

Monitoring Access to Care Plan for New Hampshire's Fee-for-Service Medicaid Medical Services Program



New Hampshire Department of Health and Human Services
October 1, 2016

DRAFT for Public Comment

*The Department of Health and Human Services' Mission is to join communities and families
in providing opportunities for citizens to achieve health and independence*

Portions of this report were developed with the assistance of the Health Services Advisory Group on behalf of the Department of Health and Human Services: Office of Medicaid Services and Office of Quality Assurance and Improvement and Office of Finance.

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1. Executive Summary

Ensuring access to care for all New Hampshire Medicaid beneficiaries is a priority of the NH Department of Health and Human Services. The Department has created a comprehensive system of monitoring access for the 4% of Medicaid beneficiaries who continue to receive their benefits from the Fee for Service (FFS) delivery system. NH's system is a multi-stage process of routinely monitoring a variety of data (e.g. utilization, other payer rates) for potential access issues. Issues that are confirmed receive rigorous analysis for root causes and corrective action if warranted. While the system includes quarterly monitoring, this document is the first annual report covering January 2014 – December 2015, consistent with the Center for Medicare and Medicaid new rules governing FFS access monitoring.

Currently the data do not indicate existing access problems. Provider to member ratios are favorable, consistent with the Medicaid managed care standards, and network analysis shows the majority of NH licensed practicing physicians are enrolled as NH FFS Medicaid providers. While no potential access issues have been identified, given new benefit coverage for substance use for the FFS population, the Department is actively engaged in building an adequate network of substance misuse providers.

A robust access analysis is challenged by significant change and reductions in the FFS population from December 2013 through February 2016 due to the staged implementation of Medicaid managed care. The majority of the current FFS population are beneficiaries who are in a plan selection period and awaiting transition to managed care, i.e., less than 90 days. Only a small number of beneficiaries will remain in FFS and are not eligible to enroll in managed care. Given a FFS population in transition, the Department is unable to provide an accurate baseline or develop reliable controls. While monitoring will continue, in approximately 3-4 years, the Department anticipates having sufficient baseline data from a stable FFS population and will identify appropriate access standards.

NH Medicaid will continue to review and refine its monitoring and response plans to assure that the report continues to add meaningful information and value to policy discussion and to the administration of the Medicaid Program.

2. Introduction

The New Hampshire Department of Health and Human Service (the Department, DHHS) Medicaid-Fee for-Service Access Monitoring Plan is a matrixed collaboration between the Office of Medicaid Services (OMS), the Office of Quality Assurance and Improvement (OQAI), the Division of Client Services, and the Office of Finance. This report describes New Hampshire Medicaid’s healthcare access activities for beneficiaries receiving medical services for its fee-for-service (FFS) program. The report analyzes service data from January 2014 through December 2015 to report on the level of FFS provider availability and utilization of healthcare by Medicaid FFS beneficiaries over the two-year period. When available, more recent data is also used to describe the current Medicaid population and anticipated program changes impacting subsequent access planning.

Background

New Hampshire Medicaid provides coverage for children, pregnant women, parents, seniors, individuals with disabilities; and adults between age 19 and 65 with income at or below 133 percent of the federal poverty limit. Beginning in December 2013 and continuing in staged rollouts, New Hampshire, through state plan authority and a 1915(b) waiver, requires enrollment in managed care for all but a very small percent of beneficiaries. The following beneficiaries are excluded from MCO enrollment:¹

- Are in a presumptive eligibility period;
- Receive certain financial Veterans Affairs (VA) benefits, i.e. VA Aid and Attendance Allowance, VA Frozen Pension, VA Disability-Veteran, VA Nursing Facility Pension-Veteran, and VA Pension;
- Participate in the New Hampshire Health Insurance Premium Payment Program (HIPP);
- Are Qualified Medicare Beneficiaries (QMB) only;
- Are Specified Low Income Medicare Beneficiaries (SLMB 120) only;
- Are Qualifying Individuals (SLMB 135) only;
- Are Qualified Disabled and Working Individuals (QDWI) only;
- Have family planning only benefits; and
- Are in a spend-down category.

Medicaid services provided through Medicaid managed care plans including medical, pharmacy, and behavioral health services (i.e., mental health and substance misuse). As of May 2016, excluded services include dental care and long-term care services provided as part of the state’s 1915(b) waivers, specifically nursing facility services, services provided under the Choice for Independence (CFI) waiver, and services provided under the developmental disability (DD), acquired brain disorder (ABD), and in-home support (IHS) support waivers. Planning is underway to include these long-term care services in managed care in the near future. Currently, 4.5% of the Medicaid beneficiaries are covered by the FFS-only program (Figure 1), with the majority of beneficiaries in the “Plan Selection Period” prior to mandatory managed care enrollment (Figure 2).²

¹ New Hampshire Administrative rules He-W 506.05(c)

² Background data for all figures can be found in the Appendix.

Figure 1. New Hampshire FFS Only and Non-FFS Enrollment, 12/1/2013 - 5/1/2016

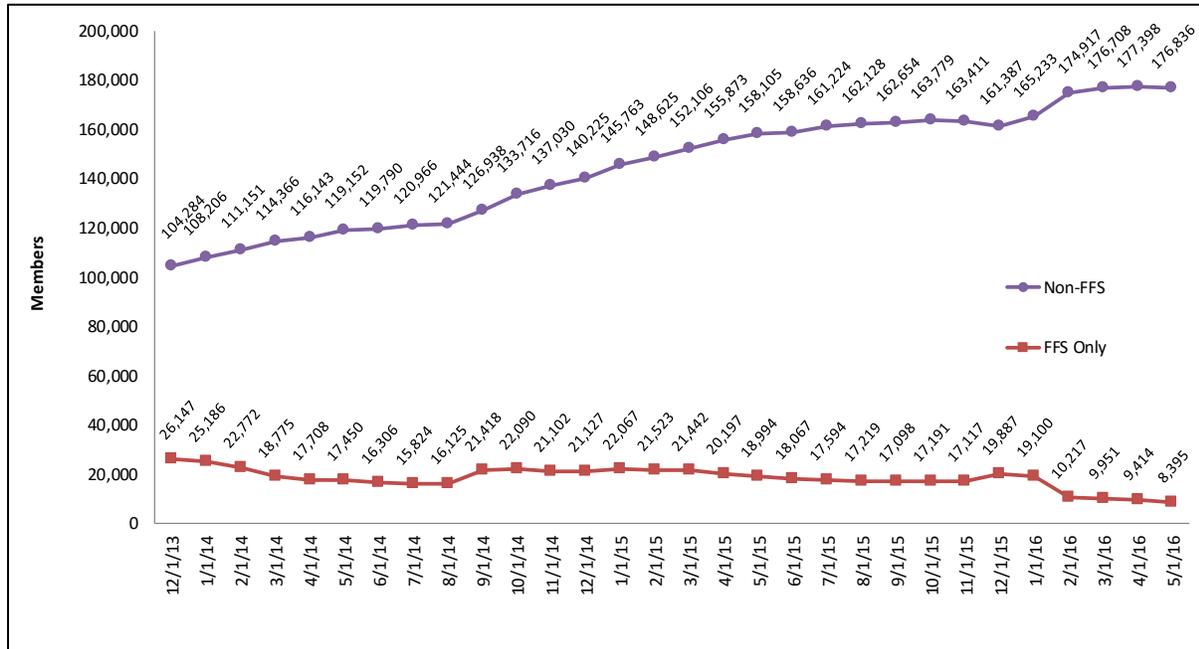
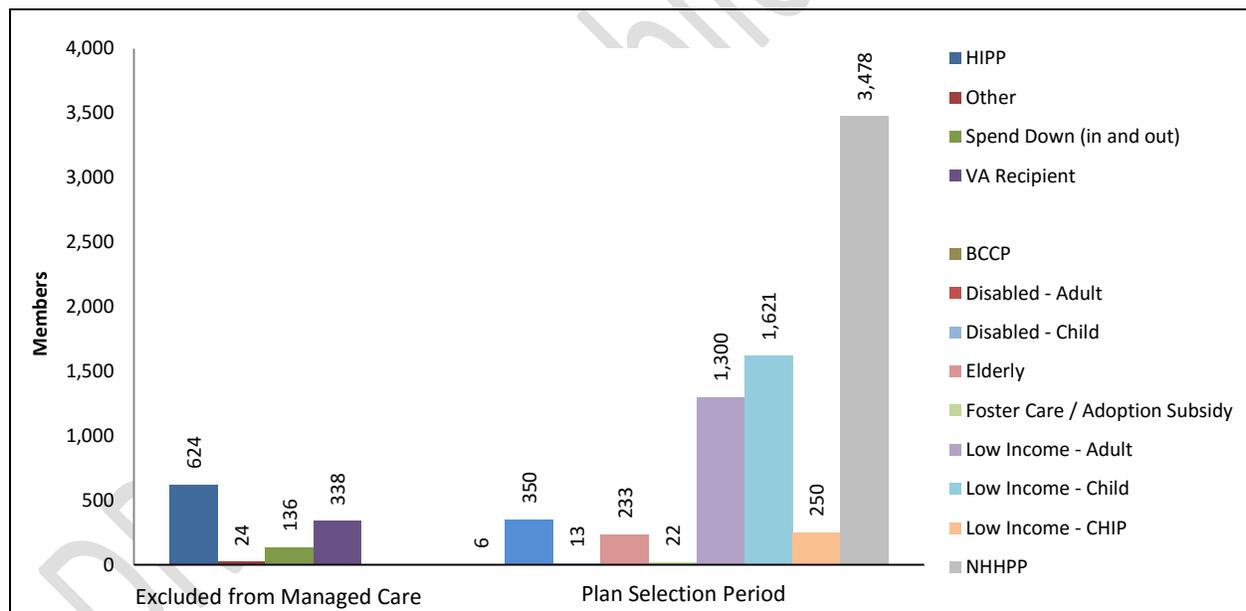


Figure 2. New Hampshire Medicaid Members Not in Medicaid Managed Care Program and the Medicaid Expansion Premium Assistance Program-Plan Section Period, 5/1/2016



Note: HIPP: Health Insurance Premium Program, VA: Veteran's Administration coverage, BCCP: Breast and Cervical Cancer Program, NHHPP: New Hampshire Health Protection Program.

Medicaid Transition to Managed Care

The proportion of the NH Medicaid population covered through FFS-only has declined steadily since managed care commenced December 2013. Figure 1 displays how enrollment for the FFS population has

changed over time. Before December 2013, there were over 130,000 beneficiaries covered by FFS. Beginning in December 2013, the majority of the FFS population transitioned to Medicaid managed care program.

In July 2014 NH implemented the New Hampshire Health Protection Program (NHHPP), New Hampshire's Medicaid expansion program. The NHHPP program consisted of three parts: an expansion of the Health Insurance Premium Program (HIPP), requiring all beneficiaries with cost effective access to private insurance to enroll in private plans; a Bridge to Marketplace Premium Assistance Program, in which newly eligible adults were initially enrolled into the state's existing Medicaid managed care program; and the Marketplace Premium Assistance Program, also known as the Premium Assistance Program, implemented in January 1, 2016 under a state 1115 Premium Assistance Program Demonstration waiver, and in which all newly Medicaid eligible adults, who were not considered frail adults, chose from qualified health plans (QHPs) offered on the federally-facilitated exchange. On December 31, 2015, the Bridge to Marketplace program ended and all non-frail beneficiaries were moved into the federally-facilitated exchange. The NHHPP program has grown steadily and currently covers approximately 50,000 Medicaid expansion beneficiaries.

With the implementation of New Hampshire's 1915(b) waiver on February 1, 2016, mandating participation in managed care, additional NH Medicaid beneficiaries, who had previously (voluntarily) elected to not enroll, were subsequently required to enroll in managed care.

Medicaid Fee-For-Service Population

Figure 2 illustrates the distribution of eligibility status among within the FFS-only population. New Hampshire beneficiaries receiving medical services through the FFS-only program are primarily comprised of members in a managed care plan selection period. The "Plan Selection Period" includes beneficiaries who, after becoming Medicaid eligible, have up to 60 days to choose a health plan; plan enrollment then begins the first of the following calendar month. The "Excluded from Managed Care" category refers to those FFS beneficiaries who are not eligible for any Medicaid managed care program; this group is also known as the "FFS-only" group. On May 1, 2016, there were a total of 8,395 FFS beneficiaries with more than 85% those being Plan Selection Period beneficiaries who will stay in the FFS population for a less than 90 days. The remaining 1,122 Excluded from Managed Care beneficiaries are primarily beneficiaries in the HIPP and those with Veterans Affairs benefits receiving medical services in that system and comprise the majority of the FFS-only population.

In providing analysis of claims data for this Access to Care Monitoring report, New Hampshire has divided the FFS population into a period of time prior to February 1, 2016, when the 1915(b) waiver further reduced the FFS population by eliminating opting out of managed care; this period will be labeled the "Voluntary" population. These members are currently being served by the managed care health plans however, during their tenure in FFS, it is possible that the Voluntary population utilized services differently than the remaining FFS population. For this reason, data analysis has been stratified by Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care beneficiaries in this report, as appropriate. Voluntary beneficiary reporting will not continue after this Access report.

PART 1 – ACCESS MONITORING PLAN

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3. Approach to Access Monitoring

The Department's Medicaid Fee-for-Service Access Monitoring Plan involves a three stage process:

- Monitor for Potential Access Concerns;
 - Analyze Potential Concerns; and
 - Remedy Confirmed Access Issues.
-

New Hampshire's Medicaid program must provide for methods and procedures relative to the utilization of and payment for covered care and services as are necessary to safeguard against unnecessary utilization of care and services, and assure that payments are consistent with efficiency, economy, and quality of care.³ New Hampshire must also ensure that payments are sufficient to enlist enough providers to provide care and services to Medicaid beneficiaries at least to the extent that such care and services are available to the general population in the geographic region. Before the Medicaid managed care program, New Hampshire Medicaid's approach to measuring and monitoring healthcare access was based on the Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC) framework. The current report is re-designed to align with the Methods for Assuring Access to Covered Medicaid Services Final Rule (Final Rule).⁴

The goals of CMS' Final Rule are to measure and link beneficiaries' needs and utilization of services with availability of care and providers, increase beneficiaries' involvement through multiple feedback mechanisms, and to increase stakeholder, provider, and beneficiary engagement when considering proposed changes to Medicaid FFS payment rates that could potentially impact beneficiaries' ability to obtain care. Consistent with Section 447.203(b)(4) of the Final Rule, the Department will review the following core services: Primary Care, Physician Specialists, Behavioral Health, Pre- & Post-Natal Obstetrics, and Home Health Services. This report focuses on the following three distinct areas for the data analyses:

- Beneficiary demographics and enrollment trend;
- Provider network enrollment and beneficiary to provider availability ratios; and
- Beneficiary utilization of services.

The data and analysis set forth in this report establish the current access levels for these providers and focal areas through analysis of trends from January 2014 through December 2015. Because of the significant decrease in the FFS population related to the managed care program, control limits utilized in past access evaluations are no longer applicable to the current study period and are not included in this report. New Hampshire intends to establish and use new control limits as the FFS population stabilizes to monitor trends.

³ 42 U.S.C. 1396a(a)(30)(A)

⁴ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 80, No. 211/Monday, November 2, 2015/Rules and Regulations, p. 67576. 42 CFR Part 447 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, Final Rule.

At this time, New Hampshire Medicaid will use this analysis to measure and monitor New Hampshire Medicaid FFS beneficiaries' access to health care. As well, the Department will use grievances captured by the Department's Division of Client Services as an early warning system for access disruptions. Should access problems occur, the Department will develop corrective action plans to remedy and monitor issue. Together, monitoring, data analysis and action, form the basis of New Hampshire Medicaid's access measuring and monitoring framework.

Step 1 - Monitoring For Potential Access Issues

Office of Quality Assurance and Improvement and the Office of Financial Services will routinely monitor a variety of data to identify potential access issues. Areas of inquiry include:

- Characteristics of FFS beneficiary population;
- Identification of beneficiaries needs;
- Changes in health service utilization;
- Availability of health services; and
- Actual or estimated levels of provider payment available from other payers.

Characteristics of the FFS Beneficiary Population

The OQAI monitors enrollment trends for New Hampshire FFS Medicaid beneficiaries through monthly measurement and annual updates of this report. Data for the FFS Medicaid population are analyzed by age and eligibility groupings, and by metropolitan and non-metropolitan areas of the State. Trends are monitored to determine the stability of the population volume over time. At any point, if enrollment grows by more than 20% over the baseline period, Office of Quality Assurance and Improvement will reexamine the health services availability and utilization to conduct additional analysis as needed. The Office of Medicaid Services will then instigate any needed corrective action. Policy changes expected to increase enrollment will also be assessed in a timely fashion for any indications that access to care is at risk.

Identification of FFS Beneficiary Needs

New Hampshire Medicaid engages beneficiaries in a variety of ways to keep abreast of medical needs and satisfaction with the availability and quality of health services and providers. The Medical Care Advisory Committee meets monthly to help the Office of Medicaid Services better understand the needs of Medicaid beneficiaries. New Hampshire Division of Client Services monitors beneficiary trends through grievance logs and review of routine client service calls for any notable concerns or patterns. (See Chapter 4 for additional detail on New Hampshire's engagement of beneficiaries.)

Availability and Changes in Utilization of Health Services

Office of Quality Assurance and Improvement updates and analyzes quarterly the components of this *Monitoring Access To Care Plan* for the following provider types:

- Primary Care Providers,
- Physician specialists (e.g. Cardiology, urology, radiology),
- Behavioral Health services,
- Pre/post natal obstetric services including labor and delivery,
- Home health services, and

- Other services with identified access issues.

