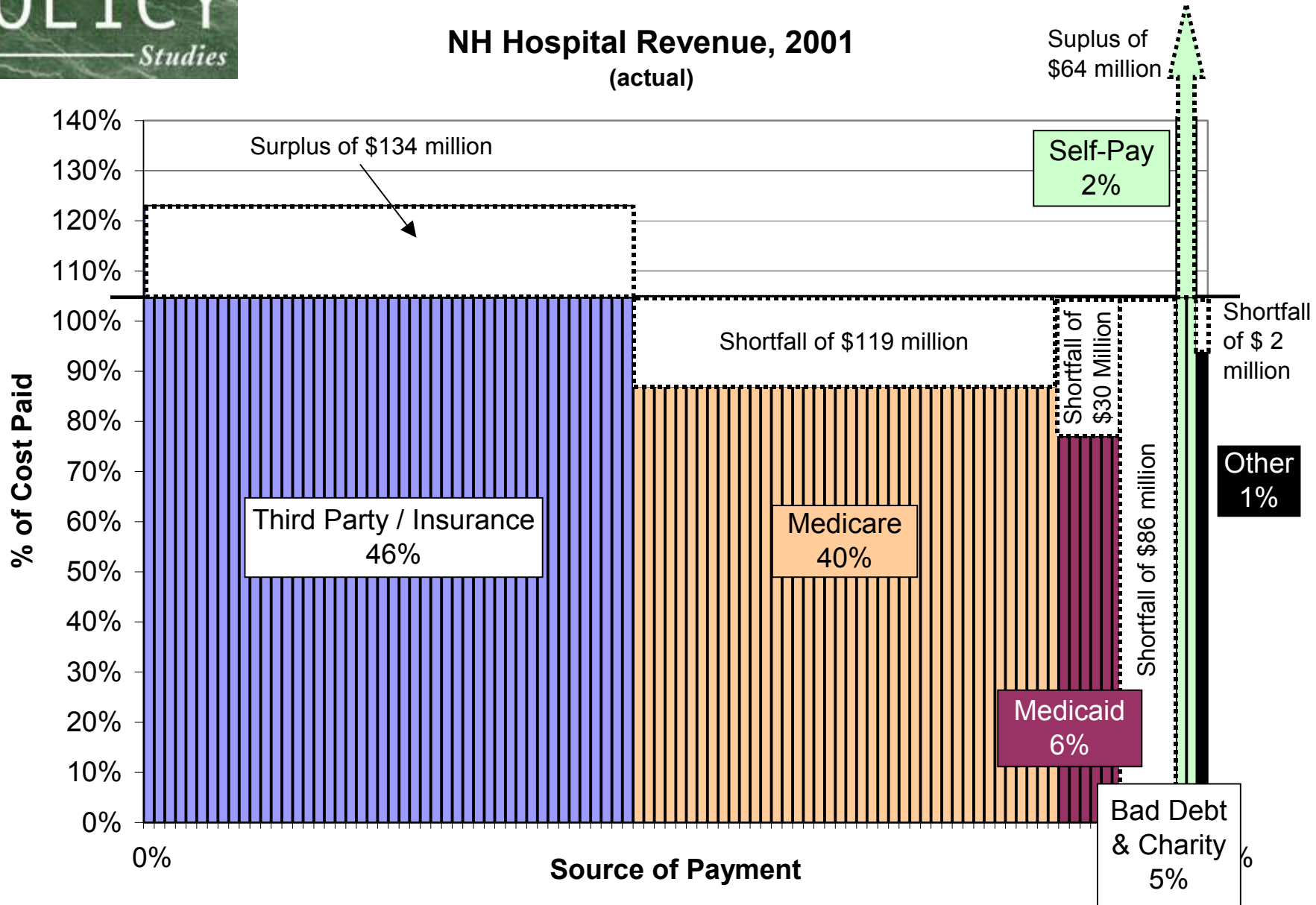
NH Hospital Revenue, 2001
 (theoretical situation where all payers pay cost + 5% margin)



NH Hospital Revenue, 2001
 (actual)



