STATE OF NEW HAMPSHIRE

OFFICE OF THE GOVERNOR

September 29, 2004

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The Honorable Tommy G. Thompson
Secretary of the United States
Department of Health and Human Services
200 Independence Avenue, S.W., Room 615-F
Washington, D.C. 20201

Dear Mr. Secretary:

It was a pleasure to meet with you on September 17th, as Commissioner Stephen and I outlined proposed Medicaid changes we would like to implement in New Hampshire, which we believe will lead the nation in the area of Medicaid reform. Your leadership as Secretary of Health and Human Services, through the opportunity to revamp our Medicaid program has created the atmosphere of change in New Hampshire and it is something of which we can all be proud.

Enclosed with this letter is the framework for our vision of GraniteCare, the evolution of Medicaid for New Hampshire. This enclosure, representing our discussion in your office, is a series of concepts that I hope Commissioner Stephen and his staff can quickly begin fleshing out with members of your office.

New Hampshire is truly excited about the opportunity to start working immediately with your agency in seeking whatever process is necessary to implement our GraniteCare plan, which will protect important services to those in need across the State. That is why we need to discuss the changes needed so that we can commence the process of securing necessary approval from our legislature for any waivers, plan amendments and state statute changes to accomplish this reform effort.

Our Medicaid modernization process has been an open one that has engaged numerous stakeholders within many communities. Our Department of Health and Human Services has held public forums across the State that over 1400 residents have attended and we have received numerous ideas for change. This has been an interactive process and the suggestions from the public have been incorporated with our GraniteCare proposal.

Pending legislative approval, we anticipate filing necessary GraniteCare waivers as soon as possible. I understand that time is short, so we need to move this forward quickly. Commissioner Stephen has left messages for Director Dennis Smith to expedite this process and has a team ready to travel to Washington as soon as he is given the green light.

Thank you again for your consideration and the support you have shown for this endeavor. New Hampshire truly hopes to take this opportunity to improve the lives of those who utilize Medicaid in a manner that is consistent with President Bush's commitment to developing an ownership society. If you have reason to contact me, please call me at (603) 502-2900.

Sincerely,

Craig R. Benson
Governor

Enclosure

cc: John A. Stephen, Commissioner, NH DHHS
Mr. Dennis Smith, Director, Center for Medicaid and State Operations
Mr. Brian Cresta, Administrator, Region I

Transforming the Medicaid Program with GraniteCare

Value Proposition:

- Without change, the New Hampshire Medicaid program is projected to grow at approximately 8.0% per year though 2010.
- The proposed plan reduces the growth curve by more than 5%. By 2010, the proposed plan could save as much as $100 million per year.

Principles

- Choice
- Consumer Empowerment and Personal Responsibility
- Competition
- Quality
- Community based services
- Independence

Transform

- Rebalance the long-term care system for the elderly by reducing the reliance on nursing home care.
- Consolidate and coordinate long-term care services, eliminate duplicative case management services and strongly manage long-term care supports.
- Empower clients through the expansion of cash and counseling efforts in the developmental disability, behavioral health and elderly long-term care systems.
- Develop a health savings account for optimal services with personal responsibility and quality incentives.
- Develop an informatics system capable of supporting the Medicaid program, and communities, which will empower consumers in their decision-making around health care and hold individuals, providers and the state accountable to appropriate measurables.

Critical Steps

I. Create an integrated service delivery model for developmental disability, behavioral health and long term care that includes:
   a. Comprehensive Assessment and Counseling
   b. Development of individual budgets based on medical and financial necessity and based on the natural and generic supports that exist within the community and the client's family
   c. Comprehensive care management of both physical and social services provided to the client.

II. Reduce reliance on nursing facilities by 30% by:
   a. Eliminating the entitlement to nursing facility care, by creating an intensive and uniform statewide assessment and counseling system, enacting legislation to require screening for all persons seeking to enter nursing facilities, intensifying the level of care requirements for admission to a nursing facility;
   b. Promoting various healthy living initiatives such as fall prevention programs; and
   c. Maximizing personal and family participation in long term care costs paid with public funds.