Availability of care monitoring includes provider ratios, and time and distance standards for specific provider types. (See Chapter 5 for results). Monitoring includes utilization of specific provider services by geographic location and beneficiary eligibility type to isolate specific trends.

Control limits will be used as the primary tool to monitor access trends by providing a consistent indication of a potential access problem as each new quarter of data are available. Control limits are set statistically above and below the trend data to represent the boundaries of the trend. Fluctuation outside of control limits will signal DHHS to investigate further. Because the FFS population decreased considerably after the implementation of Medicaid managed care program in December 2013 and then again with the implementation of the 1915b waiver on February 1, 2016, historical control limits are not applicable for this year's study. Control limits will be included in subsequent access plan reports, after the FFS population has stabilized and sufficient data have been collected to produce statistically sound control limits. When control limits have been calculated and can be used, Office of Quality Assurance and Improvement will work with the Office of Medicaid Services to frame any further needed analysis such that the Office of Medicaid Services can initiate any needed corrective action.

Provider Rate Review Including Review of Rates from Other Payers

The Office of Financial Services reviews provider reimbursements on a quarterly basis, including any needed corrections to CPT (Current Procedural Terminology) codes, vendor rate reimbursement requests and a general review of provider rates. Upon completion of the quarterly review, a decision will be made to immediately change the rate for urgent concerns, change the rate effective July 1- with a new state fiscal year, or maintain the current rate.

There are four steps to each rate review: First the DHHS system data is queried to provide an annual volume of the service, any previously requested rate changes, and the execution date of any changed rates. Second, rates are collected from all of the New England Medicaid programs⁵, Medicare and commercial payers via New Hampshire's legislatively mandated All Payer Claims Database, the NH Comprehensive Healthcare Information System. All collected rates are charted to include the average, minimum, maximum and median price. Next, the NH volume of services is used to calculate the fiscal impact using 60% of the Medicare rate. Finally recommendations and analysis are provided to the Department's Chief Financial Officer and Medicaid Director which include:

- A recommended rate;
- A comparison of the rate to other regional payers;
- Analysis of the volume of NH Medicaid practitioners providing the service; and
- The NH DHHS budget impact. are provided to the Department's Chief Financial Officer, Medicaid Director for final decision making.

For access monitoring, the history and final rate determination will be considered.

⁵ New England Medicaid rates gathered from individual state websites.

Step 2 - Analyze Any Potential Concerns

The Office of Quality Assurance and Improvement will analyze potential access issues and, upon confirmation, present the issue to the Medicaid Director. Correction action plans are the responsibility of Office of Medicaid Services.

The Medicaid Director, at her/his discretion may activate a cross-Departmental Medicaid Access Response Team (Response Team) to inform any needed additional analysis. Under the direction of the Medicaid Director, the Response Team will also make recommendations for corrective action. The members of the Response Team may also include the provider network relations manager, and staff from the Office of Quality Assurance and Improvement, client services, and Medicaid financial management.

Step 3 - Respond to Confirmed Access Issues

The Response Team will be responsible for determining the proximate and root causes of the access issue, and to develop a corrective action plan, including assessing the need to make modifications to the access monitoring plan or DHHS systems. The CAP will include specific steps and timelines for remediation; it will be submitted to CMS within 90 days of the confirmation of the access deficiency. Approaches for addressing access issues may include but are not limited to:

- Resolving provider administrative burdens, such as claims submission and payment issues;
- Assisting beneficiaries in obtaining necessary primary or specialty care services through provider referral, or transportation assistance;
- Assessing and realigning covered benefits so that additional resources can be directed toward a resource-challenged area;
- Incentivizing the expansion of health care providers in underserved areas in the State;
- Restructuring rates and targeting them to address the particular underserved areas; and/or
- Increasing the proportion of the Medicaid population served by managed care plans.

Corrective action plans will include specific resolution timeframes for the identified access issue. The timing and nature of any responsive action taken will necessarily depend upon the particular nature, complexity and magnitude of the access problem identified, and the beneficiary population affected.

If the Response Team determines that an access issue does not exist, the Medicaid Director will write a summary report of the issue and include the summary in an update to the Access to Care Plan report, along with any recommendations for improved monitoring.

4. Community Engagement

New Hampshire Medicaid engages beneficiaries, advocates, providers and other stakeholders in a variety of ways to keep abreast of satisfaction with provider availability and quality of services, medical needs and population characteristics. The NH Medicaid community has opportunities to provide input into program and policy design, as well as to contribute feedback during program implementation. A summary of the key ongoing methods and recent engagement used to surface potential issues is provided below.

Medical Care Advisory Committee (MCAC)

New Hampshire Medicaid created the New Hampshire Medical Advisory Committee (MCAC), well over twenty years ago, to advise the Medicaid Director about New Hampshire Medicaid health policy, planning, and comprehensive health care. The primary purpose of New Hampshire's MCAC is to serve as a source of consumer and stakeholder involvement for health service delivery in the Medicaid program. The MCAC has also has an advisory role in the design and implementation of Medicaid Managed Care in New Hampshire. In particular, members review and provide input on:

- The annual report on managed care required under 42 CFR § 438.66(e)(3);
- Marketing materials submitted by managed care entities, in accordance with 438.104(c);
- The managed care quality rating system, in accordance with 42 CFR § 438.33(c);
- The managed care quality strategy, in accordance with CFR § 438.340(c); and
- The development and update of the Medicaid access monitoring review plan, in accordance with 42 CFR § 447.203(b).

New Hampshire's MCAC meets on a monthly basis to formulate or help formulate, review and evaluate, policy proposals with consideration of fiscal, program and provider and recipient impact; and to make recommendations accordingly. MCAC ensures communication between MCAC members and the New Hampshire Medicaid leadership.

The New Hampshire MCAC does not exceed 21 members and is comprised of Medicaid beneficiaries, beneficiary/consumer advocacy groups, members of the general public concerned about health service delivery to Medicaid beneficiaries, healthcare professionals (including dentists) who serve Medicaid beneficiaries, and other knowledgeable individuals with experience in healthcare, rural health, Medicaid law and policy, healthcare financing, quality assurance, patient's rights, health planning, pharmacy care, and those familiar with the healthcare needs of low-income population groups and the Medicaid population.

These meetings are open to the public, and routinely, three representatives of the general public are in attendance. In addition, DHHS program staff members from all aspects of the New Hampshire Medicaid program are in attendance. The MCAC will serve as a resource to engage stakeholders in this process of resolving any identified access issue as part of the response.

Provider Relations

NH Medicaid established the position of Provider Relations Manager in 2014. The Provider Relations Manager is responsible for:

- Communicating program updates to all enrolled providers and their professional associations;
- Identifying and resolving claims issues with the MMIS;
- Developing/conducting provider trainings on how to enroll in NH Medicaid, as well as new program and policy initiatives; and
- Working with managed care organizations to resolve provider issues.

The Provider Relations Manager developed and implemented the provider education and training, information and collaborative sessions for the managed care program from August 2015 through November 2015 which helped prepare for the February 2016 mandatory enrollment of the remaining Medicaid population. Sessions were conducted in person, via WebEx and phone conferencing. Numerous written communications were delivered via e-mail Blasts and were posted on the website to keep providers informed and supportive of beneficiary needs.

Provider education for the FFS program is ongoing as there are still a small number of beneficiaries and waiver services excluded from managed care.

Other Stakeholder Involvement

As a part of designing, developing and implementing policy changes at the DHHS, a stakeholder engagement process is used whereby community forums are held throughout the state to provide information to and solicit input from community partners, providers, institutions, and beneficiaries. Stakeholders also have the opportunity to submit feedback via WebEx live during community forums, e-mail or US mail. The purpose of stakeholder meetings are to: begin and sustain dialogue leading to shared understanding, set principles and strategies to guide transformation, and outline the approach for moving forward.

While 96% of NH Medicaid participants are currently receiving state plan services under managed care, there are a small number of beneficiaries that are excluded from Managed Care and others receiving waiver long-term services and supports managed and reimbursed by the FFS program. An extensive public engagement process was held in 2014 to gather input and feedback on the anticipated inclusion of New Hampshire's long-term services and supports (LTSS) into managed care. Twenty-eight stakeholder sessions were attended by over 850 individuals; written comments as well as a dedicated e-mail box were also utilized to gather stakeholder input. Additionally, six public forums - also available via WebEx – were held late-2015 to mid-2016 prior to submission of three 1915(c) waiver renewals. Stakeholders were also given the opportunity to submit comments via a dedicated e-mail box, in-person or via US mail.

Customer Services for Medicaid Beneficiaries

New Hampshire Medicaid works collaboratively with the Division of Client Services to provide assistance to Medicaid beneficiaries. Client Services engages with beneficiaries on a daily basis to determine and assist with their needs whether in person, on-line or telephonically. The Division's Customer Service Center, which is designed as a single point of entry for calls, is also used as a real-time surveillance tool to monitor poten-

tial trends and problems as phone calls from beneficiaries alert staff to disruptions to access and provider availability. The Division of Client Services manages beneficiaries' eligibility, concerns, requests for information, explanation of services available, and provider access and availability. As a result, Customer Services is on the forefront of New Hampshire Medicaid's efforts to understand beneficiaries' needs and respond to those concerns.

All beneficiaries are informed from the outset that assistance is available from Client Services should they have any difficulty with covered benefits, provider access and availability or with scheduling appointments. Beneficiaries' Medicaid membership cards are mailed to them, and the information on the card contains toll-free telephone numbers for pharmacy, client services and provider services. Written notifications, online resources, and in person assistance inform beneficiaries of the availability of assistance with transportation options and costs, and professional interpretation services so that these common difficulties do not become barriers to healthcare access

For those Medicaid beneficiaries participating with a Managed Care Organization or Qualified Health Plan in the Marketplace, these organizations work closely with New Hampshire Medicaid and the Division of Client Services to assure client and provider requirements and service expectations are met.

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PART 2 – 2016 ACCESS ASSESSMENT

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5. Data and Analysis

The sections in this chapter present New Hampshire FFS Medicaid information on areas related to access to health care services. The data are divided into the following sections:

- Characteristics of FFS beneficiary population;
- Identification of beneficiaries needs;
- Availability of health services;
- Changes in health service utilization; and
- Actual or estimated levels of provider payment available from other payers.

For this report, data throughout is presented as two-year trends and information is presented quarterly. As new periods of data become available, more quarters will be added to the charts, so that rolling five-year trends will be presented when available.

The focus of the data presented is general medical physician/APRN/group/clinic, maternity care, emergency department, inpatient hospital, cardiology, radiology, surgery, home health, and behavioral health services.

Methodology

For this report, the Final Rule was used for developing New Hampshire Medicaid's framework for evaluating healthcare access (i.e., includes reviewing the core set of five service areas from CMS' Final Rule).

Using the CMS Final Rule, New Hampshire Medicaid evaluated the unique characteristics of New Hampshire Medicaid FFS beneficiaries. New Hampshire Medicaid documented the size of the Medicaid FFS population, demographics, enrollment data, trends in enrollment, and geographic dispersion. This was performed to provide a baseline for the current FFS population, their healthcare needs, and provide context for evaluating New Hampshire Medicaid's network of FFS providers.

Evaluating FFS provider network capacity entailed a determination of FFS provider capacity for physicians, physician groups, clinics, and hospital emergency departments. New Hampshire Medicaid used provider enrollment, time/distance analysis, and beneficiaries to active provider ratio trends, to evaluate FFS provider availability in New Hampshire.

Service utilization by Medicaid FFS beneficiaries represents realized access. Realized access refers to how New Hampshire Medicaid FFS beneficiaries are actually using available healthcare services. Utilization statistics were generated by age, geography, and eligibility group. New Hampshire Medicaid's examined patterns of healthcare service use differs among eligibility groups, age groups, and geographic regions; how healthcare service venues may have changed; and any healthcare service use trends that may have changed during the reporting period.

Historically, New Hampshire Medicaid compiled eligibility and administrative claims data for four years (16 quarters) of FFS paid claims reflecting services used by Medicaid FFS beneficiaries to set monitoring standards. However, for this report, two years of results were presented since the FFS population has changed

considerably after related to the implementation of Medicaid managed care program in December 2013; prior periods of data would no longer be representative of the current period. Future reports will not rely on all data used in this report, as additional populations have transition from FFS to managed care since 2013.

New Hampshire Medicaid compiled service utilization statistics for physician/APRN/group/clinic, surgery, radiology, cardiology, home health, emergency department, inpatient hospital, and behavioral health services. These provider utilization rates were calculated per 1,000 Medicaid FFS beneficiaries.

Data Sources

Membership, utilization, and provider network results are based on data extracted from the New Hampshire's Medicaid Management Information System (MMIS), the State's Medicaid claims processing system. Inherent in this data are differences in coding practices across providers, which potentially affect results and contribute to observed differences.

Population Included in Trend Data

The populations included in the member and utilization trend data are FFS beneficiaries who are:

- Excluded from Managed Care: Beneficiaries who will never be mandatory for Medicaid Managed Care such as members receiving medical benefits from the Office of Veterans Affairs;
- In a Plan Selection Period: Beneficiaries in their plan selection period who will shortly move to Medicaid managed care program or Qualified Health Plans within the next two months; or
- Voluntary for Managed Care: beneficiaries who initially opted out of Medicaid managed care program before February 1, 2016 and who transition into Medicaid managed care program in February 1, 2016 due to the implementation of New Hampshire's 1915b waiver (subsequent reporting will remove this category).

In addition, the populations included in the member and utilization trend data are FFS beneficiaries for whom New Hampshire Medicaid provides the only known sole source of general health care coverage. Beneficiaries with Medicare and/or other insurance are excluded because for this group, New Hampshire Medicaid only plays a secondary role in providing general health coverage and as a result does not have complete claims data.

Service Date Periods and Claims Run-out

All utilization reports are based on last date of service for calendar year quarters. In order to provide a consistent basis for comparing reports over time, it was necessary to also provide consistent claims run-out for each quarter. Quarterly measures are based on six months of claims run-out (e.g., where the service period being reported covers –July - September 2014, the report will include all claims paid through March 31, 2015).

Geographic Grouping

FFS beneficiaries are subdivided geographically based on their county of residence. Because of the small numbers involved County-level reporting would not be meaningful, therefore counties are aggregated into those that are Metropolitan and those that are Non-Metropolitan based on USDA rural/urban continuum codes. Metropolitan counties are Hillsborough, Rockingham, and Strafford and the Non-Metropolitan counties are Belknap, Carroll, Cheshire, Coos, Grafton, Merrimack, and Sullivan. The counties in both groupings

are contiguous, with the Metropolitan area counties located in the south-eastern part of the State. A small number of beneficiaries with out-of-state addresses are excluded from the report.

Age and Eligibility Grouping

Beneficiaries are subdivided based on their age and aid category of assistance during each month of a quarter. Data for most trends is reported using the following groupings which like geography must be presented at a high-level to be meaningful:

- Children, including disabled children and those who gained coverage due to foster care or adoption subsidy.
- Low-Income Parents & Breast and Cervical Cancer Program:
- NH Health Protection Program
- Elderly and/or Disabled Adults

Medicaid Managed Care Enrollment Status Grouping

Beneficiaries are subdivided based on their enrollment status for Medicaid managed care. Data for most trends is reported using the following groupings which like geography must be presented at a high-level to be meaningful:

- Excluded from Managed Care;
- Plan Selection Period; and
- Voluntary for Managed Care.

Control Limits

Control limits have been used in New Hampshire's previous six published access reports as the primary tool to monitor access. However, since the FFS population decreased considerably after the Medicaid managed care program transition in December 2013, control limits are not appropriate for this year's study. Control limits based on historical trends will be included in subsequent access evaluations, after the FFS population stabilizes and sufficient data are collected to produce statistically sound control limits. When instated, control limits will be employed in quarterly trend charts to provide a consistent indication of a potential access problem as each new quarter of data are available. Control limits will be set as three standard deviations (following conventional practice⁶) from the mean based on historical data. The final control limits will be determined when there are four years (16 quarters) of results from a relatively stable FFS population.

Small Numbers

Because New Hampshire is a small state, it is necessary to take into account the volume of data available for reporting. For some combinations of age and eligibility, the volume of data is too small to allow for meaningful reporting. Rates based on smaller numbers are more volatile due to random variation.

⁶ E.g., <http://www.qualitydigest.com/aug/wheeler.html>, <http://www.isixsigma.com/dictionary/control-limits/>

New Hampshire Medicaid FFS Beneficiaries

Overview of New Hampshire Medicaid FFS Beneficiaries

The two figures below show the distribution of beneficiaries by age, eligibility group, and gender as of May 1, 2016.

Children (members 18 years or less) make up 27.6% of the New Hampshire Medicaid FFS population. As shown below, beneficiaries age 19 to 64 represent 67.0% of beneficiaries and the remaining 5.5% are members aged 65 plus.

Females account for over half (53.4%) of FFS Medicaid beneficiaries. Gender differences are observed in three eligibility categories with females predominating the low-income parent & BCCP category (73.1%, due to pregnant women eligibility category and greater likelihood of heading single parent low-income households) and the elderly and/or disabled adults category (52.3%, due to longer lifespan and likelihood of having fewer resources than males). As shown below, the only group in which males make up a notable larger proportion of beneficiaries is the children and/or disabled child category.