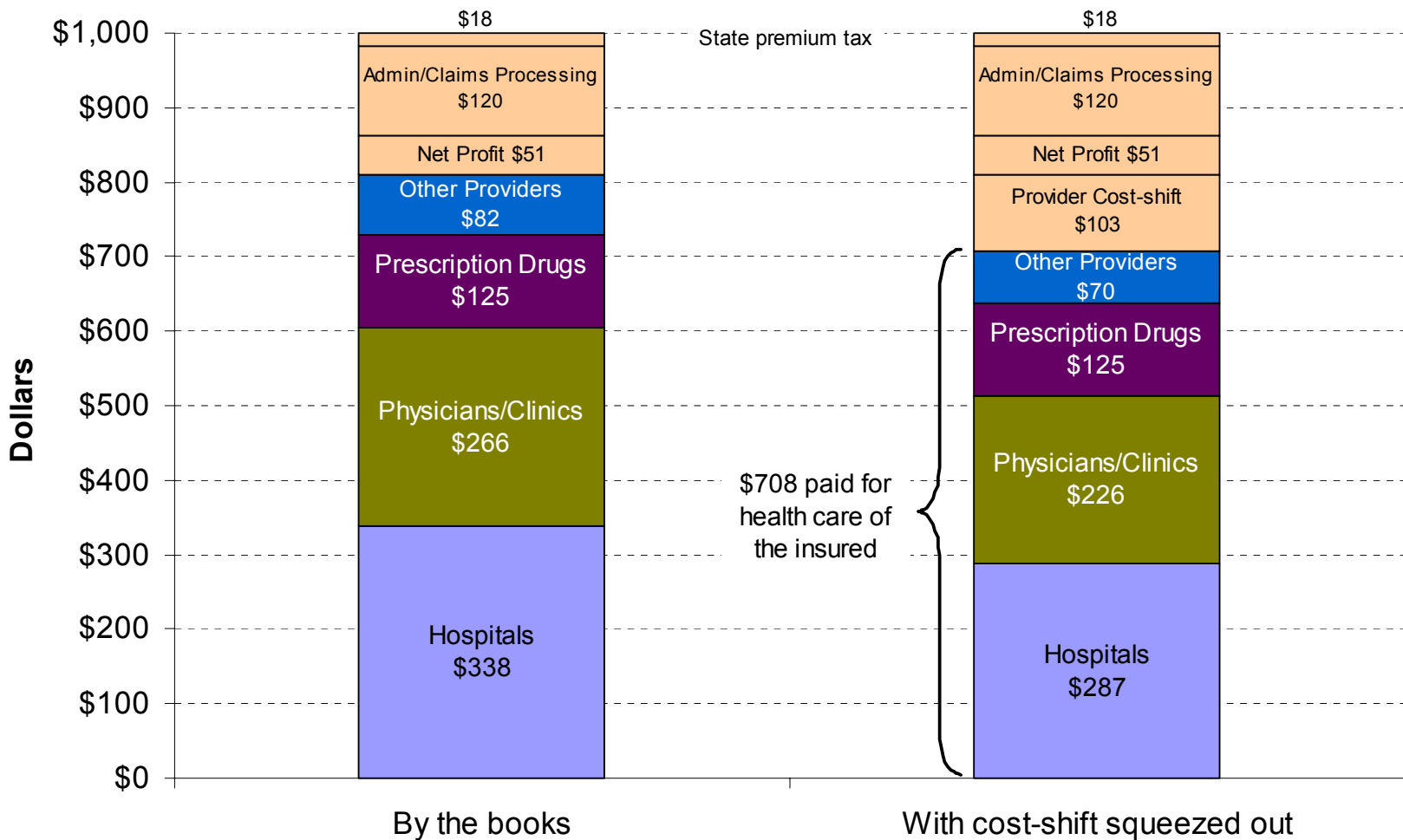
NH Hospital Revenue, 2001 (actual)



Quantifying the 2001 Cost-Shift in 26 New Hampshire Hospitals

Payer	Revenue		
	Actual Revenue	Needed to Meet Expenses Plus 5% Margin	Excess or (Shortfall)
Shortfalls			
Medicare	\$559,189,410	\$678,444,353	(\$119,254,943)
Medicaid	\$82,259,512	\$111,966,988	(\$29,707,476)
Bad Debt/Charity Care	\$0	\$85,566,423	(\$85,566,423)
Other	\$19,864,074	\$22,283,430	(\$2,419,356)
		Total	(\$236,948,198)
Surpluses			
Insurance	\$916,840,046	\$782,740,939	\$134,099,107
Self-Pay	\$91,660,528	\$27,833,046	\$63,827,482
		Total	\$197,926,588
		Remaining shortfall	(\$39,021,610)
Operating margin			
Theoretical operating margin		5.0%	\$81,373,104
Actual margin		2.6%	\$42,351,494
Reduced margin			\$39,021,610

What Did Each \$1,000 of Health Insurance Premium Buy in 2002?