III. Increase clients choice to seek home and community based care by:
   a. Enhancing the community-based infrastructure through redirecting budgetary resources from nursing facilities to community care options; and
   b. Controlling the "woodwork" effect by developing individual budgets based on medical and financial necessity and based on the natural and generic supports that exist within the community and the client's family

IV. Develop a medical home for all clients and manage care aggressively by:
   a. Enhancing the community health center infrastructure
   b. Contracting with a vendor to implement a primary care case management program;
   c. Implementing comprehensive disease and high cost case management where necessary; and
   d. Integrating with the service delivery system for developmental disabilities, behavioral health and long-term care for the elderly.

V. Establish a health services account for optional Medicaid eligibles (Pregnant Women and Children > 133% of FPL)
   a. Health Services Account model includes
      i. Prevention component
      ii. Optional services to be managed by clients
      iii. Catastrophic coverage
   b. Clients will receive incentive bonuses if they
      i. Meet prevention guidelines
      ii. Spend less than budgeted amount.

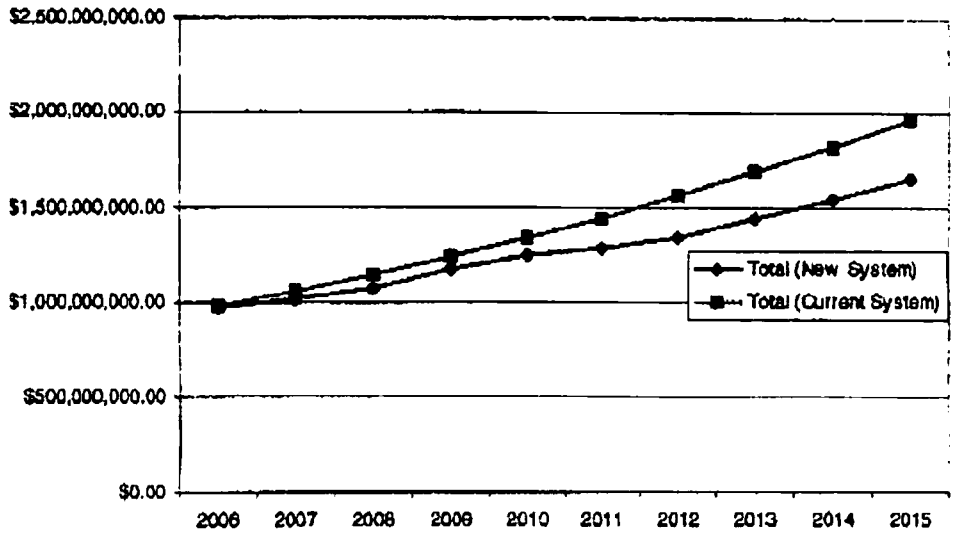
VI. Increase accountability by developing Medicaid report cards that use:
   a. A set of indicators against which the New Hampshire Medicaid program will be measured;
   b. A set of quality indicators against which participating providers will be measured; and
   c. A set of indicators (e.g. compliance with well child visits) against which participants will be measured.

New System Compared to Old System

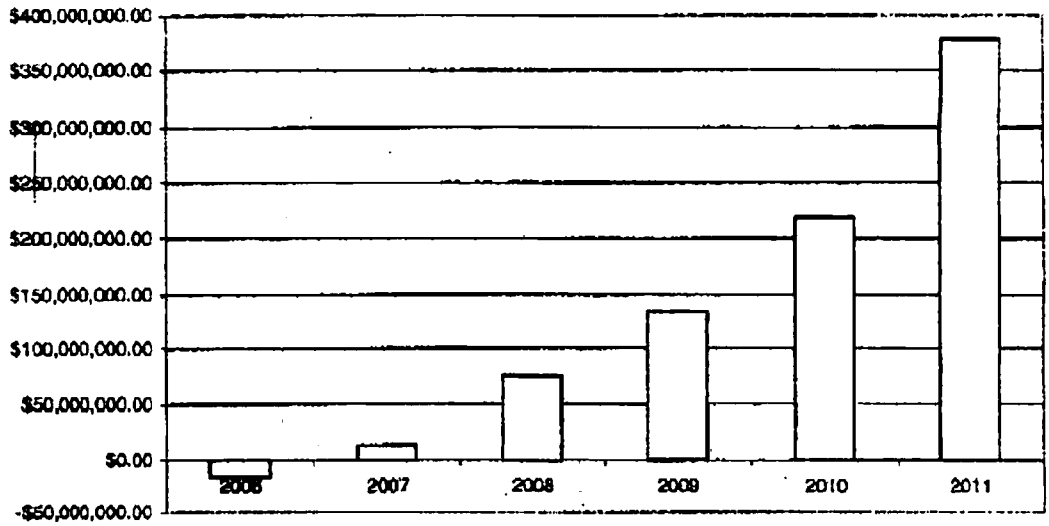
Unchanged, the Medicaid system is anticipated to grow at an average of 8 percent over the next fifteen years.