Figure 3. NH Medicaid FFS Beneficiaries by Age Categories, May 1, 2016

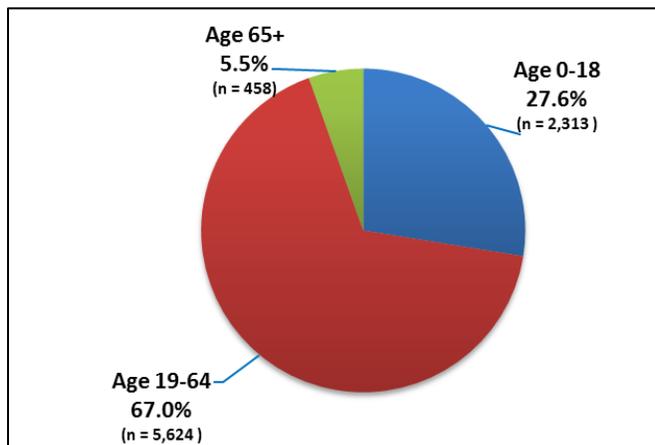
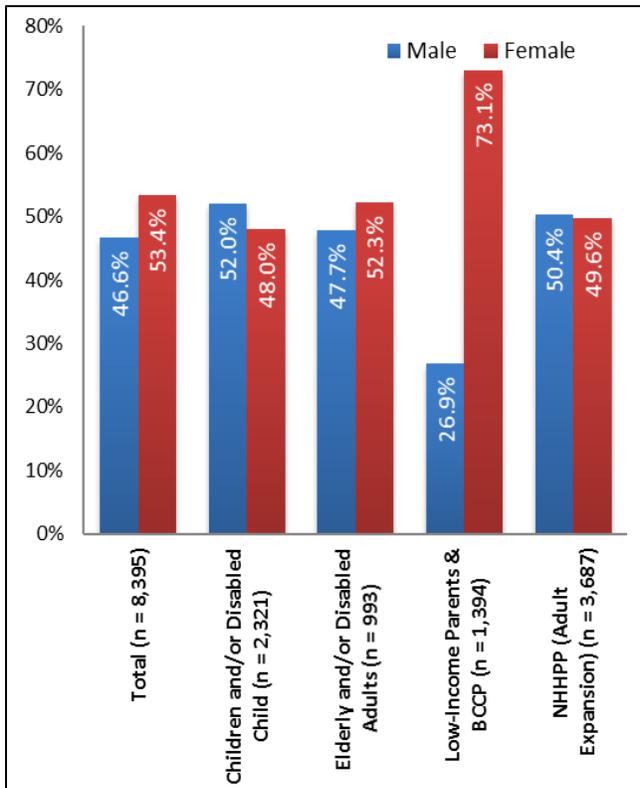


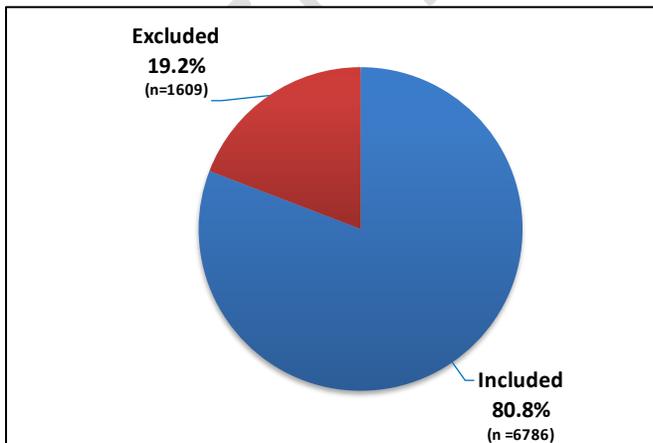
Figure 4. NH Medicaid FFS Beneficiaries by Gender and Eligibility Category, May 1, 2016



Population Subject to Access Monitoring

The figures above are based on the entire Medicaid FFS beneficiary population. The following figures on enrollment, and all later figures showing utilization trends, exclude Medicare dual eligibles, and those beneficiaries known to have other medical insurance. These beneficiaries are excluded because the focus of this report is access to medical and behavioral health care for beneficiaries with Medicaid as their primary source of health insurance, and not for services paid for by other payers. Figure 5 shows that 19.2% of the beneficiaries were excluded as of May 1, 2016 due to Medicare and/or other medical insurance.

Figure 5. NH Medicaid FFS Beneficiaries Subject to Access Monitoring Plan, May 1, 2016



New Hampshire Medicaid FFS Beneficiary Enrollment Trends

This section reviews trends in average monthly enrollment by quarter of New Hampshire FFS Medicaid beneficiaries. The data in the figures are presented by quarter. Utilization trends are tracked for these beneficiaries.

Data are presented for the total Medicaid population, broken down by age and eligibility groupings, and by metropolitan and non-metropolitan areas of the State.

Figures for enrollment trends show that the FFS population has continued changing throughout 2014 and 2015 due to the following:

- Decreases from the children and/or disabled child and low-income parents & breast and cervical cancer program (BCCP) eligibility groups between Quarter 1 of 2014 and Quarter 3 of 2014
- NHHPP beginning in Quarter 3 of 2014 which impacts the trend in Plan Selection Period population as enrollment increased, leading to an increase in FFS population transitioning to Medicaid managed care program and an increase in Excluded from Managed Care population due to efforts to increase use of the Health Insurance Premium Payment (HIPP) program as required by the state statute that implemented the NHHPP.
- Increases in Medicaid managed care program population in Quarter 4 of 2015 due to the previously voluntary children and/or disabled children moving to the Medicaid managed care program in advance of the group being mandatorily enrolled for managed care, February 1, 2016.

Figure 6. NH Medicaid FFS Enrollment, CY 2014-2015, Average Members in Quarter: Total Population
Note: excludes Medicare dual eligibles and members with other medical insurance

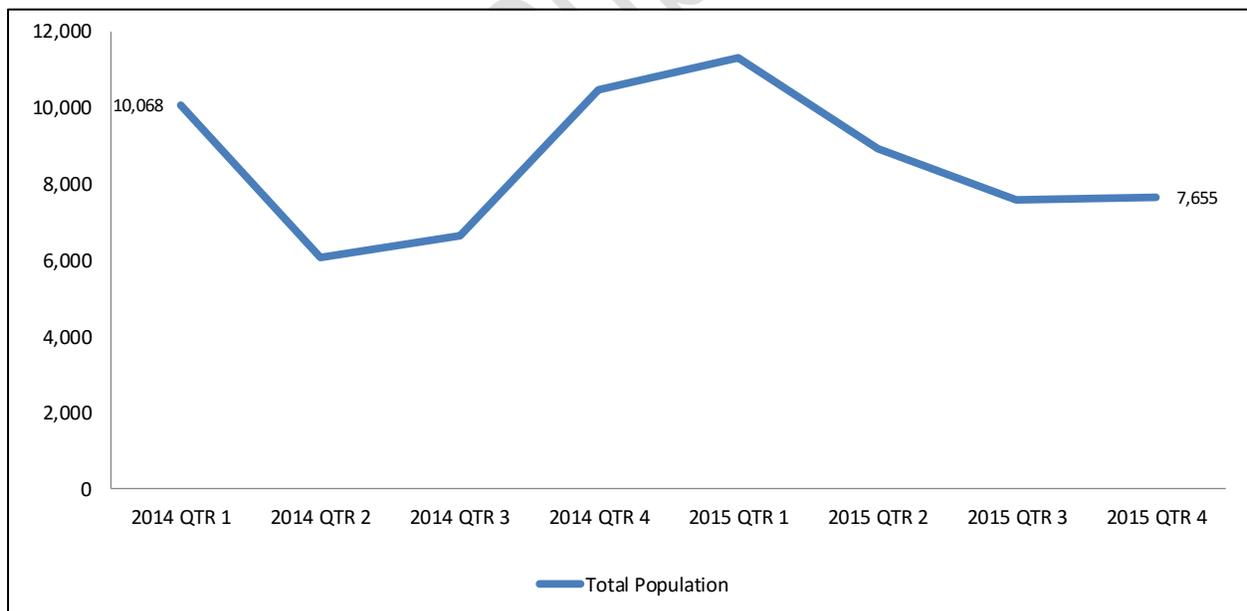


Figure 7. NH Medicaid FFS Enrollment, CY 2014-2015, Average Members in Quarter: Children and/or Disabled Child

Note: excludes Medicare dual eligibles and members with other medical insurance

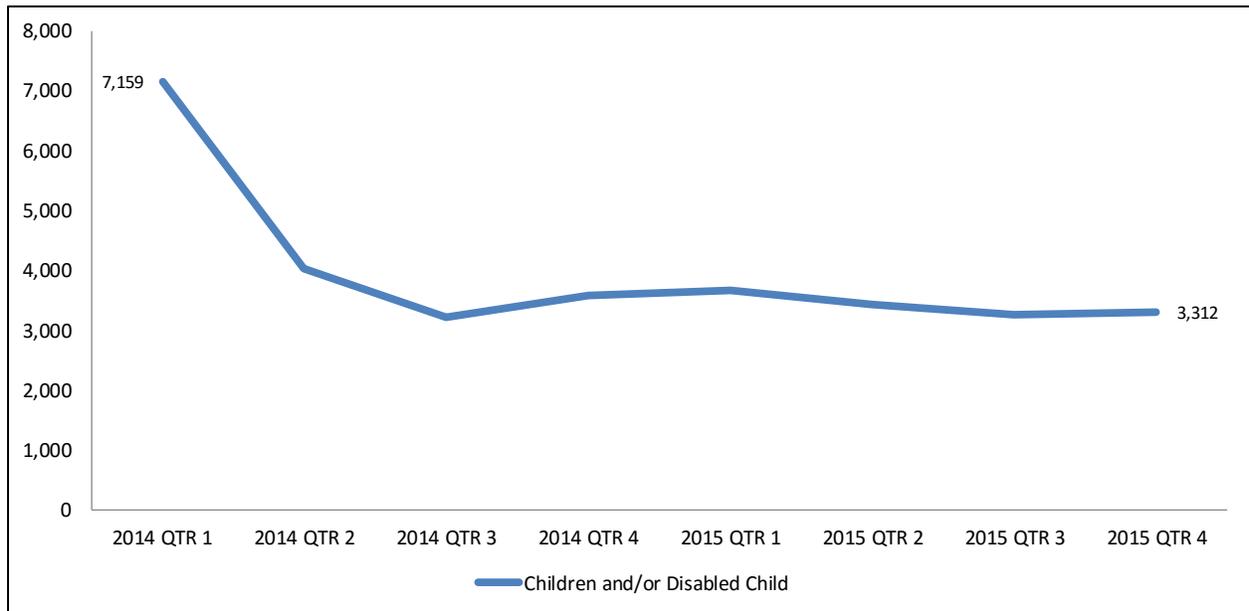


Figure 8. NH Medicaid FFS Enrollment, CY 2014-2015, Average Members in Quarter: Adults by Eligibility Group

Note: excludes Medicare dual eligibles and members with other medical insurance

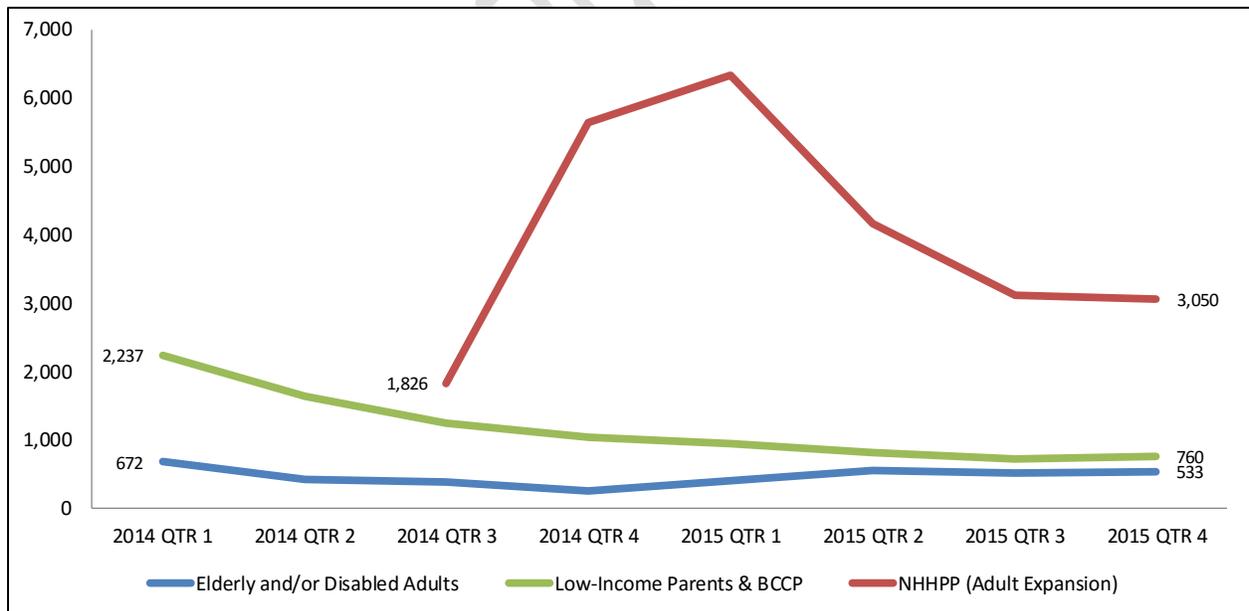


Figure 9. NH Medicaid FFS Enrollment, CY 2014-2015, Average Members in Quarter: Metropolitan and Non-Metropolitan Counties

Note: excludes Medicare dual eligibles and members with other medical insurance

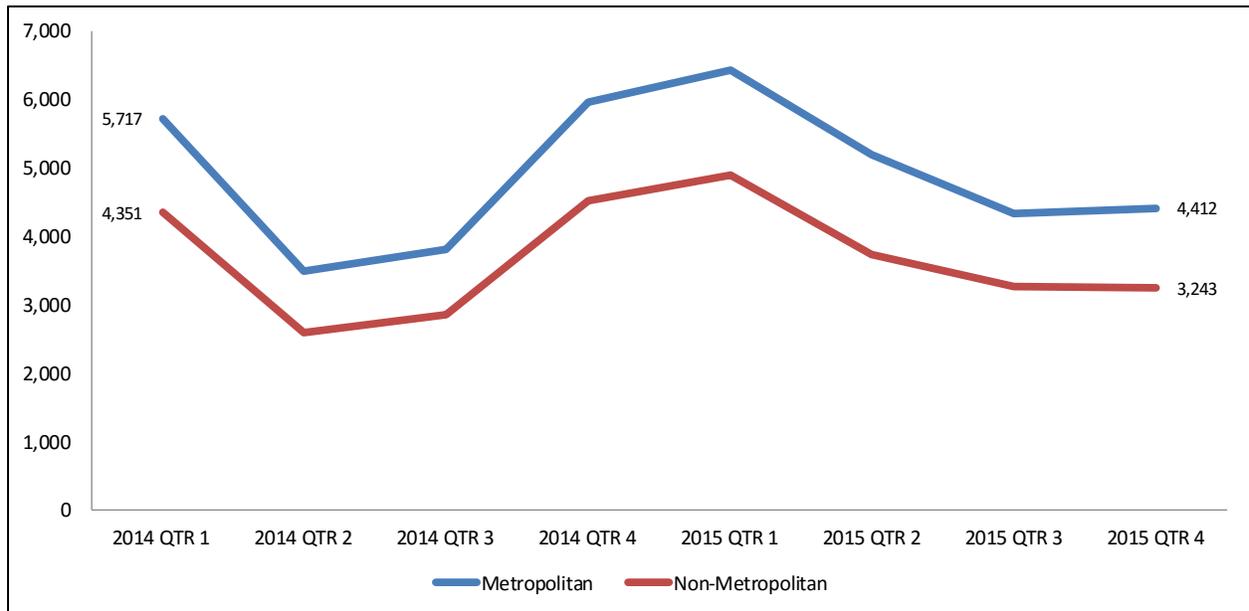
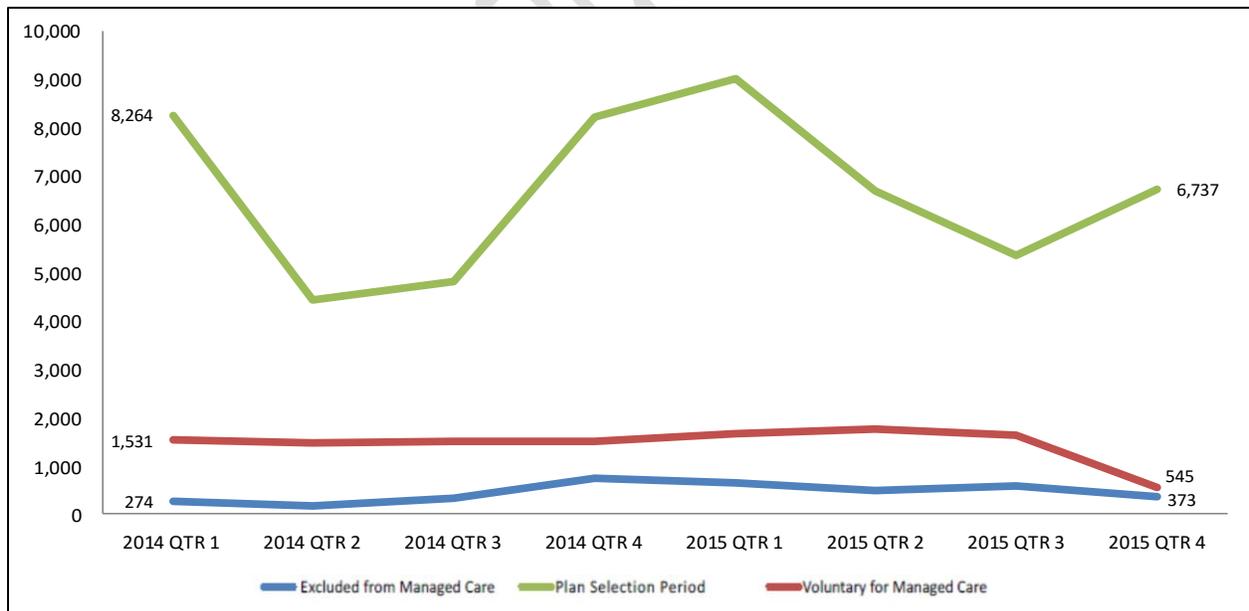


Figure 10. NH Medicaid FFS Enrollment, CY 2014-2015, Average Members in Quarter: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care

Note: excludes Medicare dual eligibles and members with other medical insurance



FFS Provider Availability

The provider availability analysis focuses on whether healthcare services are accessible to Medicaid beneficiaries. Measures are included on provider participation in the New Hampshire Medicaid FFS Program, per-

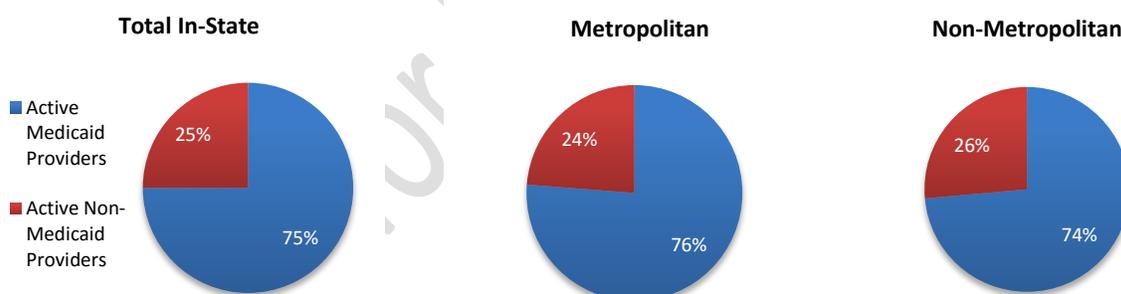
cent of active providers from all enrolled FFS providers for Quarter 4 of 2015, time/distance analysis for primary care providers, and ratios of beneficiaries to active providers.