The 3rd Safety Net: RSA 165

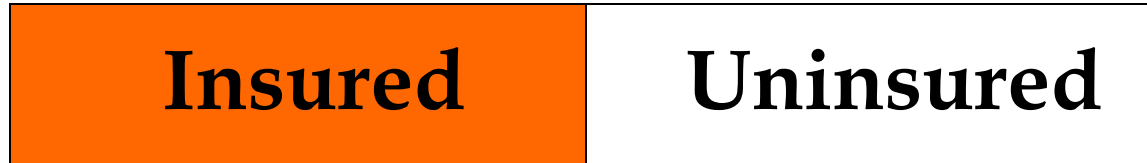
- The State's General Assistance law;
- Towns must provide for basic necessities of life, including shelter, food, and medical care for those who are poor and cannot afford same;
- Relatively unused since mid-1960s for health care with the exception of some prescription drug purchases;
- Long recorded history of NH towns paying for doctor and hospital care of the poor;
- Could erupt in a future year when a hospital bills a town for the \$200,000 treatment of a resident that would otherwise go unpaid.

Population and Medicaid Recipients in some NH Municipalities

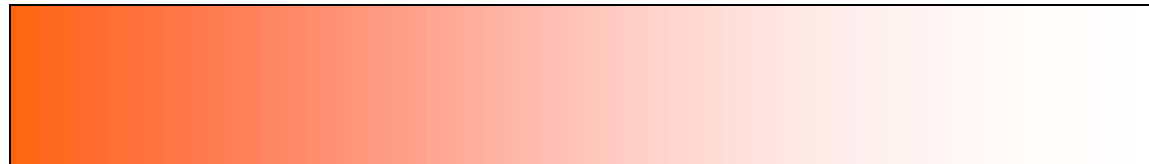
	2003 Medicaid Persons	2003 Est. Pop.	% of Population
Barrington	442	7,968	5.5%
Dover	2,828	28,329	10.0%
Durham	149	13,046	1.1%
Farmington	1,015	6,273	16.2%
Lee	183	4,319	4.2%
Madbury	59	1,701	3.5%
Middleton	186	1,604	11.6%
Milton	508	4,246	12.0%
New Durham	174	2,384	7.3%
Rochester	4,319	29,642	14.6%
Rollinsford	125	2,685	4.7%
Somersworth	1,660	11,758	14.1%
Strafford	133	3,886	3.4%
Strafford County	11,781	117,841	10.0%
Amherst	197	11,342	1.7%
Berlin	2,302	10,641	21.6%
Hollis	134	7,454	1.8%
Manchester	15,950	109,234	14.6%
New London	124	4,379	2.8%
Stratford	310	984	31.5%
Windham	292	12,138	2.4%
New Hampshire	112,105	1,291,573	8.7%