The assumptions used for the new system (including the initiatives identified below) lead to substantial changes in the cost curve for the Medicaid program. Relative to current trends, the proposed Medicaid changes could save as much as $ 380 million between 2006 and 2011 if aggressively pursued.

Change in Trend Resulting from Implementation of Medicaid Modernization Plan



Cumulative Savings in First Five Years of Plan Implementation



Critical Assumptions

The costs of the future system require assumptions regarding growth rates in enrollment and average costs. The most recent CBO estimates were used to set growth estimates of 8% per year in the current system. Growth assumptions were modified when modeling the new system to account for potential cost reductions. All assumptions must eventually be assessed for actuarial soundness as the assumptions used in this document are for planning purposes only.

Assumptions Impacting Savings Estimates:

- Estimated LTC savings are primarily driven by the expected growth in nursing home costs and the ability of the integrated service system and an aggressive expansion in the home and community based care system to reduce nursing home recipients by 30% over 5 years.
- Managed care savings are primarily driven by an estimated return on investment of PCCM and disease management of 2.26:1.
- Savings resulting from the implementation of a health services account are driven by the potential change in individual behavior associated with having an account for non-preventive, non-catastrophic services, and the Department's ability to significantly reduce the growth in catastrophic care services.
- Savings estimates represent savings to the Department of Health and Human Services and don't account for potential cost shifting to municipalities or other providers.
- Costs for information technology are included as administrative costs. Administrative costs were estimated based on available information.

Initiatives

Health Services Accounts (Optional Medicaid Eligibles > 133%)

In this model, we will be creating individual budgets for those eligibles with incomes greater than 133% of the federal poverty level. The purpose of this initiative is to encourage the use of preventive services for the client, provide for self-management of non-emergent health care by the client, and ensure careful management of, and payment for, emergent health care by the Department.

The benefits for those with incomes over 133% will consist of four different components (discussed below). These different components could be built into the existing fee-for-service infrastructure or could be developed in concert with the development of a managed care benefit that includes both incentives and a health services component (e.g. a percent of PMPM allocated to optional services).

Prevention: Individuals will have access to preventive services up to a limit, based on the New Hampshire Foundation for Healthy Communities Prevention Guidelines and the Institute for Clinical Systems Improvement prenatal care guidelines (described below). Because different age groups and populations require different amounts and types of services for prevention, the prevention package will be developed for at least four different groups – ages < 1, 1-2, 3-18, and pregnant women.

Health Services Account: Clients will be provided with access to an actuarially sound estimate of the costs of non-emergent services. These services can be used for health care services up to the specific cap, beyond which the client is responsible. At the end of the year, if a client has resources available in a health services account (adjusted for, among other things, the number of months on the program) and has met the prevention guidelines, some portion of those resources would be returned to the client. Report cards for each individual would help to ensure compliance (again, adjusting for number of months on the program, etc.)

Access to Pharmaceutical Discounts: Clients will have access to a drug discount card – depending on pharmaceutical industry participation – that would provide access to discounted pharmaceutical prices when an individual has spent up to his or her cap.

Catastrophic Coverage: The Department will create an internal 'reinsurance pool' based on an actuarially sound estimate of the share of current services that are catastrophic. The catastrophic pool will be managed proactively by a new unit that will reimburse providers only for urgent and emergent services.