Physician and Hospital Participation

All of New Hampshire's 26 acute care hospitals as well as two of three specialty hospitals actively provide services to FFS beneficiaries. In contrast to many states, New Hampshire's Medicaid beneficiaries share the same delivery system as the general population, and the distribution of Medicaid patient utilization of these facilities is also similar to the general patient population. There are no public "safety net" hospitals in New Hampshire, and in some communities, the local community health centers (FQHC or RHC) serve as the primary ambulatory care site for commercially insured patients, as well as Medicaid and uninsured individuals.

With regard to physicians, Figure 11 provides information on the most recently available data on enrollment by active licensed providers. As can be seen in Figure 11, the majority (75%) of licensed practicing physicians are also active (at least one claim in 2015) New Hampshire Medicaid FFS providers.⁷ The same is true for both the metropolitan (76%) and non-metropolitan counties (74%). The decrease in the percentage of active Medicaid providers from 90% in 2013 to 75% in 2015 is attributed to the decrease in the FFS population after the transition to the Medicaid managed care program in December 2013. Since there are far fewer FFS enrollees in 2015, there is much lower utilization of services, and thus fewer active providers servicing FFS population. In order to ensure providers stayed enrolled with FFS after the transition to managed care New Hampshire included provisions in its contracts that required all providers enrolled with MCOs to also be enrolled in FFS.

Figure 11. Active NH Medicaid In-State FFS Physician Providers Compared to Licensed Providers With NH Billing Address, 2015



Ratios of New Hampshire Medicaid FFS beneficiaries to active providers are very high, which also explains why most individual practitioners will likely have small numbers of Medicaid FFS patients in their panel (as compared to more populous or urban states). For example, New Hampshire has 1.3 million⁸ people, and a total of 4,109 licensed practicing physicians for a ratio of 324 people per licensed physician, while there are 7,655 Medicaid FFS beneficiaries (average FFS beneficiaries as of Quarter 4 of 2015 from Figure 6) and a total of 3,081 active (billing within 2015) physicians for a ratio of 2.5 people per physician for the New Hampshire Medicaid FFS population.

⁷ NH Board of Medicine

⁸ Data Source: <http://quickfacts.census.gov/qfd/states/33000.html>, accessed on July 17, 2016.

Percent of Active FFS Providers

For the FFS providers enrolled in the New Hampshire Medicaid FFS program, the following table displays the percentage of active providers for Quarter 4 of 2015. Since the FFS provider network remains almost the same as before the Medicaid managed care program implementation and the FFS population had a large decrease, the percentages of active providers varied from 33.9 percent (Surgery) to 65.3 percent (Pediatricians). This indicates that one-third to two-thirds of the FFS providers were servicing the FFS population (i.e., submit at least one claim in Quarter 4 of 2015) for the provider types listed in the table below.

Provider Type	Total FFS Providers	Active FFS Providers	Percent
Cardiology	960	468	48.8%
Home Health	40	21	52.5%
Obstetricians/Gynecologists	2,422	990	40.9%
Pediatricians	274	179	65.3%
Primary Care Providers	2,513	1,071	42.6%
Radiology	175	104	59.4%
Surgery	469	159	33.9%

Time/Distance Analysis for Primary Care Providers, Pediatricians, and Maternity Providers

The contract with New Hampshire managed care organizations (MCOs) specifies time and distance standards for Medicaid beneficiaries to have access to specific provider types. These standards were applied to all 6,784 FFS beneficiaries as of May 1, 2016 to monitor to monitor time and distance to Primary Care Providers, Pediatricians, and Maternity providers.

Provider Time and Distance Standard	Standard Met / Not Met
Primary Care Providers – <i>Two (2) within forty (40) minutes or fifteen (15) miles</i>	Met
Pediatricians <i>Two (2) within forty (40) minutes or fifteen (15) miles</i>	Met
Obstetricians/Gynecologists <i>One (1) within sixty (60) minutes or forty-five (45) miles</i>	Met

Active FFS Primary Care Providers, Pediatricians, and Maternity Provider Ratios

The following three figures show the trend in the ratio of FFS beneficiaries to active providers (those with one claim in the quarter) or FFS deliveries to delivery providers. One chart each is presented for Primary Care Providers, Pediatricians, and Maternity. For each chart, there are three trend lines, one representing the statewide data, one for metropolitan area data, and another for non-metropolitan area data. Appropriate control limits will be developed as the FFS population stabilizes and more data points become available in future reports.

The deliveries-to-delivery provider ratio chart compares active providers to deliveries, as opposed to the general female population-to-providers, which accounts for changes in fertility rates in the population.

Results

- The beneficiaries to active primary care providers and pediatricians ratios, as well as, deliveries-to-delivery provider ratios in CY 2014 and 2015 were much lower than the historical trends found in prior reports. This is because the FFS population reduced to less than 20% of its size before the Medicaid managed care program transition while the number of active providers did not have a large change, e.g., the percentage of active providers in the previous section shows that one-third to two-thirds of the FFS providers were still active in Quarter 4 of 2015.
- The trends for the beneficiaries to active primary care providers and pediatricians ratios were similar to the corresponding beneficiary enrollment trends (e.g., the drop, an improvement, in the first two quarters of Figure 13 was due to a drop in the number of FFS children, not due to a change in active provider numbers).

Figure 12. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians), CY 2014-2015

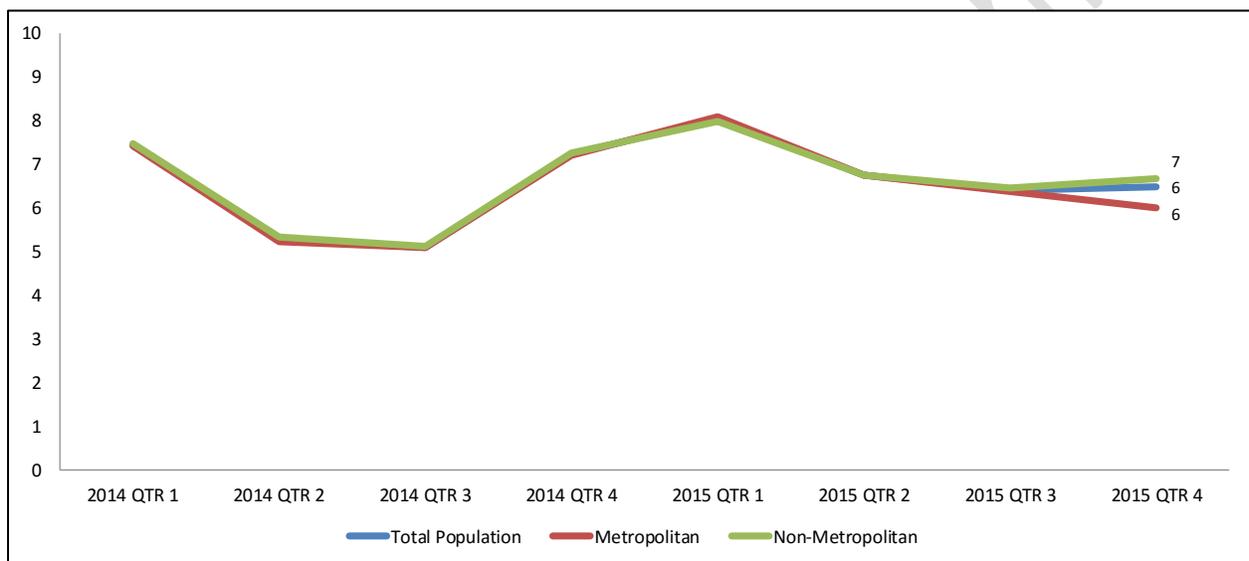


Figure 13. Ratio of NH Medicaid FFS Child Beneficiaries to Active In-State Pediatricians, CY 2014-2015

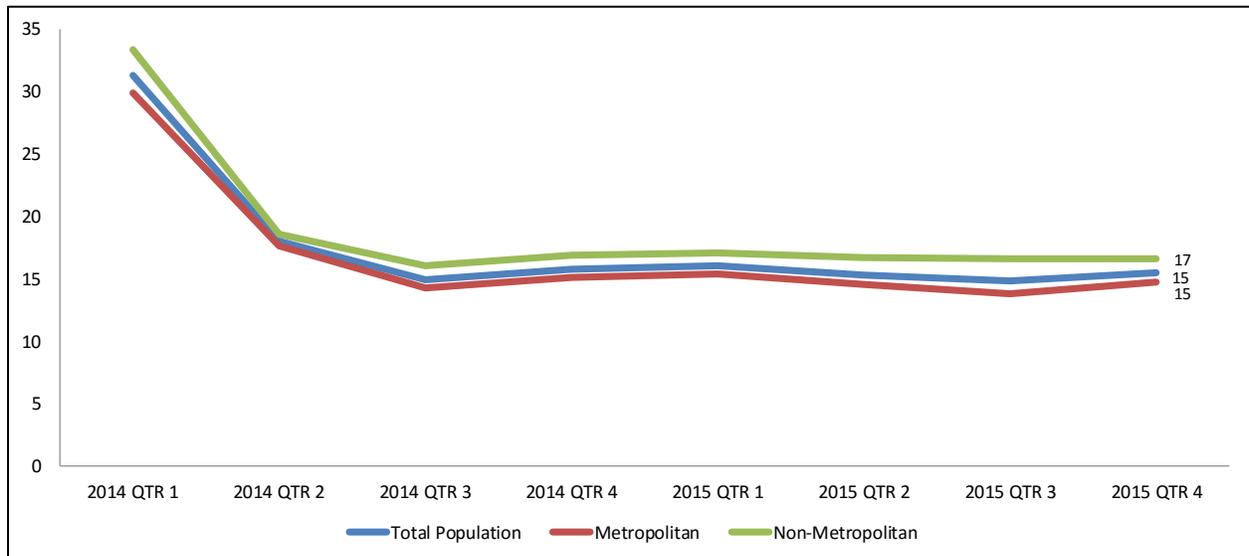
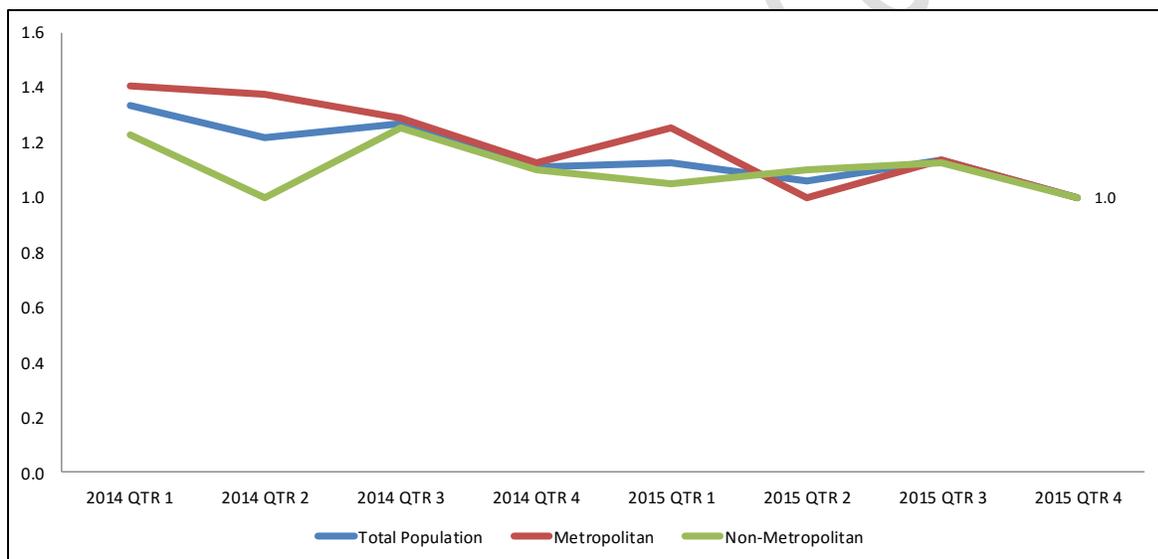


Figure 14. Ratio of FFS Deliveries to Active Delivery FFS Providers, CY 2014-2015



Active FFS Cardiology, Radiology, Surgery, and Home Health Providers Ratios

The following three figures show the trend in the ratio of FFS beneficiaries to active cardiology, radiology, surgery, and home health providers (those with one claim in the quarter). For each chart, the statewide trend is presented together with the trends by metropolitan and non-metropolitan areas. Appropriate control limits will be developed as the FFS population stabilizes and more data points become available in future reports.

Results

- The statewide ratios for the four different provider types varied from approximately 35 FFS beneficiaries per one active cardiology provider to approximately 150 FFS beneficiaries per one radiology provider.

- For all provider types except home health providers, the upward and then downward trend over time for the statewide, metropolitan, and non-metropolitan areas were all similar to the enrollment trend, i.e., the ratios are being driven by changes in enrollment, not changes in active providers.
- Different sets of control limits may be set up for the statewide, metropolitan, and non-metropolitan areas for each of the three provider types.
- For home health providers, the total number of active providers for each quarter was less than 30. Therefore, please use caution when interpreting results for Figure 18.

Figure 15. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Cardiology Providers, CY 2014-2015