Common View

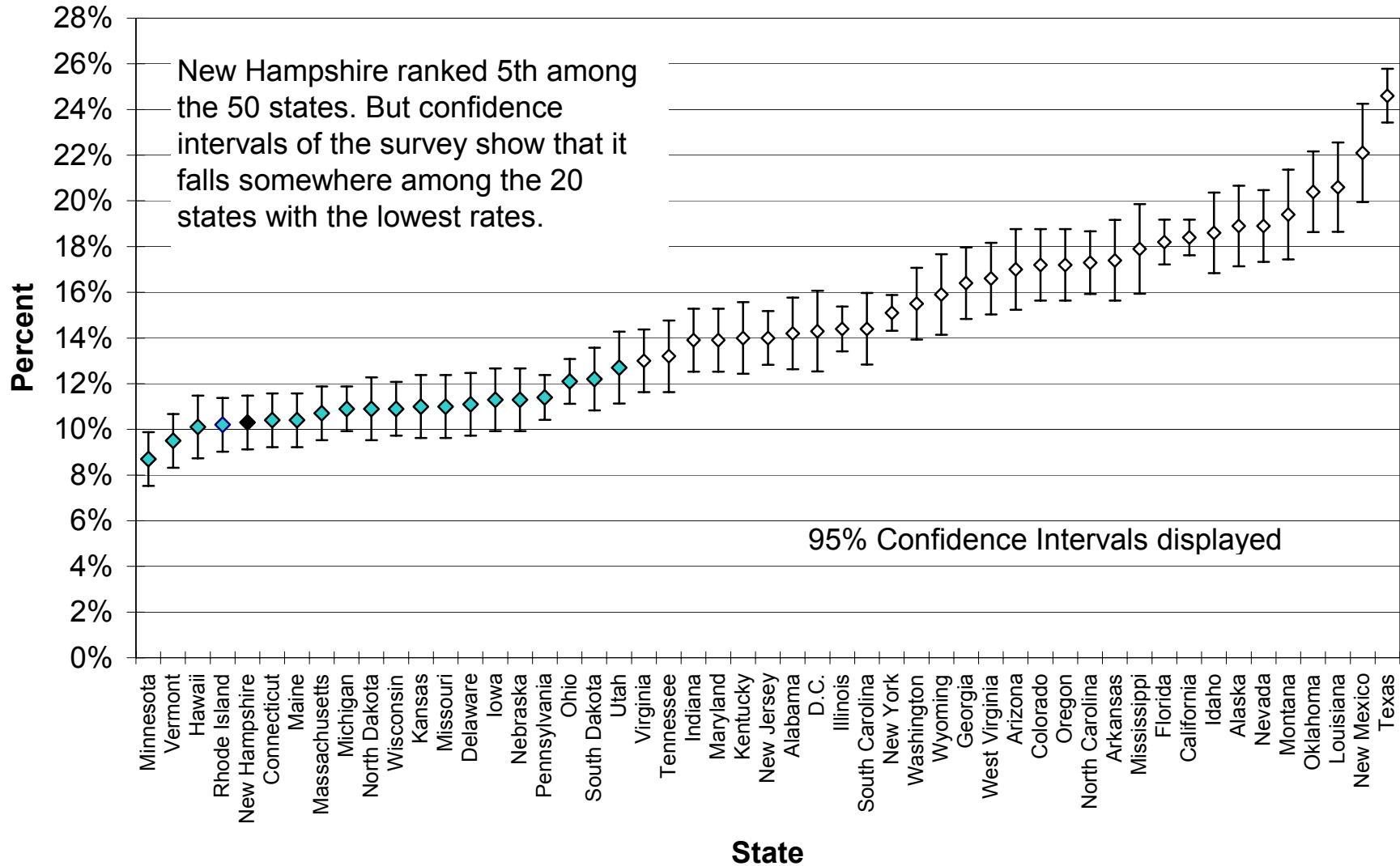


Realistic View



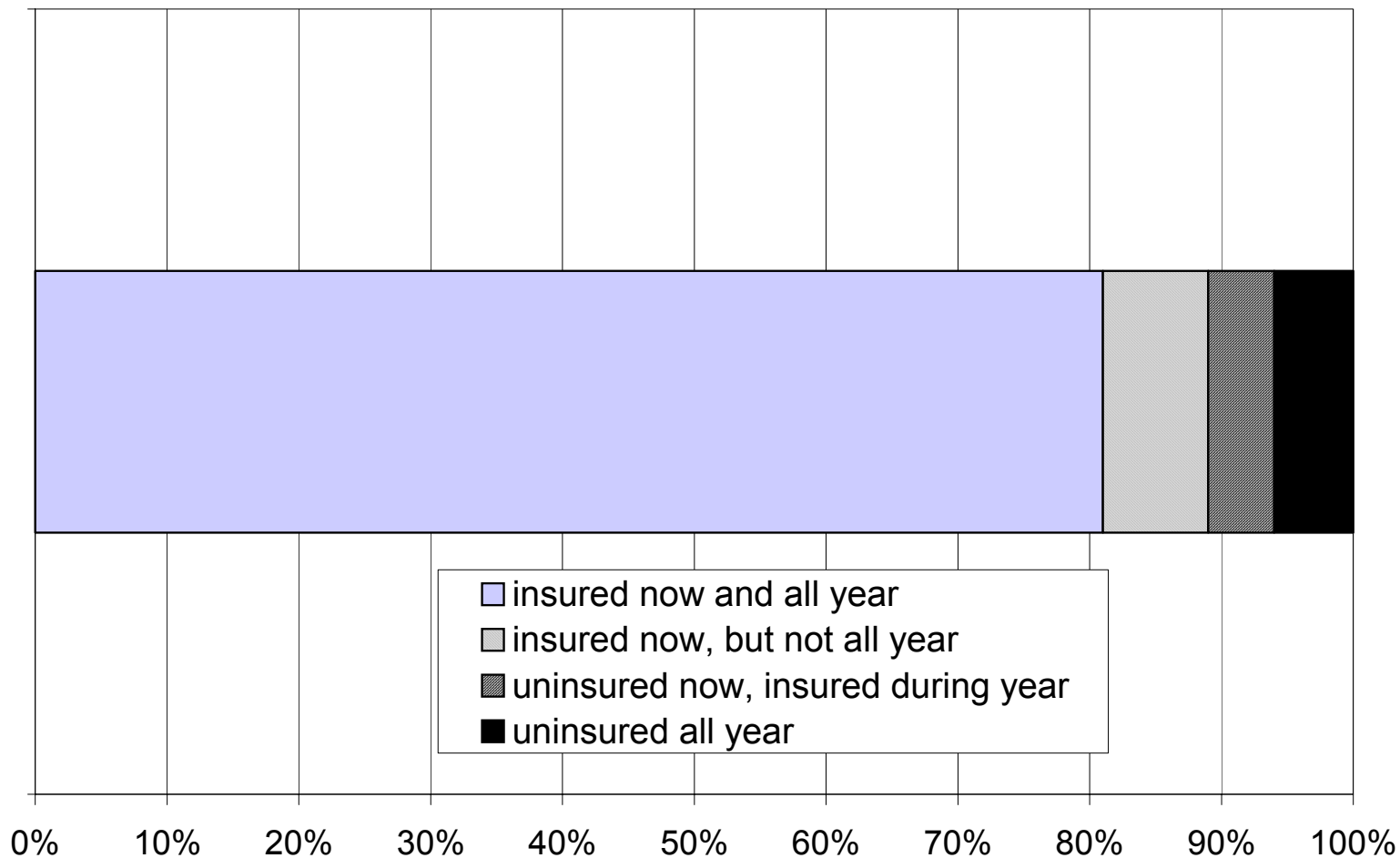
- Insured for what? drug rehab, prescription drugs, mental health, “experimental” procedures, dental, ...
- How much annual deductible and out-of-pocket?
- Pre-existing conditions