Cost of Program

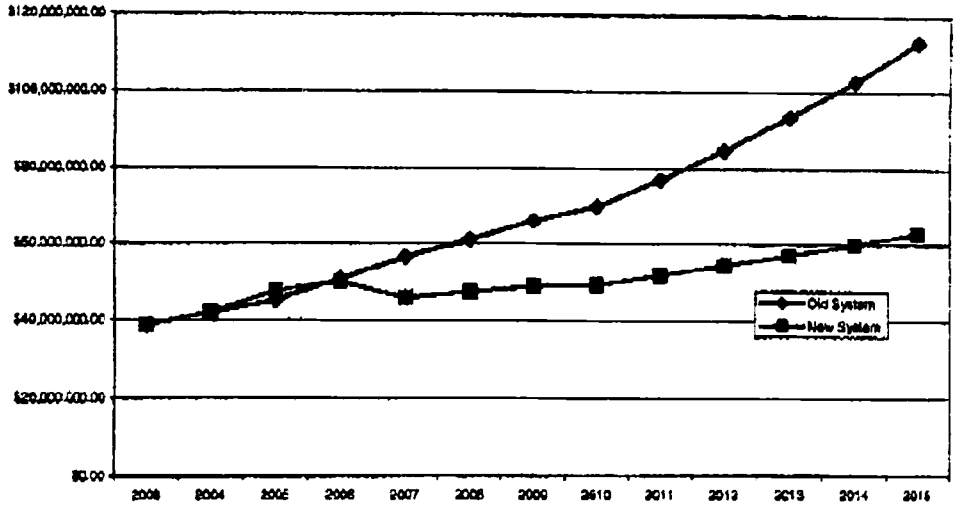
This is a demonstration and it is anticipated that, in the first two years, the costs of producing report cards (estimated at $275,000) and the development of a clinical unit to assess emergent versus non-emergent care ($350,000) will exceed the existing cost of coverage. After two years, the change in incentives is likely to reduce growth in service costs.

Other Critical assumptions in estimating the potential costs (savings) of such a program:

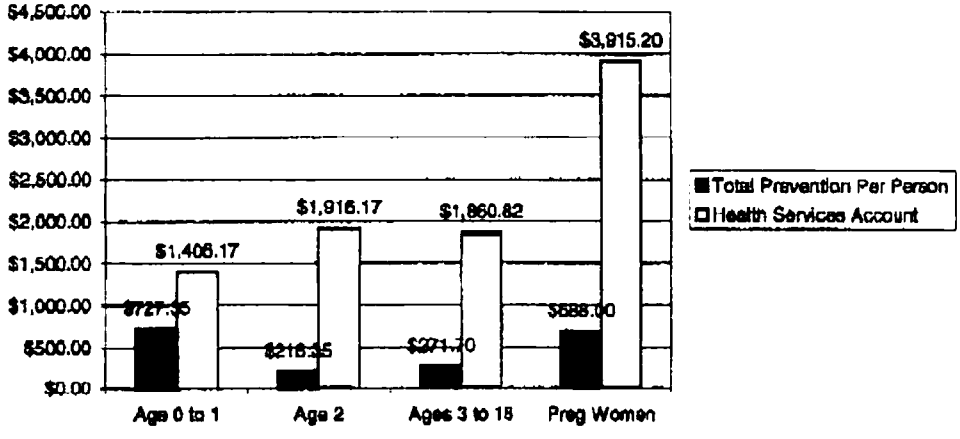
- Expenditures for optional groups currently expected to grow by:
  - Average cost: 8%; and
  - Enrollment 2-4%
- Health Services Accounts include:
  - Prevention component (costed out based on guidelines and increases at 3% per year);
  - Catastrophic component (50% of the current average cost of services); and
  - Optional services component (the remaining costs)

- Clients will receive an incentive if they both meet their prevention requirements and don't spend the full budgeted optional services component.
- Savings: Cumulative savings of $61 million over 5 years.
    - Savings result from reduction in catastrophic payments (from 8% to 3% trend); and
    - Reduction in optional service payments resulting from changes in individual behavior (from 8% trend to 3% trend)

Impact of Health Services Account on Expenditures



Prevention Expenditures and Estimated Health Services Account for Non-Mandatory populations SFY 2004



Prevention Guidelines

EPSDT *

Age 0-1

7 office visits
1 dentist visit
17 vaccinations (administration fee, *not* cost of vaccine)
1 lead screening test
1 anemia screening test

Age 2

1 office visit
1 lead screening test
8 vaccinations (age 2 only) (administration fee, *not* cost of vaccine)
1 dentist visit