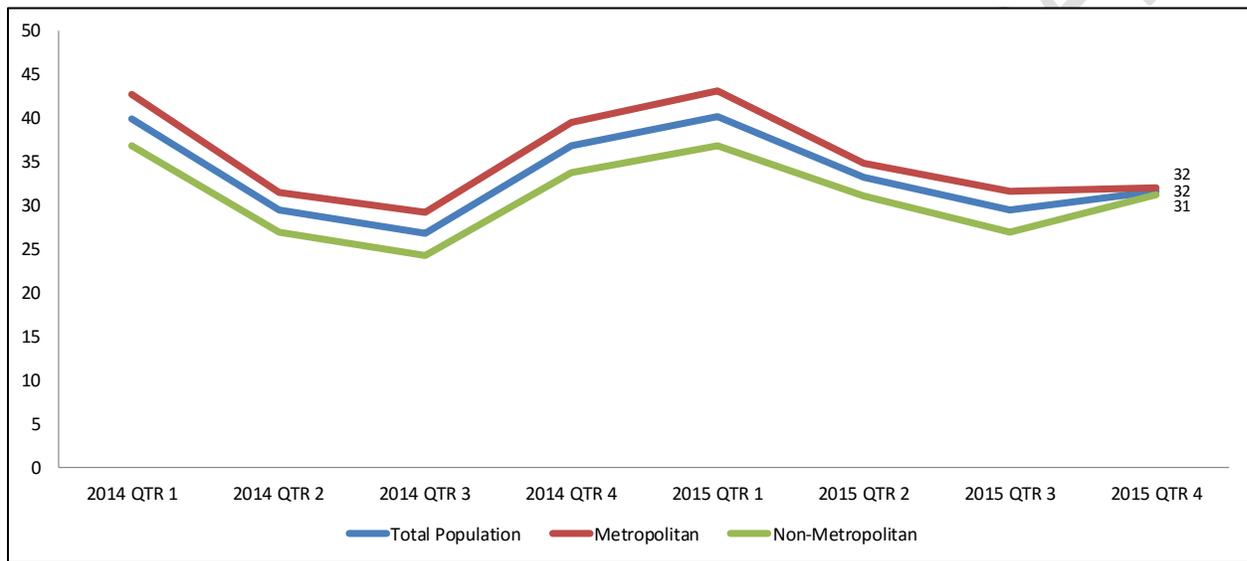
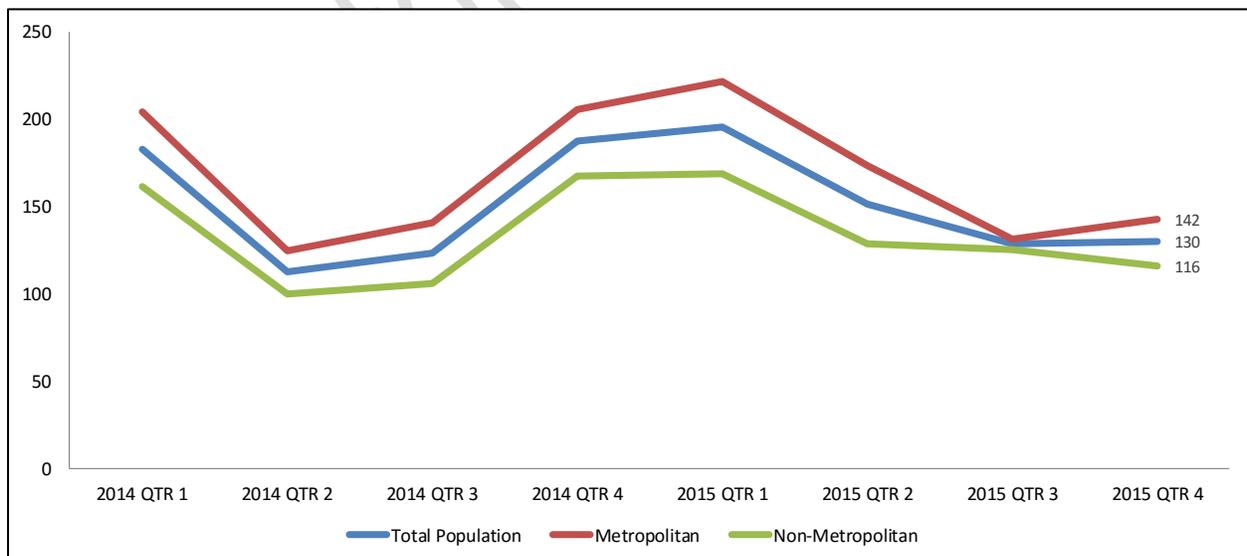
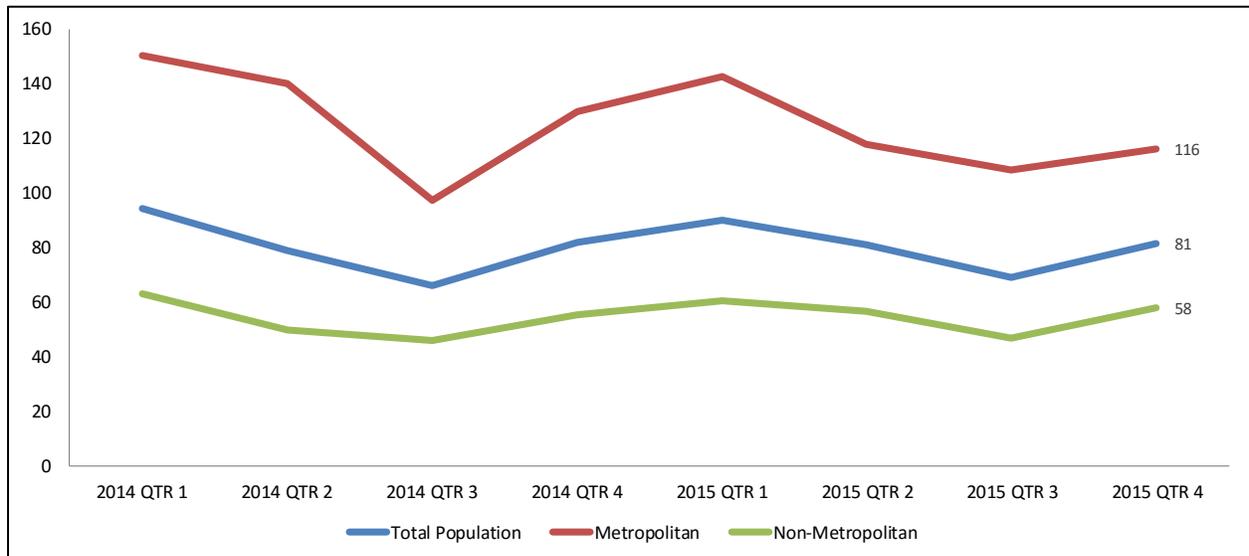


Figure 16. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Radiology Providers, CY 2014-2015



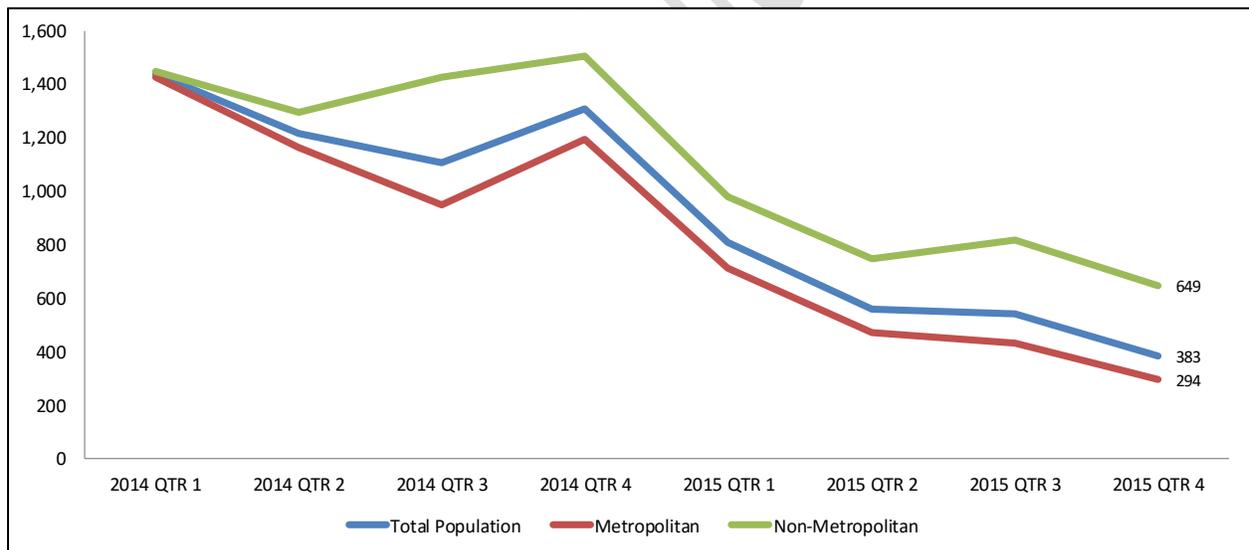
Note: The total number of active radiology providers in metropolitan and non-metropolitan counties was less than 30 for the first five quarters and for all quarters, respectively. Please use caution when interpreting results.

Figure 17. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Surgery Providers, CY 2014-2015



Note: The total number of active surgery providers in metropolitan counties was less than 30 for Quarter 2 of 2014. Please use caution when interpreting results.

Figure 18. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Home Health Providers, CY 2014-2015



Note: The total number of active home health providers for each quarter was less than 30. Please use caution when interpreting results.

Utilization of Services

Appropriate health care utilization is influenced by both provider availability and beneficiary choice and behavior. Studying healthcare utilization patterns can provide a signal that a particular subgroup or region of the State may have an access issue.

Figures in this section show the utilization trends in quarterly use of key physician and hospital services by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data⁹. Rates are the number of FFS visits in the quarter divided by the number of FFS beneficiary months for the quarter times 1,000. The data in the figures are presented by quarter and are broken down by age and eligibility groupings, and also broken down by metropolitan and non-metropolitan areas of the State (to take a special look at areas with a potentially greater sensitivity to access problems).

All trends are based on administrative FFS eligibility and claims data. Inherent in these data are differences in coding practices across providers, which potentially affect results and contribute to observed differences.

In prior reports on the entire Medicaid population, control limits were included on the charts to provide a trigger indicating a potential access problem requiring further investigation. Since the FFS population has dramatically changed in its size after the Medicaid managed care program transition in December 2013, the historical control limits are not appropriate. New control limits will be developed as the FFS population stabilizes and more data points become available in future reports.

Measures presented in this section are:

- Physician/APRN/Clinic Utilization,
- Emergency Department Utilization for Conditions Potentially Treatable in Primary Care,
- Total Emergency Department Utilization,
- Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions,
- Total Inpatient Hospital Utilization,
- Utilization of Cardiology Providers,
- Utilization of Radiology Providers,
- Utilization of Surgery Providers,
- Utilization of Home Health Providers, and
- Mental Health Utilization

Physician/APRN/Clinic Utilization

Figures in this section show the trend in quarterly use of physician, APRN, FQHC, and RHC services by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data. Data are presented for the total Medicaid FFS population, broken down by age and eligibility groupings, metropolitan and non-metropolitan areas of the state, and by Excluded from Managed Care, Plan Selection Period, and voluntary beneficiary categories.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program, new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

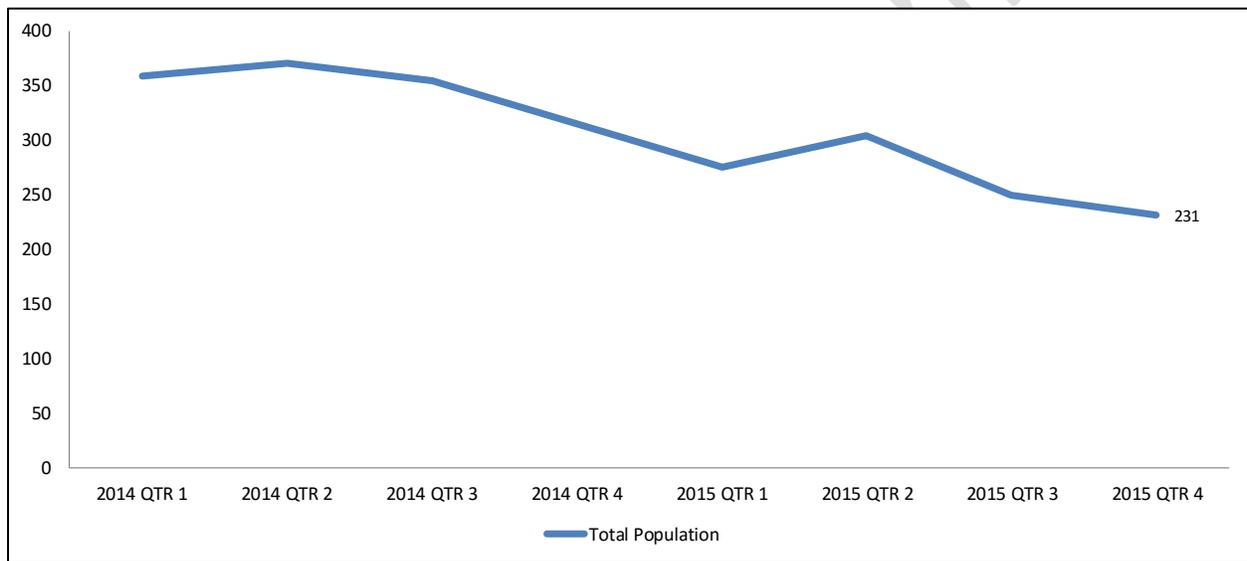
Results

- All figures for this measure show a downward trend.

⁹Excluding Medicare dual eligibles, and those beneficiaries known to have other medical insurance, as their physician care is nearly always paid for by third parties, not NH Medicaid.

- The 2014 and 2015 FFS population consisted of a considerable amount of Plan Selection Period beneficiaries (refer to Figure 10) who stayed in FFS temporarily for a few months and then transitioned to the Medicaid managed care program. Figure 23 indicates that these Plan Selection Period beneficiaries had much lower physician/APRN/clinic utilization. In addition, Figure 28 in this report shows that the Plan Selection Period beneficiaries generally had a higher rate of emergency department utilization for conditions potentially treatable in primary care, which indicated that the Plan Selection Period beneficiaries did have access to care provided in emergency departments, but may not through physician/APRN/clinics due to the short stay in FFS.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP¹⁰ segment of the NHHPP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 23.

Figure 19. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population



¹⁰ An early component of the New Hampshire Health Protection Program was a mandatory assessment of access to cost-effective employer sponsored coverage through a Health Insurance Premium Payment (HIPP) program. During the assessment period the member was held in FFS. This assessment period has ended and members move into employee sponsored health care.

Figure 20. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

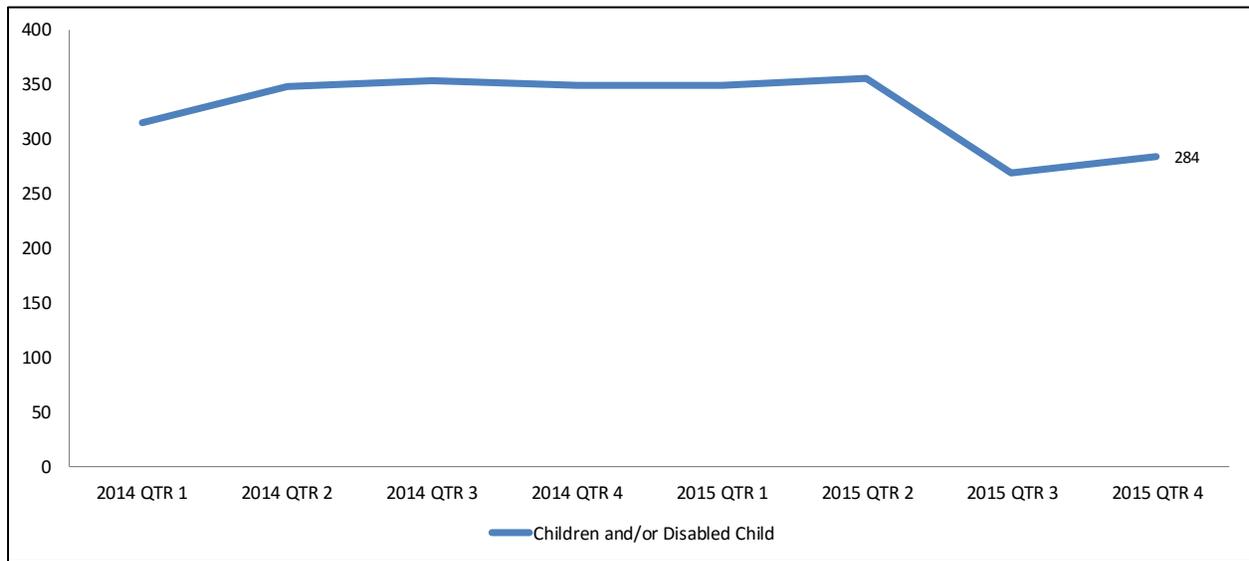
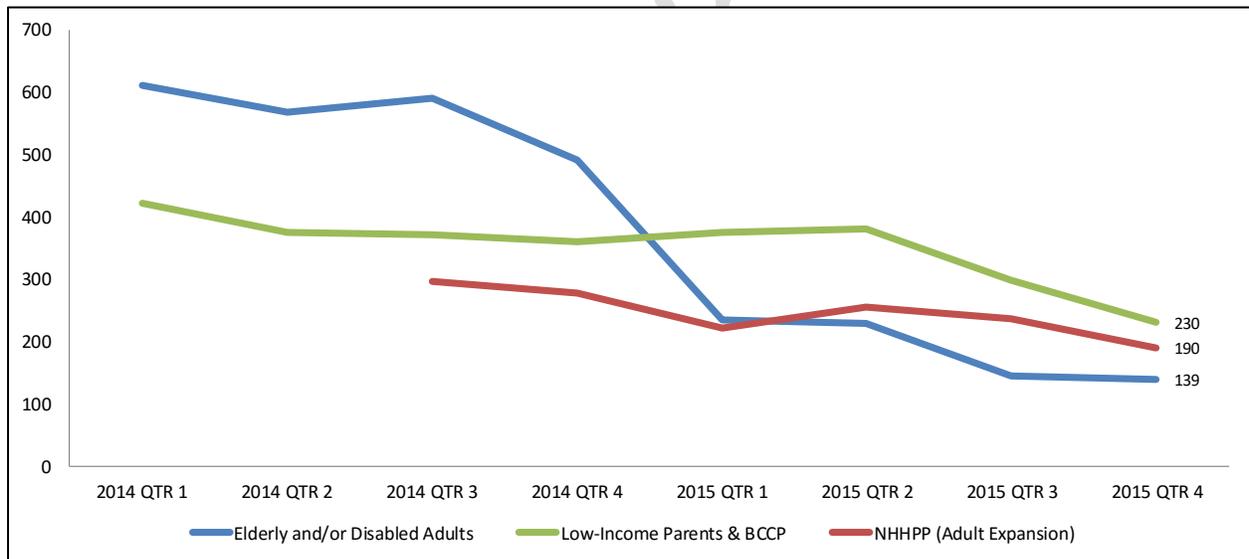


Figure 21. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014.