Percent of Population Uninsured By State, 2003

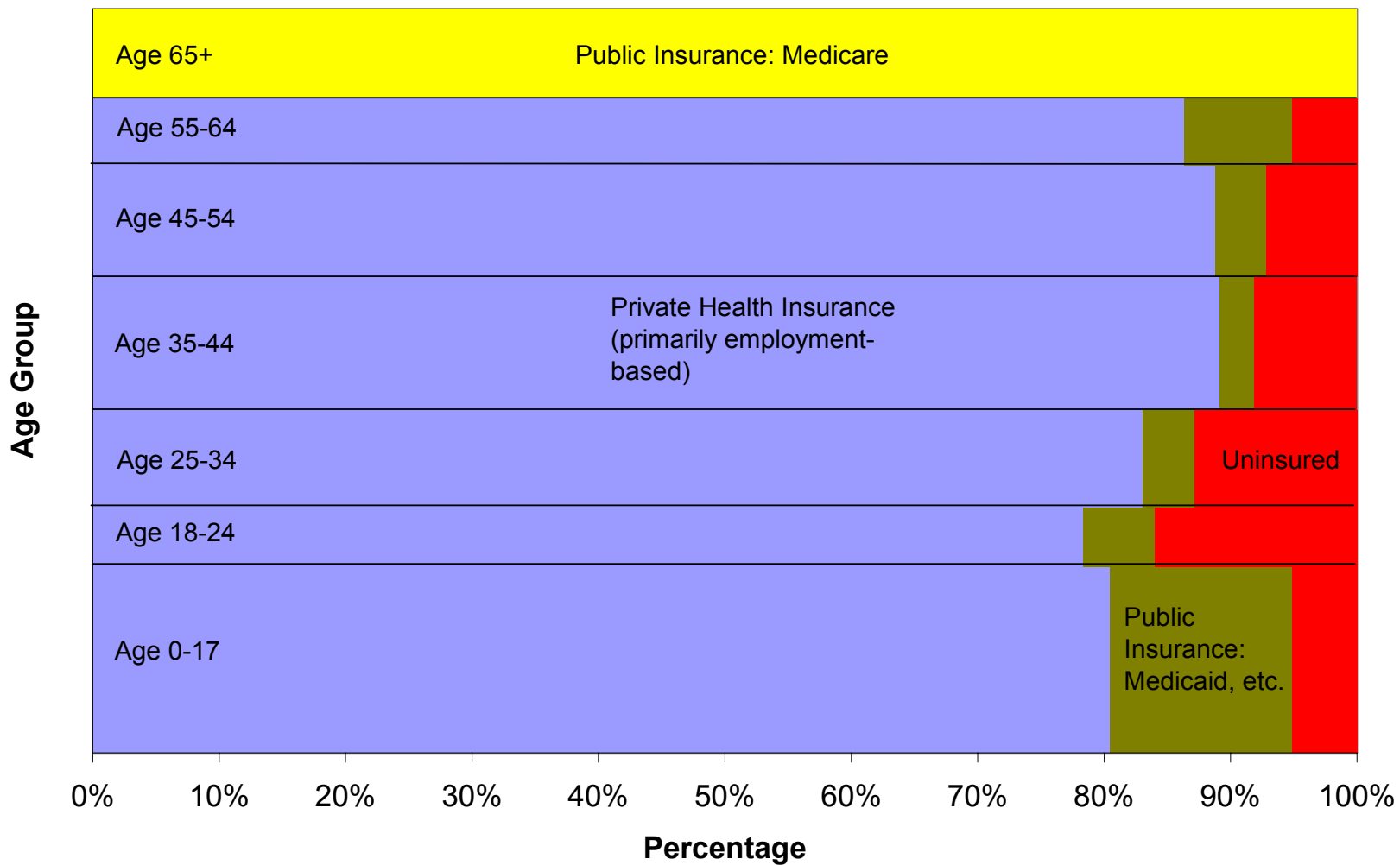


6% chronically uninsured
13% transitionally insured

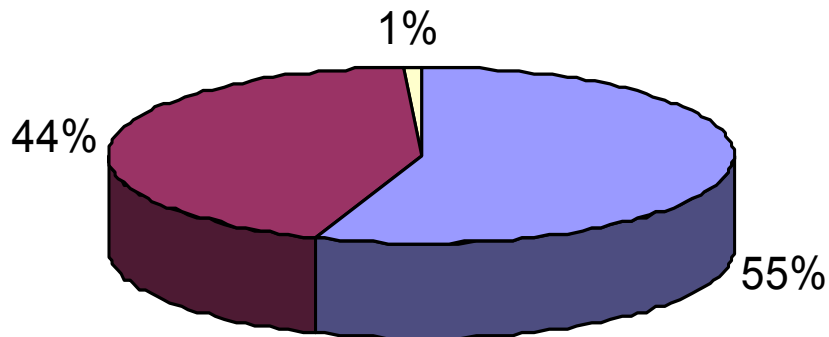
Insurance Status of New Hampshire Adults, 2003