Age 3-18

1 office visit
5 vaccinations (age 4 only) (administration fee, *not* cost of vaccine)
2 dentist visits with fluoride treatment
dental sealants (age 7 and 14 only)

Pregnant women **

11 prenatal office visits
Lab tests:

- Hemoglobin
- Rubella/rubeola
- Varicella
- RPR
- Urine culture
- Hepatitis B surface Ag
- HIV
- Chromosome/neural tube defect (NTD) screening
- Culture for group B streptococcus
- ABO/Rh/Ab (RhoGAM)

5 vaccinations (Tetanus-diphtheria [Td] booster , MMR , Varicella , Hepatitis B, Influenza); includes the cost of vaccinations.

* Foundation for Healthy Communities Prevention Guidelines
** Institute for Clinical Systems Improvement (ICSI). Routine Prenatal Care Guideline

Individual Budgets and Single Point of Entry: Behavioral Health, Developmental Disabilities, and Long Term Care Services for the Elderly

Purpose: New Hampshire will plan, develop, implement, and demonstrate a transformative organizational and information technology model tha tintegrates the operational methods embedded in the access, assessment, treatment planning, individualized budgeting, outcomes, and care management elements required for the develiry of behavioral health, developmental disabilities, long term care, primary care, and prevention services finances by Medicaid resources.

The model is based on a matrix conceptualization that the following operational methods are identical, or significantly similar, for behavioral health, developmental disabilities, and long-term care:

- Access, information/referral
- Triage for appropriateness
- Specialized (BH, DD, LTC) assessment procedures/instruments standardized for each of the three presenting populations
- Development of an Individualized Services Plan (ISP), based on assessment and consumer/family involvement
- Development of an Individualized Services Budget Plan
- Development of individualized measurable outcomes embedded in the ISP

Primary Goal: Test the hypothesis that an integrated model can be developed that provides an effective and efficient organizational structure that is based on both the considerable similarities and specific needs of specialization in the assessment, provision, and management of services to individuals who require long term care and recovery services while increasing choice of community based providers, community-based care and cost efficiency.

Proposed Actions:

Create an organizational model for integrated single point of entry and resource center service method for all three populations.

Manage and control access to behavioral health services, waiver services for persons with developmental disabilities and needs associated with aging, and nursing home services by creating individual budgets for all non-institutional long-term care services which emphasizes choice, recovery and independence, and careful management of public resources. The system will meet these goals by:

- Creating a plan, eligibility and authorization for services that is based on medical necessity, financial necessity and other available natural and generic supports in the community (town, city and/or family).

- Providing standardized best practice assessment/diagnosis, individualized treatment/services and budget planning, and annual treatment plan review for all three populations by an integrated organizational method independent of service provider organizations.

- Providing an integrated care management plan inclusive of primary care and co-occurring disorders such as substance abuse and smoking.

- Providing guidance and assistance for individuals and families choosing their providers of service, in assuring primary care collaboration and involvement, and accessing follow-up with preventive and routine and specialized medical care.

- Establishing a web-based application for an integrated data base with connectivity to the MMIS, providers, and primary care in a virtual record format, that avoids duplication or contraindicated services, assures delivery of needed services/supports, and manages individualized budgets at the care management and aggregate levels.

- Promoting volunteerism through web-based e-mail lists.

- Monitoring care through a Medicaid Long Term Care Report Card for both the Department and clients.

- Holding the single point of entry accountable for:

    - Assuring client has a Medical home
    - Implementing a system of client-centered incentives to achieve personal health goals;
    - Implementing a system of provider incentives to improve compliance with evidence-based guidelines and recommended preventive care; and
    - Implementing a system to improve colaboration between primary care and mental health delivery systems.

Assumptions:

Development of an integrated resource center model to serve all clients will cost $96 million over 5 years.

Total savings are estimated at:

- Nursing Home: The single point of entry, the assessment and counseling process, and laws changing the number of available nursing home beds, will result in significant diversion from nursing home services into home and community based care. Reduction in nursing home utilization by 30% is not possible without the development of this single point of entry model.

- Behavioral Health: 5% reduction in mental health trends resulting from the implementation of individual budgets and more aggressive management of services: $17 million in savings over 5 years.