Figure 22. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

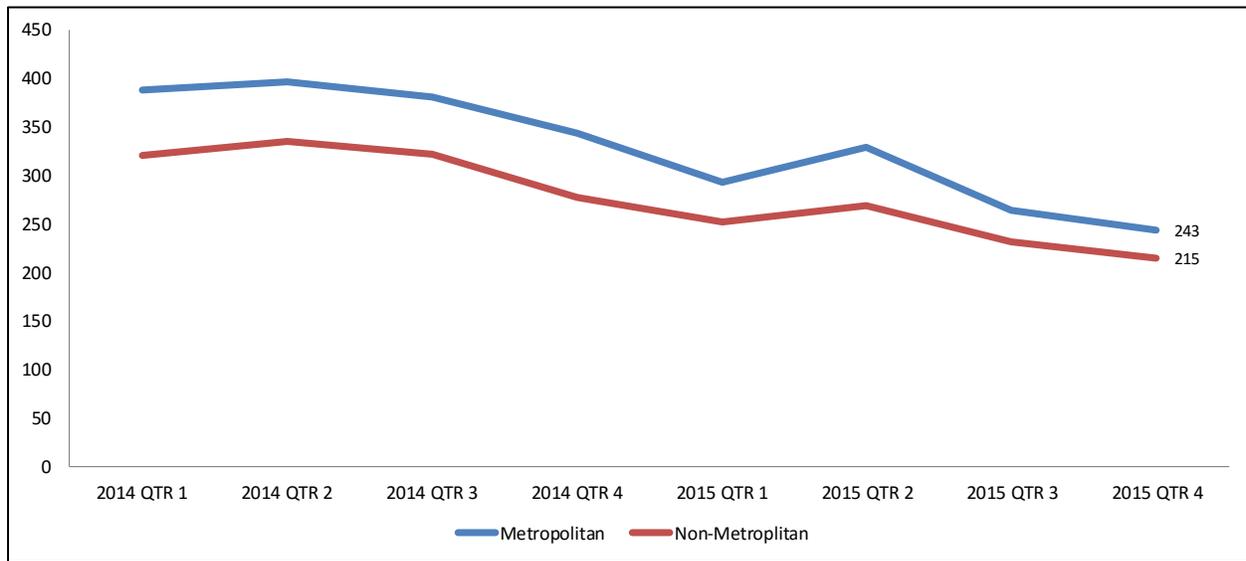
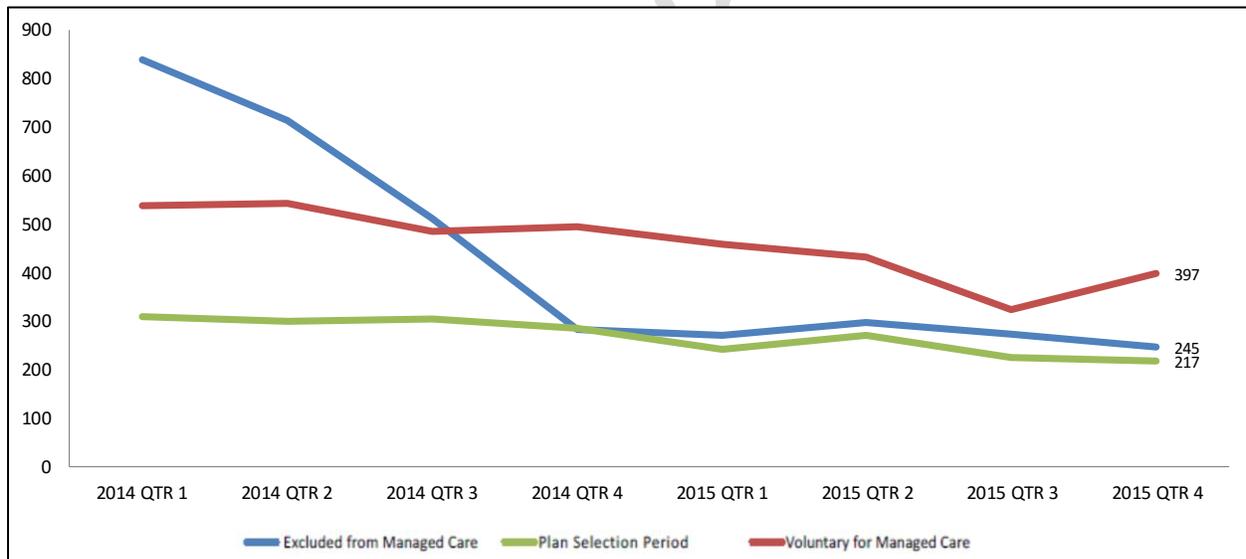


Figure 23. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



Emergency Department Utilization for Conditions Potentially Treatable in Primary Care

Figures in this section show the trend in quarterly use of hospital emergency departments for conditions that might have been more appropriately treated in primary care (e.g., upper respiratory infections) as indicated by Medicaid claims data.

Data are presented for the total Medicaid FFS population, broken down by age and eligibility groupings, and broken down by metropolitan and non-metropolitan areas of the State where supported by sufficient data needed to produce reliable results.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program, new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

- All figures for this measure show a downward trend. While lower utilization is generally the goal for this measure, DHHS will continue monitoring these trends in future access reports.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPPsegment of the NHHPP program caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 28.

Figure 24. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

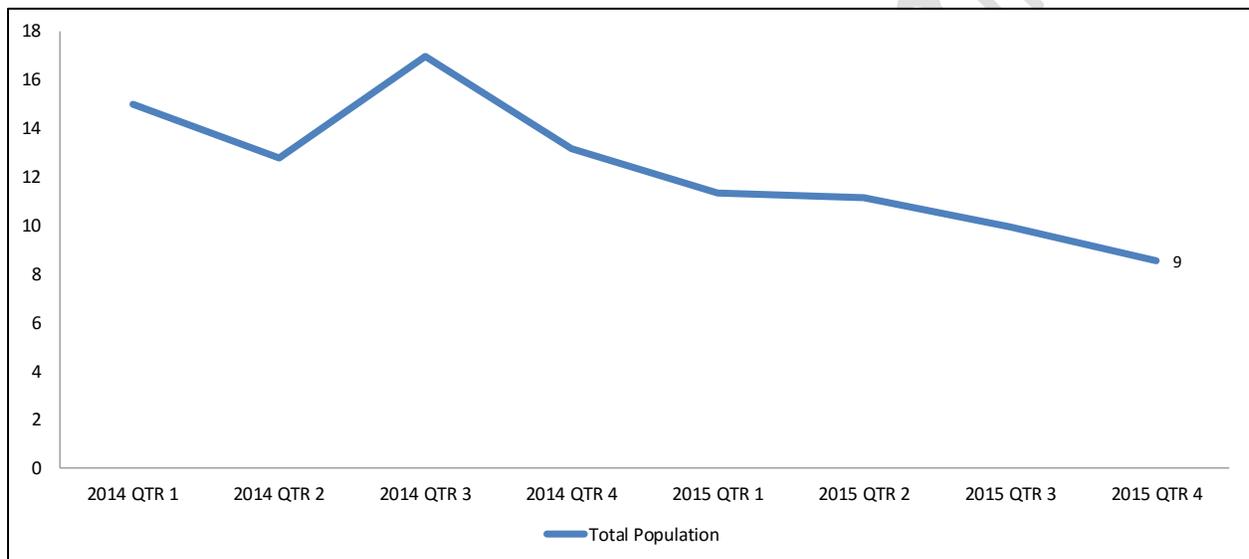


Figure 25. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

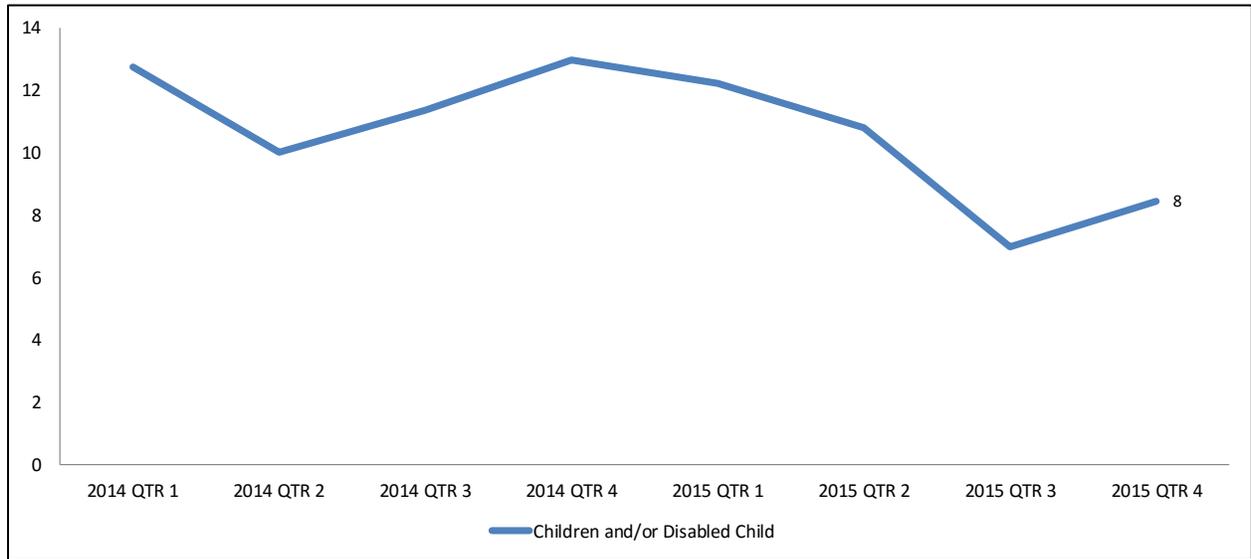
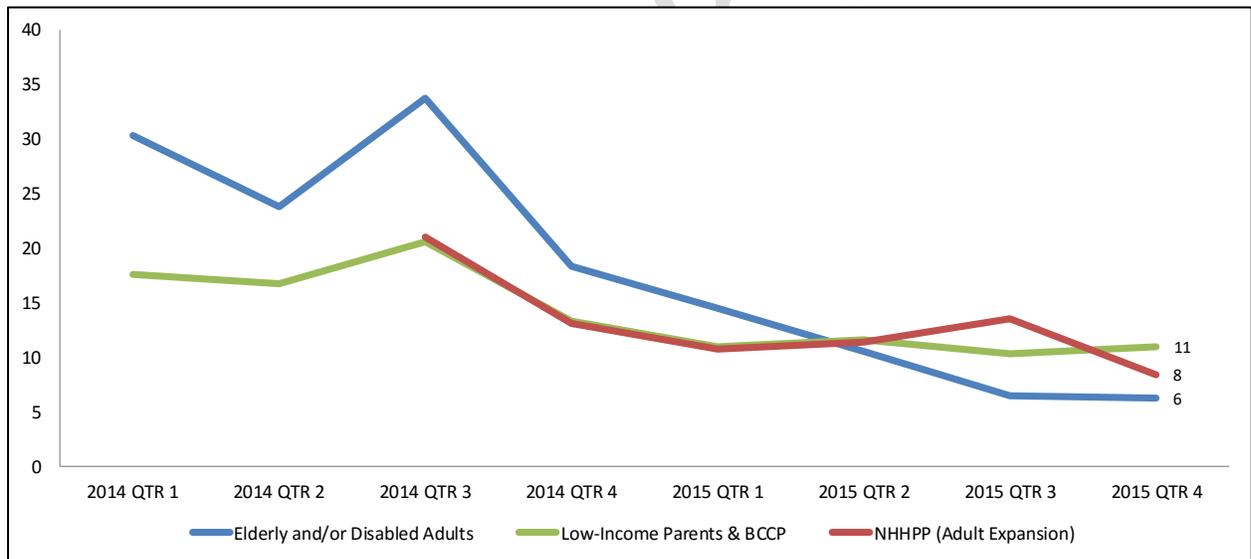


Figure 26. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The visit counts for the elderly and/or disabled adults and low-income parents & BCCP groups were less than 30 for some of the quarters. Please use caution when interpreting results. In addition, the NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014.

Figure 27. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

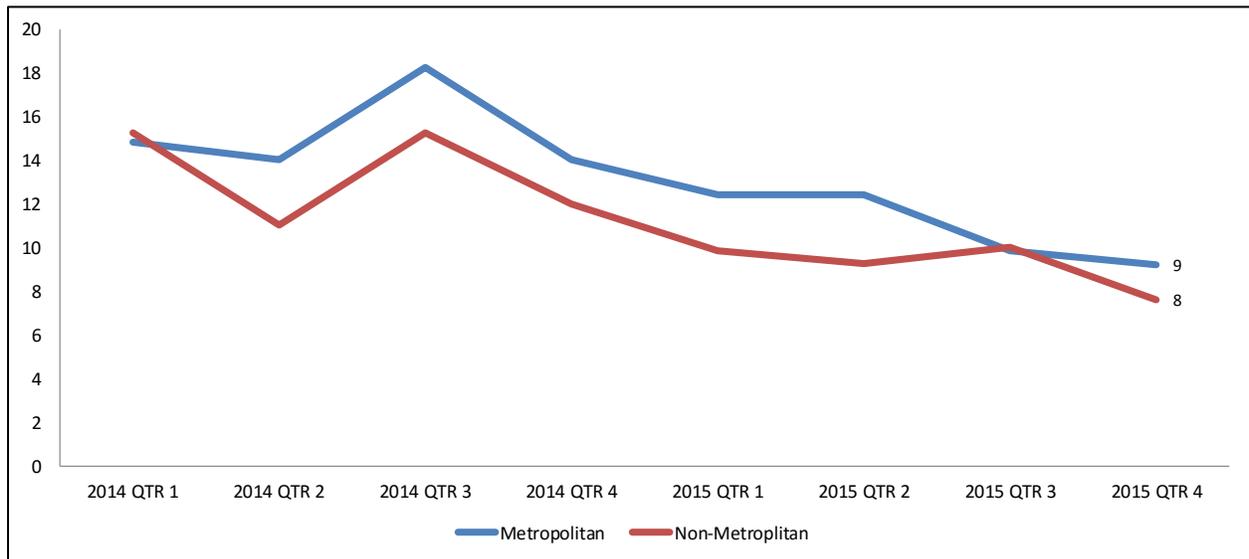
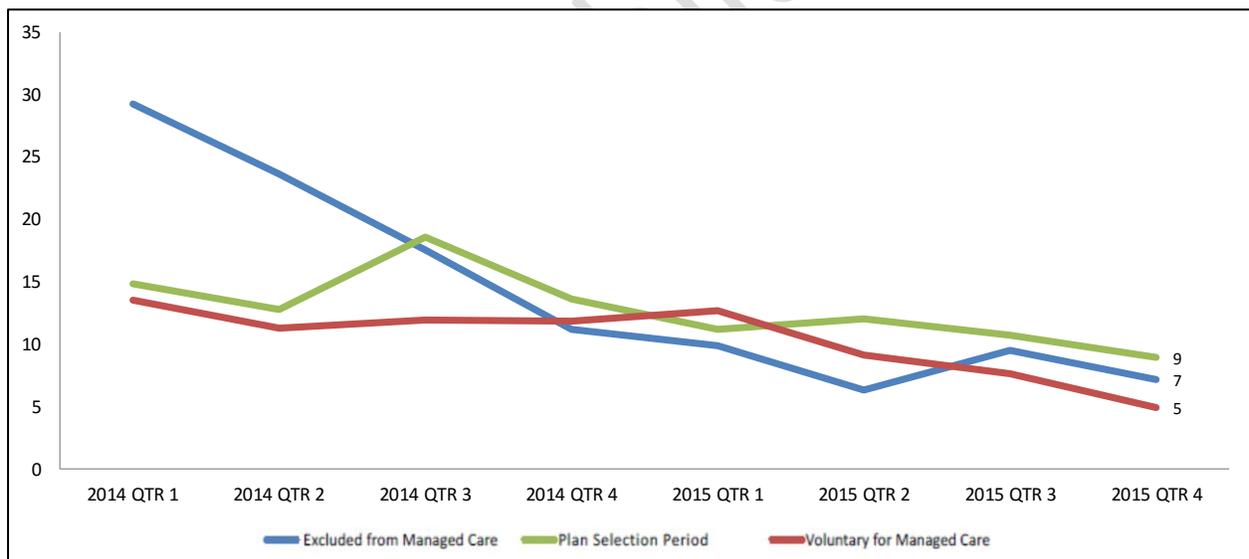


Figure 28. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



Note: For the Excluded from Managed Care category, the visit counts in all quarters were less than 30. For the voluntary category, the visit counts in Quarter 4 of 2015 were less than 30. Please use caution when interpreting the results.

Total Emergency Department Utilization

Figures in this section show the trend in quarterly use of hospital emergency departments by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data. Data are presented for the total Medicaid FFS population, broken down by age and eligibility groupings, and broken down by metropolitan and non-metropolitan areas of the State.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

- Figure 31 and Figure 33 show relatively big changes in rates from CY 2014 to CY 2015 for the elderly and/or disabled adults and Excluded from Managed Care groups. DHHS will continue monitoring these trends in the next report.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 33.