Percentage of Persons Insured & Uninsured by Age Group, 2001



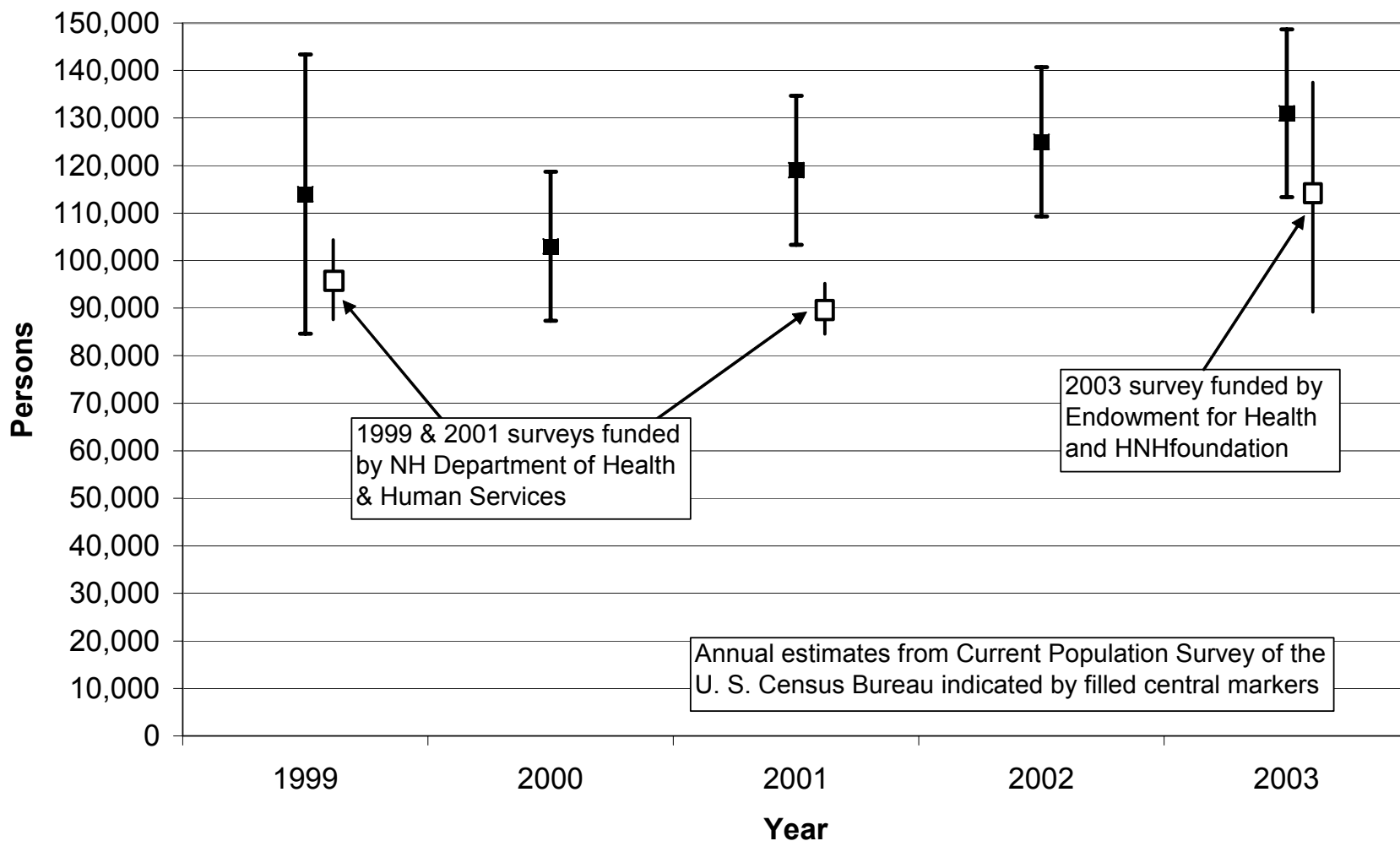
**Applicant Insurance Status
in September 2002
at New Hampshire Hospitals
(n=1,147)**