- Developmental Disabilities: 5% reduction in developmental services trends resulting from the implementation of individual budgets and more aggressive management of waiver services: $37 million in savings over 5 years.

A Medical Home: Health Care Management for All Medicaid Clients

Purpose: To ensure the quality and the cost-effectiveness of medical care

Primary Goal: To implement a primary care case management program and disease management for 90,000 Medicaid consumers

Proposed Actions:

Outsource care management activities to:

- Manage care provided aggressively and control costs for all Medicaid consumers except nursing home residents and DD/BH dual diagnosis cases;
- Provide consumers with medical homes – i.e. primary care physicians;
- Coordinate care and increase access to needed services;
- Ensure that preventive and well-visits occur; and
- Ensure appropriate access and utilization of mental health, tobacco, and substance abuse services.

Outsource telephonic management of emergency room utilization to:

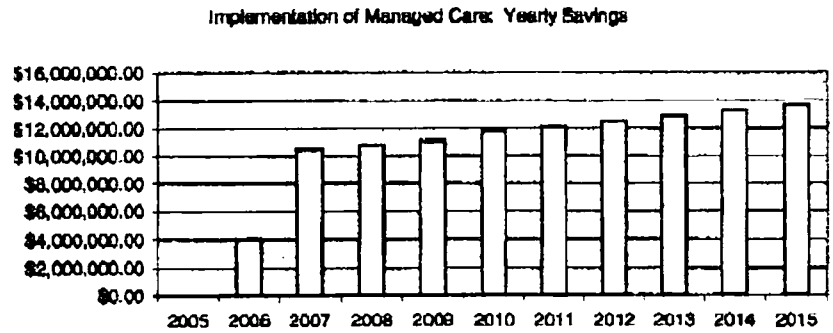
- Reduce inappropriate usage.

Outsource a disease management program for asthma, diabetes, high-risk pregnancies, etc, to:

- Improve consumer compliance;
- Improve provider access;
- Provide education to consumers;
- Provide financial incentives and penalties to vendors based on quality, utilization and cost benchmarks; and
- Double the current capacity of the community health center infrastructure

Assumptions:

- Total cost savings estimated at $42 million over 5 years.
- Current growth in acute care expenditures expected to be between 13 and 16% over the next 10 years in the absence of change.
- Supports $1.7 million per year investment in the community health center infrastructure.
- Contracts with a vendor to implement a primary care case management program and disease management at $7 pmpm.
- Assumes a ramp up in return on investment from 1:1 in first year to 2.26:1 in year 3 and on.



Transforming the Long Term Care System

Purpose: Reshape the State's long term care system by shifting the financial and service focus from nursing facilities to home and community based care resulting in savings of $332 million by 2010. Reduce the disproportionate reliance on nursing facilities through intensive screening and redirection to alternative settings. Create more community care options and increase the involvement of families in providing care and support.

Primary Goal: Reduce the number of Medicaid nursing home residents by 30% over 5 years, a reduction of about 1,450 persons.

Proposed Actions:

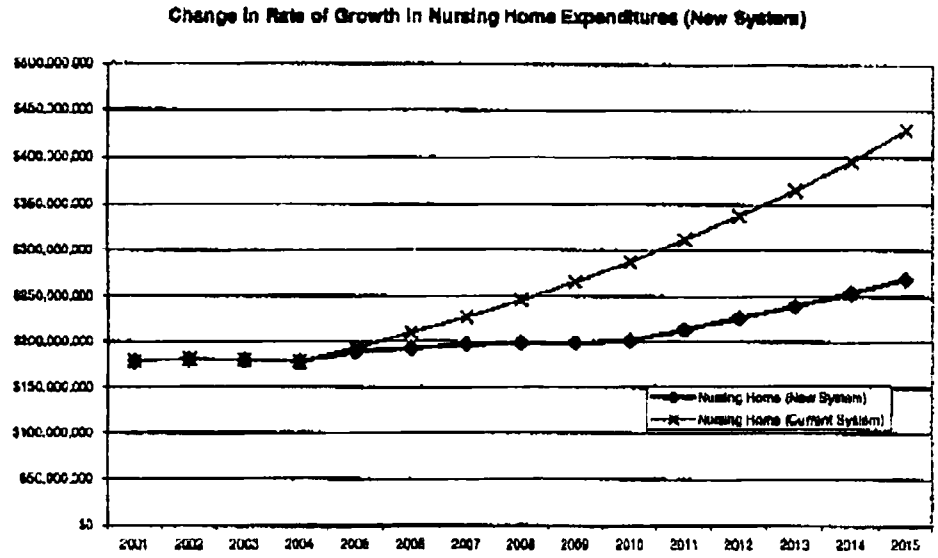
- Control access to nursing facilities by:
  - Promoting healthy living among the elderly by supporting 'wellness' programs in each community;
  - Eliminating the entitlement to nursing facility care and establishing instead an entitlement to nursing care in the least restrictive care setting;
  - Creating an intensive and uniform statewide assessment and counseling system for all proposed admissions into nursing facilities and other levels of long term care via the development of a single point of entry for the DD, behavioral health and elderly clients of Medicaid;
  - Enacting legislation requiring screening for all persons seeking to enter nursing facilities whether or not they are eligible for Medicaid at the time of admission;
  - Intensifying the level of care requirements for admission to a nursing facility;
  - Gradually reducing the cap on Medicaid nursing facility beds in the State Medicaid Plan to limit the total number of residents at any time; and
  - Maximizing personal and family participation in long term care costs paid with public funds.