Figure 29. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

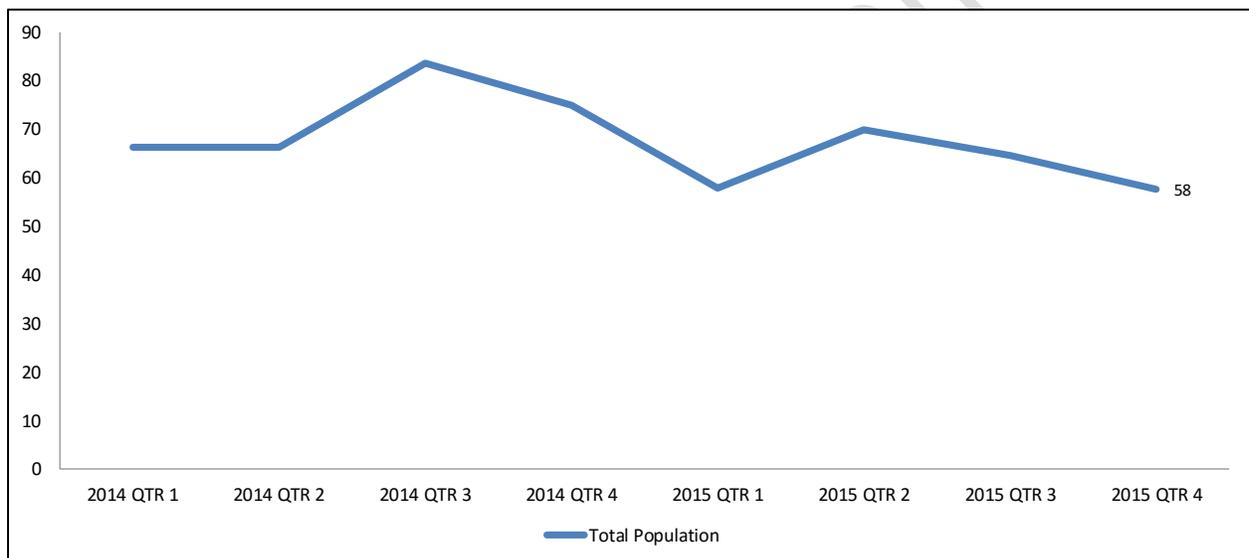


Figure 30. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

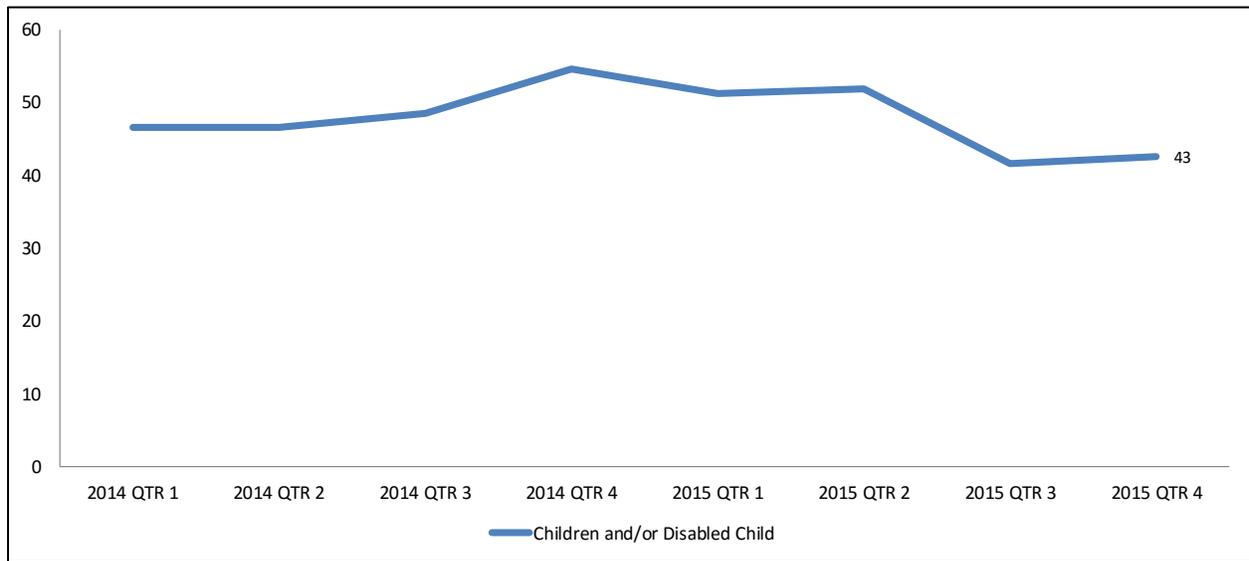
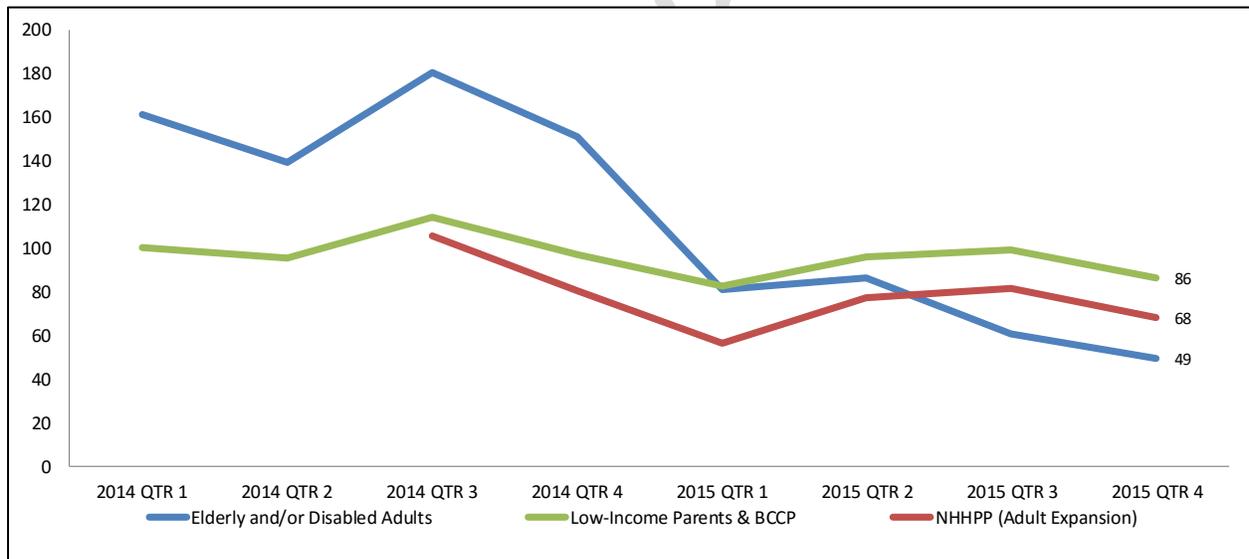


Figure 31. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014.

Figure 32. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

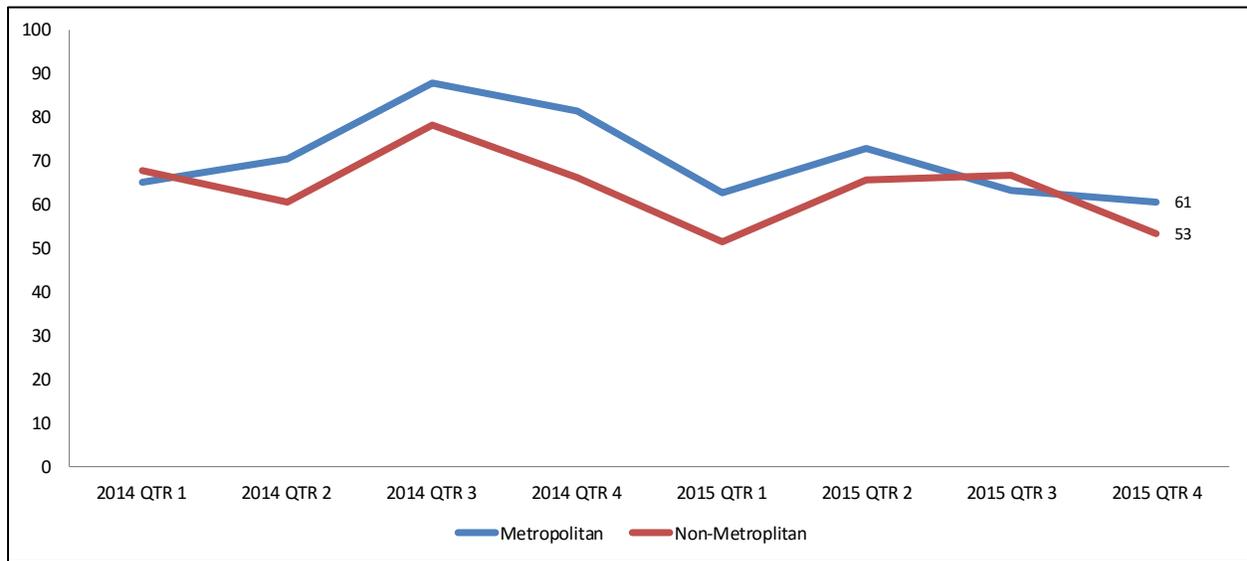
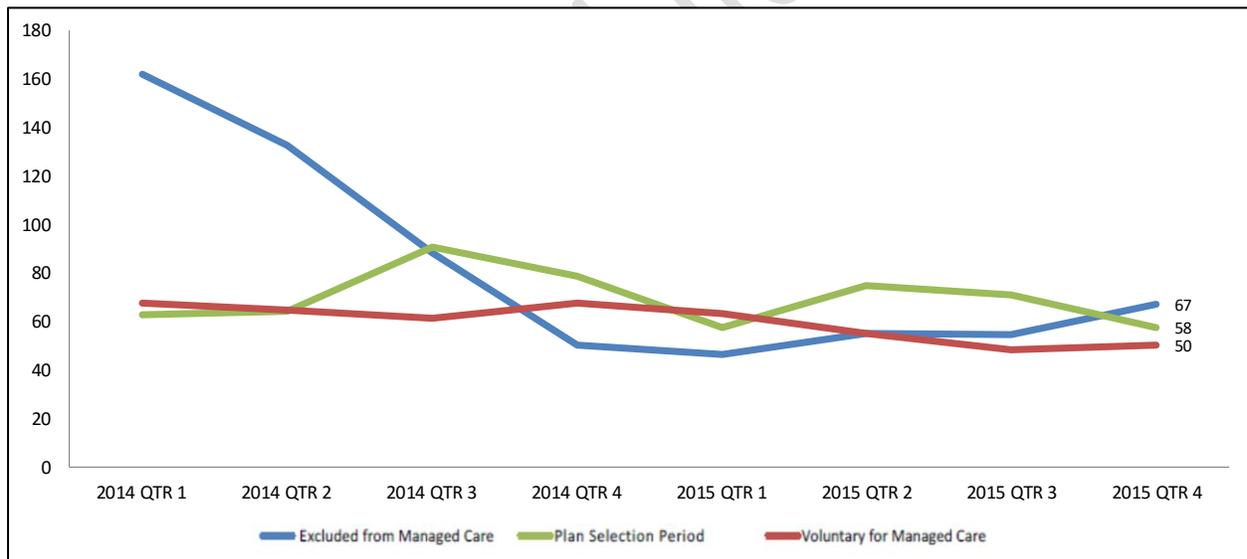


Figure 33. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-15: Excluded from Managed Care, Plan Selection Period, and Voluntary



Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions

Figures in this section show the trend in quarterly use of inpatient hospitals for ambulatory care sensitive conditions (ACSC) by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data. Rates of hospitalization for an ACSC are considered to be a measure of appropriate primary healthcare delivery. While not all admissions for these conditions are avoidable, appropriate ambulatory care can help prevent, or control, acute episodes, and improve the management of these illnesses or conditions. A disproportionately high rate of ACSC admissions may reflect underutilization of appropriate primary care. The am-

bulatory care sensitive conditions included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis, which are commonly grouped together as ACSC.¹¹

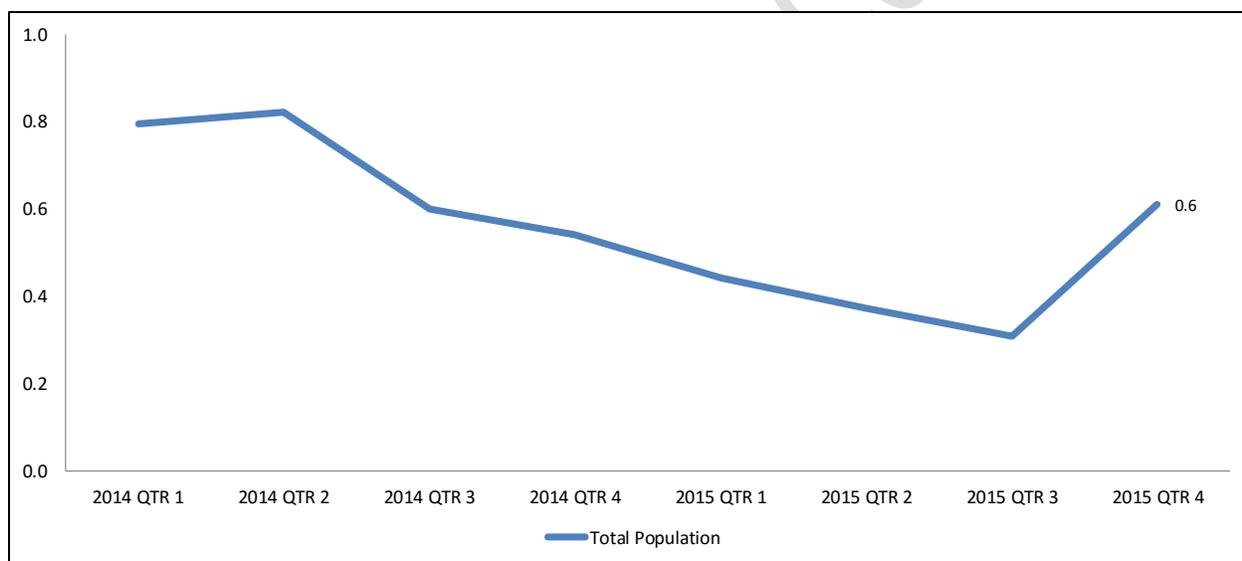
Data are only presented for the total Medicaid population due to the small number of cases that occur each quarter when broken down by age, eligibility groupings, or metropolitan and non-metropolitan areas of the state.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

- Since the FFS population became much smaller after the Medicaid managed care program transition, the numerators in each quarter for this measure were all less than 30, which means there is a larger variation. Please use cause when interpreting results.

Figure 34. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population



Note: The visit counts for all quarters were less than 30. Please use caution when interpreting results.

Total Inpatient Hospital Utilization

Figures in this section show the trend in quarterly use of general inpatient hospitals by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

Data are only presented for the total Medicaid FFS population and for the stratification by Excluded from Managed Care, Plan Selection Period, and voluntary beneficiaries due to the small number of cases in the other categories.

¹¹ Agency for Healthcare Research and Quality overall Prevention Quality Indicator Composite http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v60.aspx

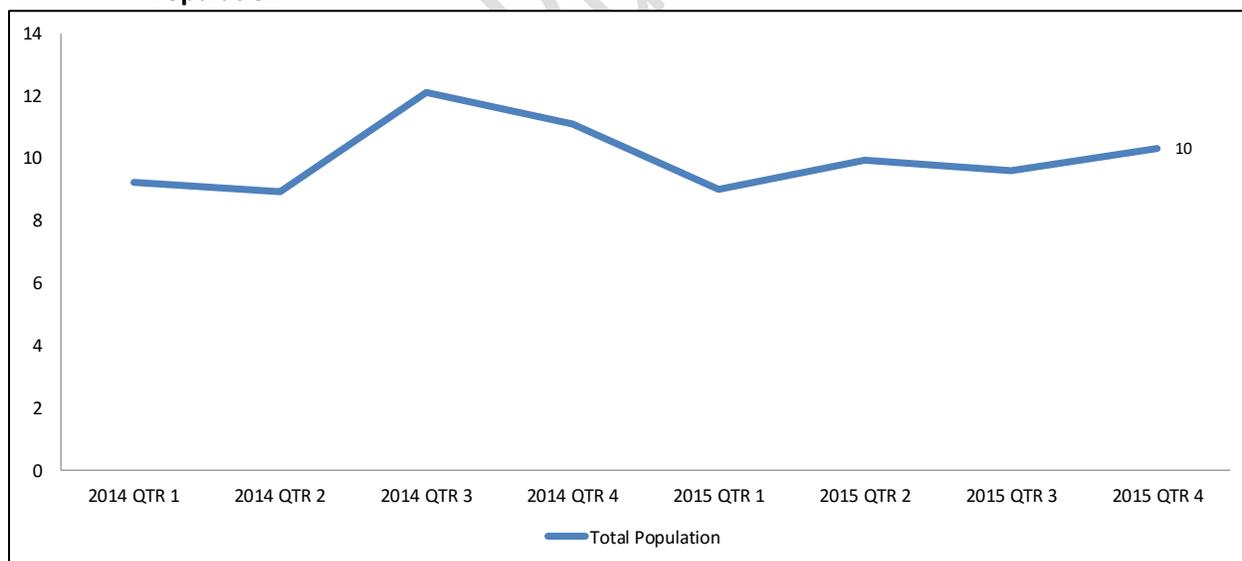
Maternity discharges (both mothers and newborns) have been removed due to declining birth rates in the Medicaid and general population. Given how common these services are in the New Hampshire Medicaid population, including them would skew the results and lead to misinterpretation.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

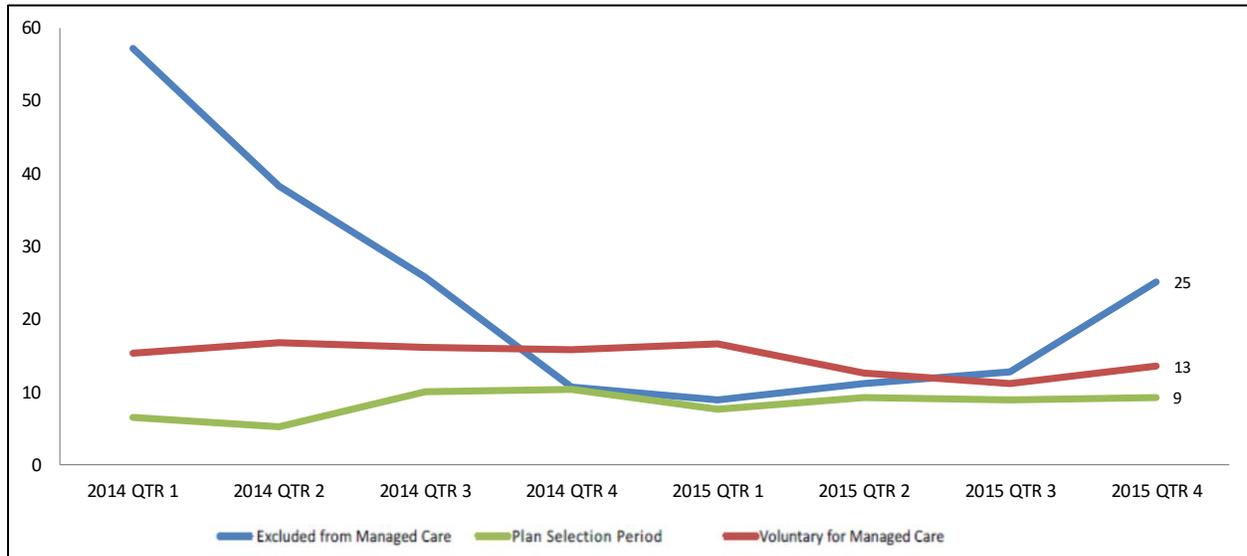
- The rates shown in Figure 56 for the total FFS population were all above the historical upper control limit.
- While the trend over time for the total population was similar to the Plan Selection Period category, the rates for the Excluded from Managed Care and voluntary categories were generally higher than the Plan Selection Period category.
- During the time frame covered by this report, the voluntary category was primarily comprised of disabled children and adults who had opted-out of the Medicaid managed care program and more likely to have a higher number of inpatient admissions.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 36.