■ Uninsured ■ Insured, but had a Balance Due ■ Unknown

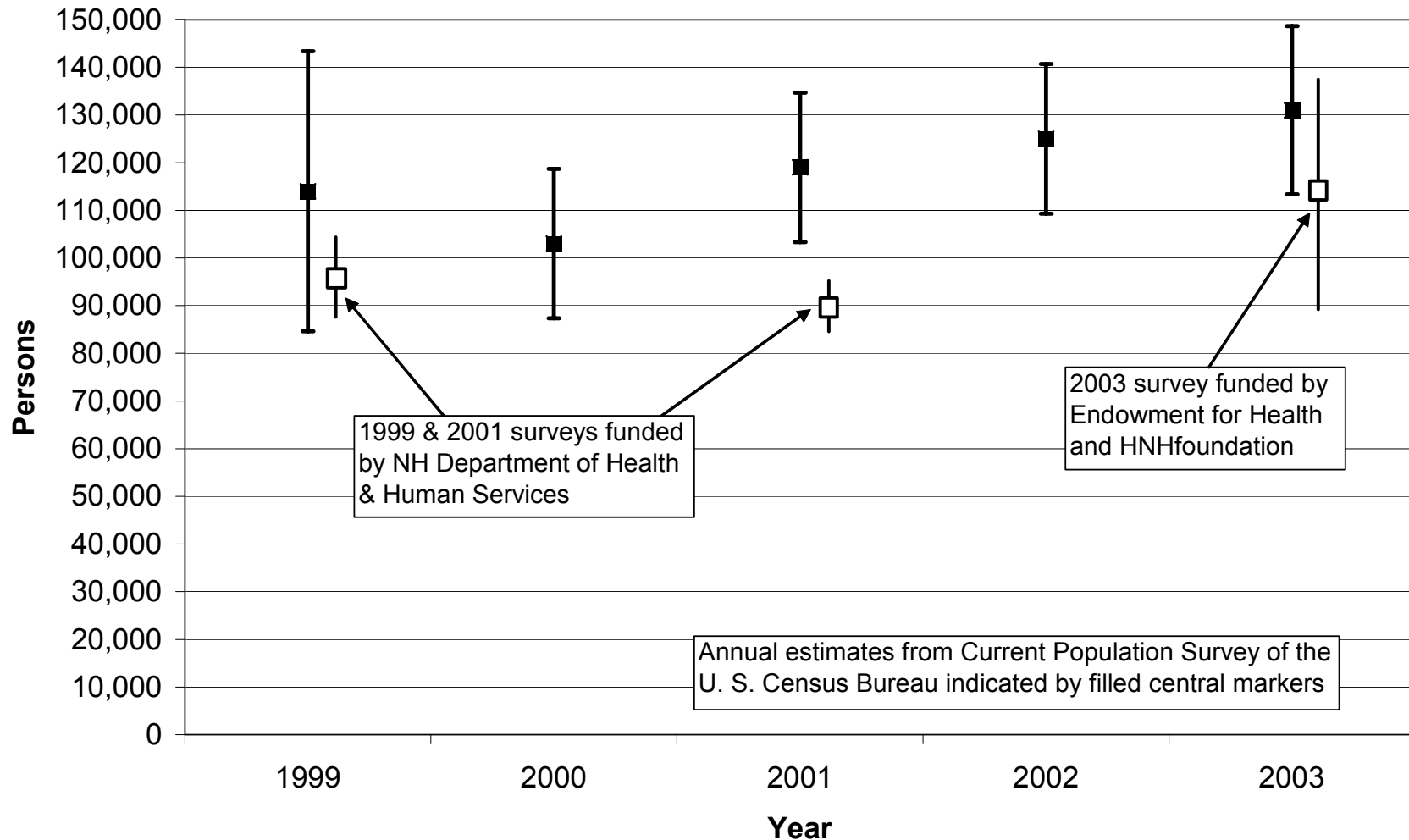
In NH, About 120,000 are Uninsured

Estimated Number of Uninsured NH Residents, 1999-2003



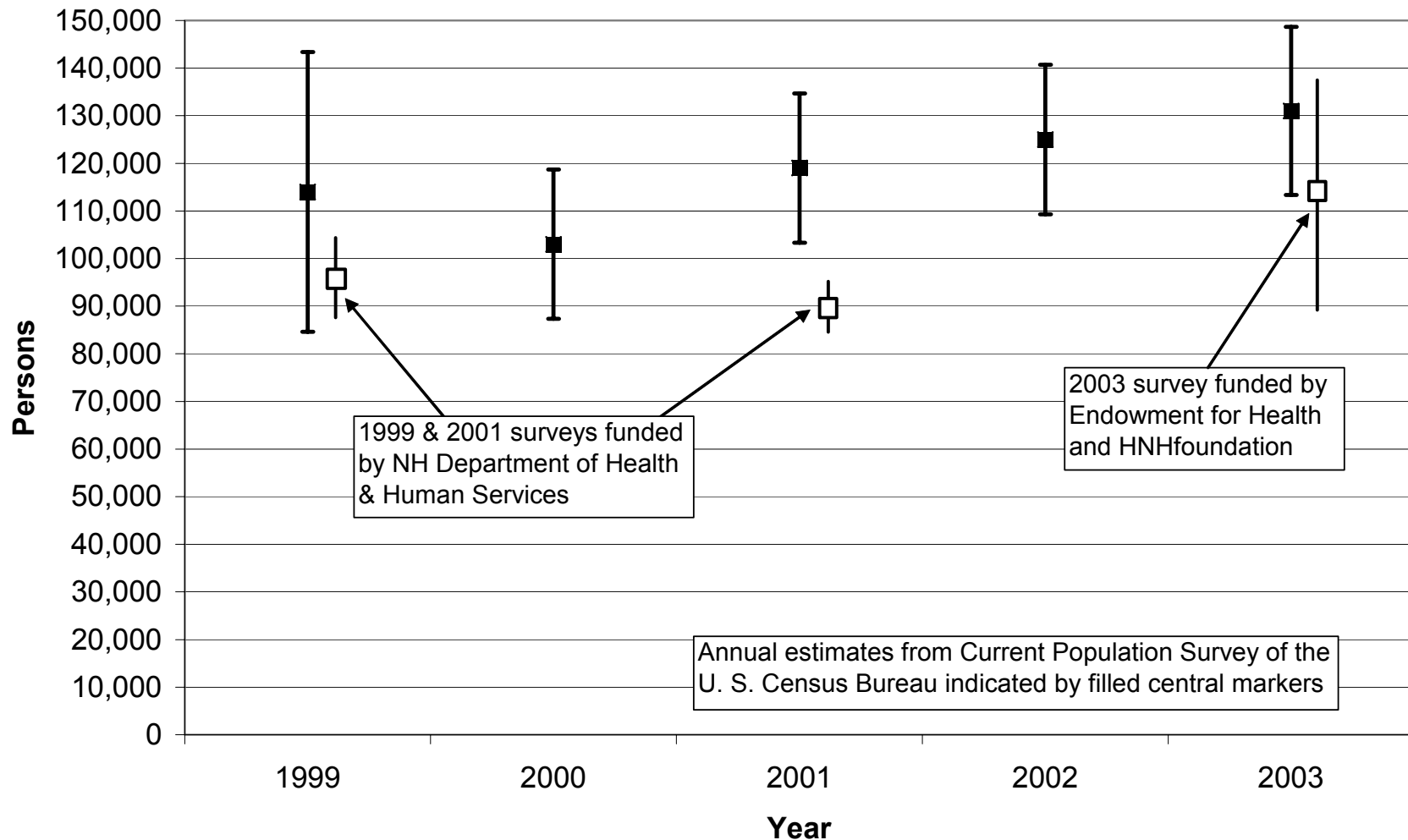
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Estimated Number of Uninsured NH Residents, 1999-2003



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Estimated Number of Uninsured NH Residents, 1999-2003



Population and Medicaid Recipients in some NH Municipalities

	2003 Medicaid Persons	2003 Est. Pop.	% of Population
Amherst	197	11,342	1.7%
Berlin	2,302	10,641	21.6%
Concord	4,264	41,940	10.2%
Gilford	461	7,216	6.4%
Hanover	165	11,116	1.5%
Manchester	15,950	109,234	14.6%
Merrimack	775	26,398	2.9%
Nashua	8,155	87,907	9.3%
Northwood	359	3,784	9.5%
Salem	1,232	29,027	4.2%
Stratford	310	984	31.5%
Tilton	407	3,561	11.4%
New Hampshire	112,105	1,291,573	8.7%