- Develop alternatives to nursing facilities for persons needing 24-hour care and supervision by:
  - Enhancing the community-based infrastructure through redirecting budgetary resources from nursing facilities to community care options; and
  - Creating tiered reimbursement structures for supported residential living, adult medical day care, adult foster care and assisted living services.

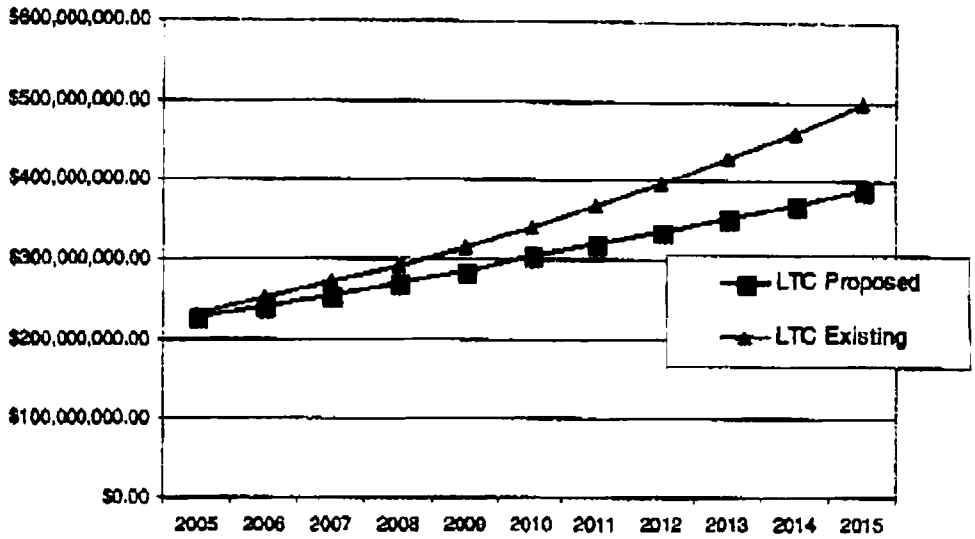
- Increase the level of non-subsidized financial and care support for long term care recipients by:
  - Providing information and advice to persons who are caring for a friend or family member; and
  - Creating access to group long-term care insurance for state employees and other large employers.

Cost Estimate Assumptions:

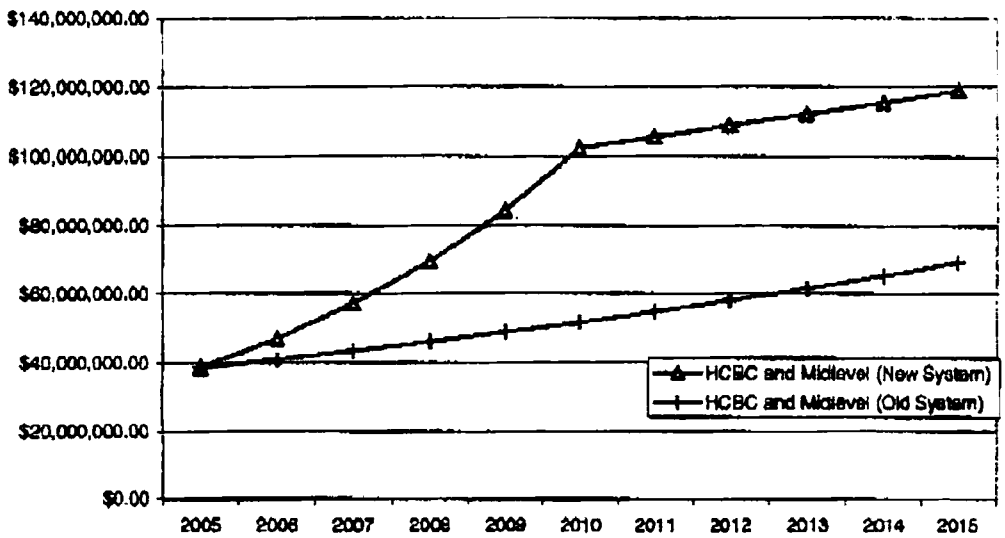
- Nursing Home caseload growth expected to significantly increase as population ages over the next 10 years resulting in significant growth unless changes are made.
- Development of an integrated resource center model to monitor and assess appropriate levels of care (costs included in integrated service model above).
- Enhancing reimbursement and enrollment in community-based care: $129 million investment over 5 years. Enrollment growth at 18% per year (capped at 5-year growth) and reimbursement increases capped at 3% per year.
- Savings: 30% reduction in nursing home beds: $337 million in savings over 5 years



Long Term Care - Proposed Vs. Current



Home and Community Based Care: Current versus Proposed



Technology and Medicaid Modernization

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

Elements include:

- The core transaction system at the heart of the program (MMIS) is currently out to bid and expected to come on line in July 2006. This system is essential to providing the logic and controls to manage the finances.

- The integrated assessment and counseling concept for clients in the long-term care, developmental disabilities and behavioral health segments is at the core of the transformation. The processes associated with that concept require an integrated front-end solution. Among its key elements are:
  - ✓ Linkage to NH's core financial eligibility management system;
  - ✓ Capture of essential client information regarding their needs and documentation in a comprehensive care plan;
  - ✓ Evolution of an "electronic medical record" where multiple providers access and update a comprehensive and integrated plan, with appropriate privacy controls;
  - ✓ Linkage to a Health Services Account where an individual budget has been set along with specific actions upon which incentives for the client can be realized ; and
  - ✓ Use of electronic funds transfer or electronic benefits transfer for the consumer to procure a range of services including transportation, substance abuse treatment and housing

- A broadband network infrastructure is required to seamlessly link all key parties to the program. The Medicaid Information Network serves as the foundation for the deployment of multiple applications enabling communication of data, voice and video across all parties. Such a network is critical to providing information enabling choice and personal responsibility. Among the applications are:
  - ✓ Information distribution using multiple media forms including paper, internet, telephony, video and touch screen kiosks enabling clients to access needed information;
  - ✓ Access to static information on resources, checking availability and scheduling services and advisory services such as "ask-a-nurse";
  - ✓ Information distribution services that are comprehensive language translation services to address the increasing number of language barriers;
  - ✓ Cross-training and collaboration across multiple disciplines using telemedicine and video to reduce costs; and
  - ✓ Other web-enabled applications for billing to ease burden of doing business, purchasing by providers and consumers alike, bulletin boards for mobilizing volunteers, and developing registries in support of the provider networks.

- Backend database systems are required for capturing data from multiple systems, internal and external, for transformation of data into knowledge. This platform supports the development of:
  - ✓ Report cards for providers, the Department and the consumer; and
  - ✓ Integration of best practices and medical pathways to continually refine disease management strategies.

The implementation of the technology infrastructure and specific solutions will be phased in over several years using a series of public-private partnerships. Existing technology investments and infrastructure

(existing and planned) will be leveraged to insure that there are minimal redundancies. Examples include working with large private payers in the State, leveraging Federal bioterrorism dollars intended to build public health infrastructure and agreements with other State agencies such as the Department of Insurance.

Cost Estimate Assumptions:

$5 million has been allocated for the development of the community IT infrastructure, increasing to $10 million in the outyears.