Figure 35. Inpatient Hospital Utilization¹² per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population



¹² Excludes maternity

Figure 36. Inpatient Hospital Utilization¹³ per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



Note: For the Excluded from Managed Care category, the visit counts were less than 30 for all quarters except the first quarter. For the voluntary category, the visit count for the last quarter was less than 30. Please use caution when interpreting results.

Utilization of Cardiology Providers

Figures in this section show the trend in quarterly use of services from cardiology providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the total Medicaid FFS population, broken down by age, eligibility groupings, and metropolitan and non-metropolitan areas of the state.

Note: because the FFS population had changed dramatically after transitioning to Medicaid managed care program, new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

Since this is the first time presenting these results, they will be treated as baseline data and will be used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- Due to frequent changes to the FFS population during 2014 and 2015, the utilization over time was not very stable and contained sudden changes.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 41.

¹³ Excludes maternity

Figure 37. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

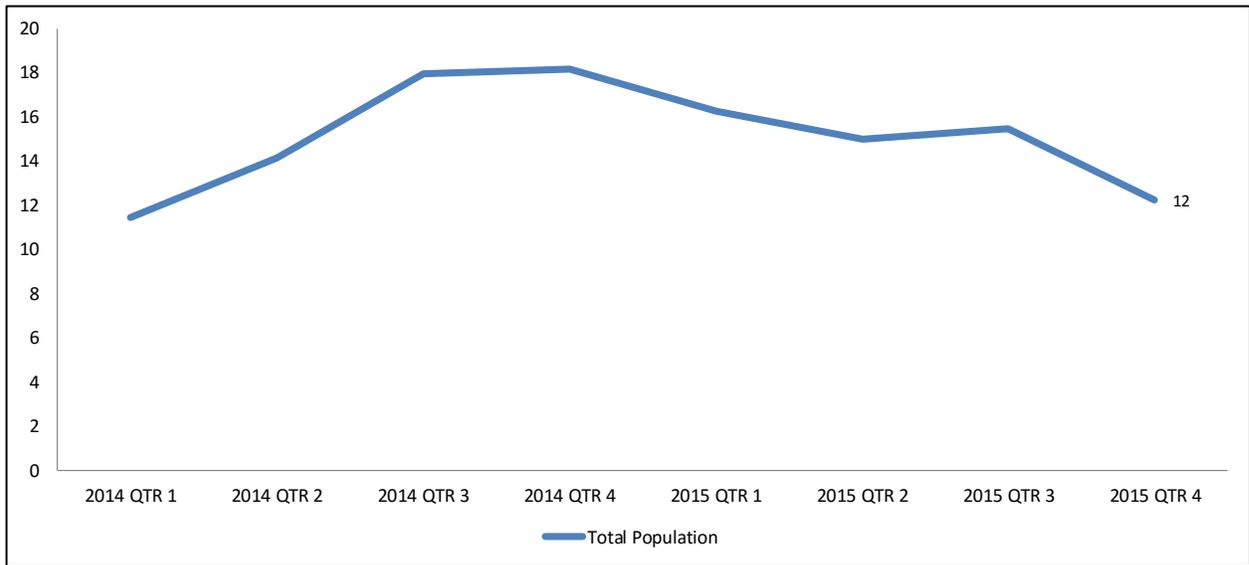


Figure 38. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

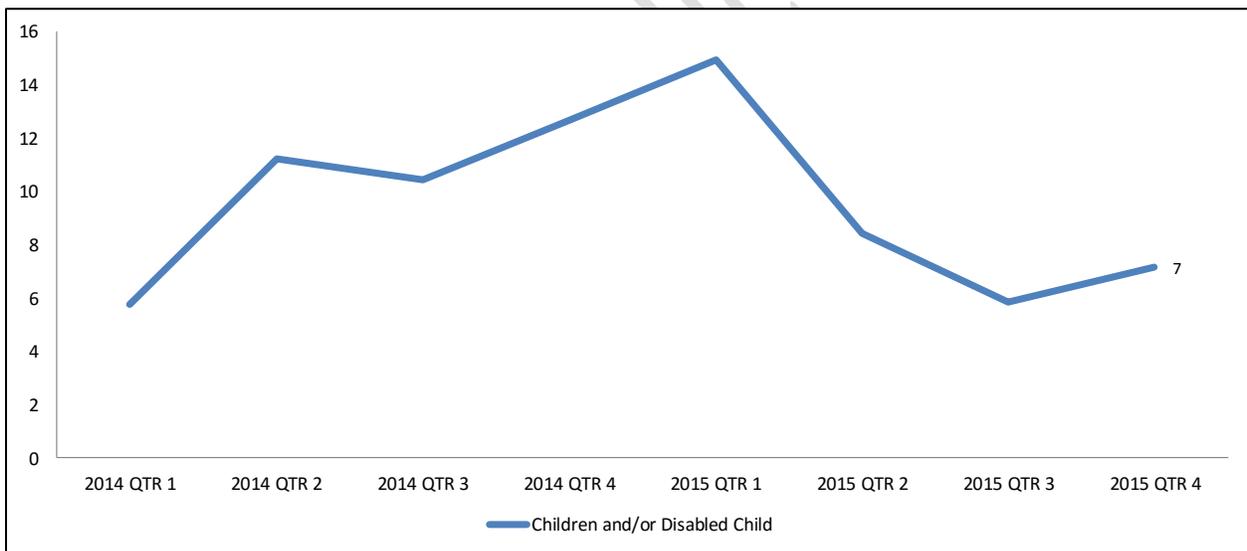
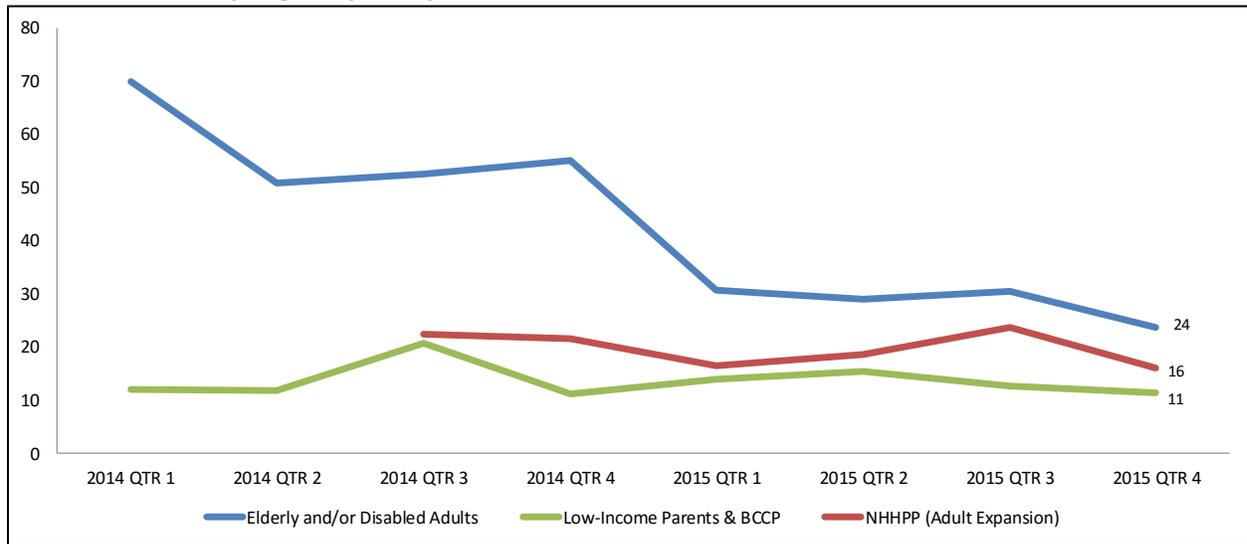


Figure 39. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, for the low-income parents & BCCP category, the visits for the last two quarters were less than 30. Please use caution when interpreting results.

Figure 40. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries: Metropolitan and Non-Metropolitan Counties

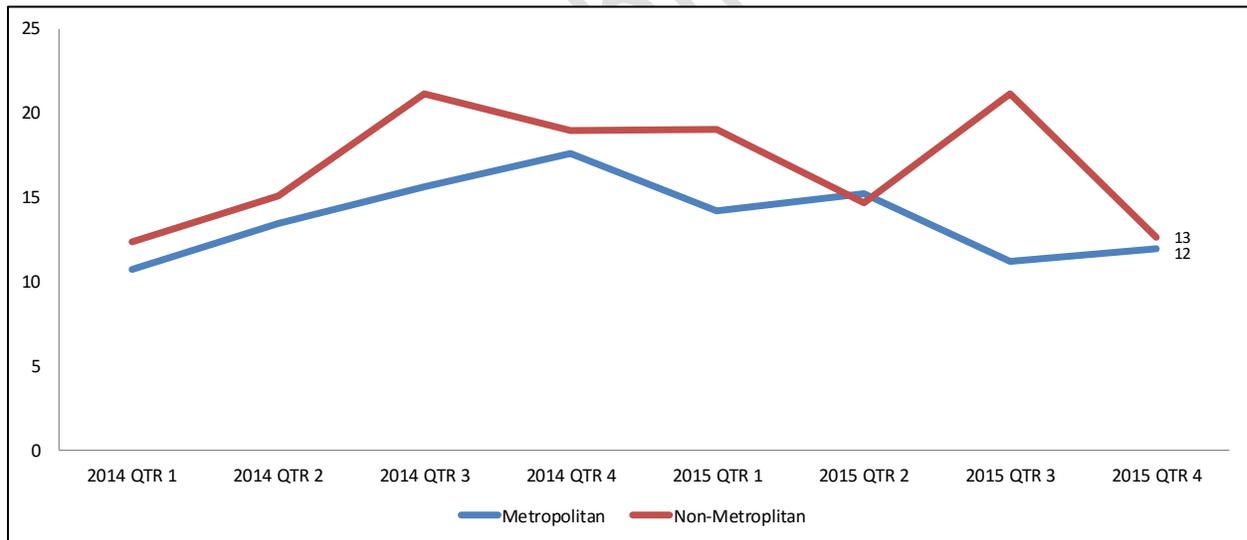
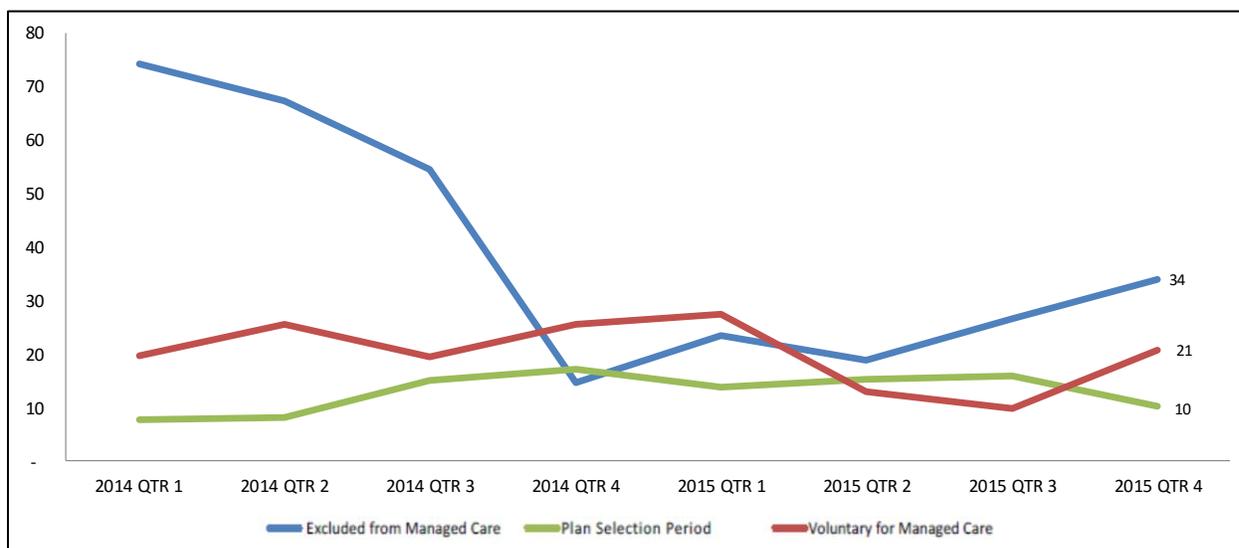


Figure 41. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



Note: For the Excluded from Managed Care category, the visits for Quarter 2 of 2015 were less than 30. Please use caution when interpreting results.

Utilization of Radiology Providers

Figures in this section show the trend in quarterly use of services from radiology providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the total Medicaid FFS population, broken down by age, eligibility groupings, and metropolitan and non-metropolitan areas of the state.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

Since this is the first time presenting these results, they will be treated as baseline data and will be used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- Due to frequent changes to the FFS population during 2014 and 2015, the utilization over time was not very stable and contained sudden changes.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPPP segment of the NHHPP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 46.

Figure 42. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

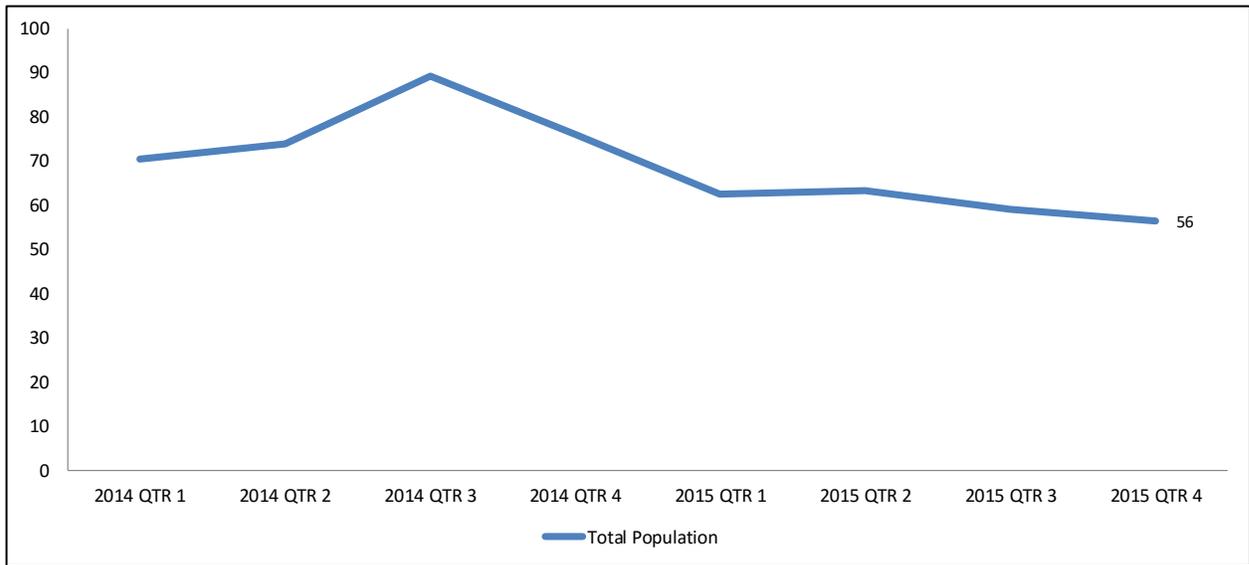


Figure 43. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

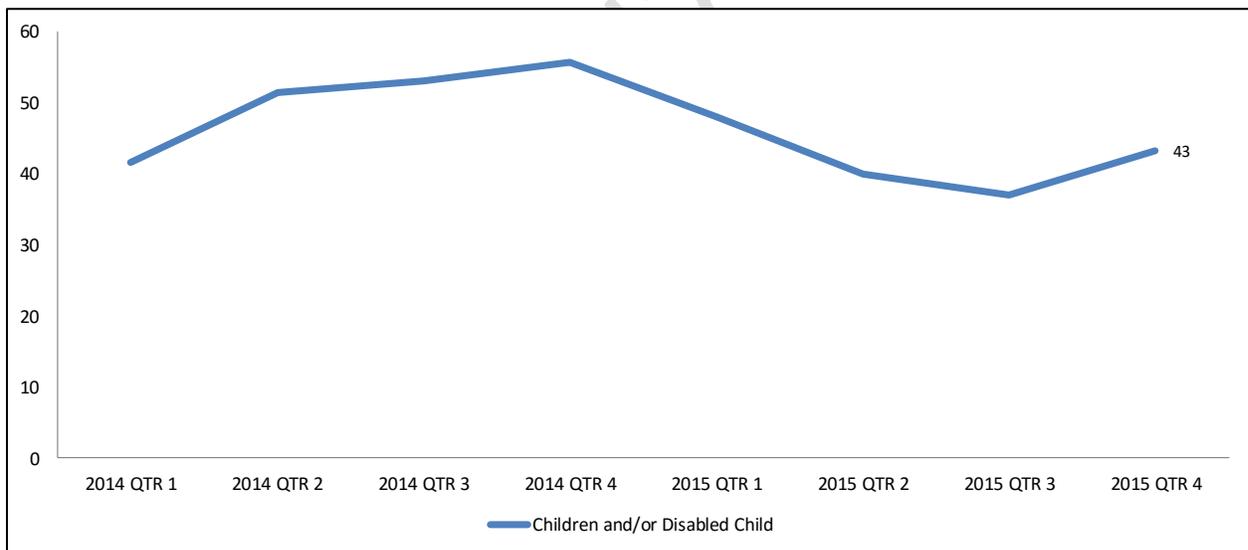
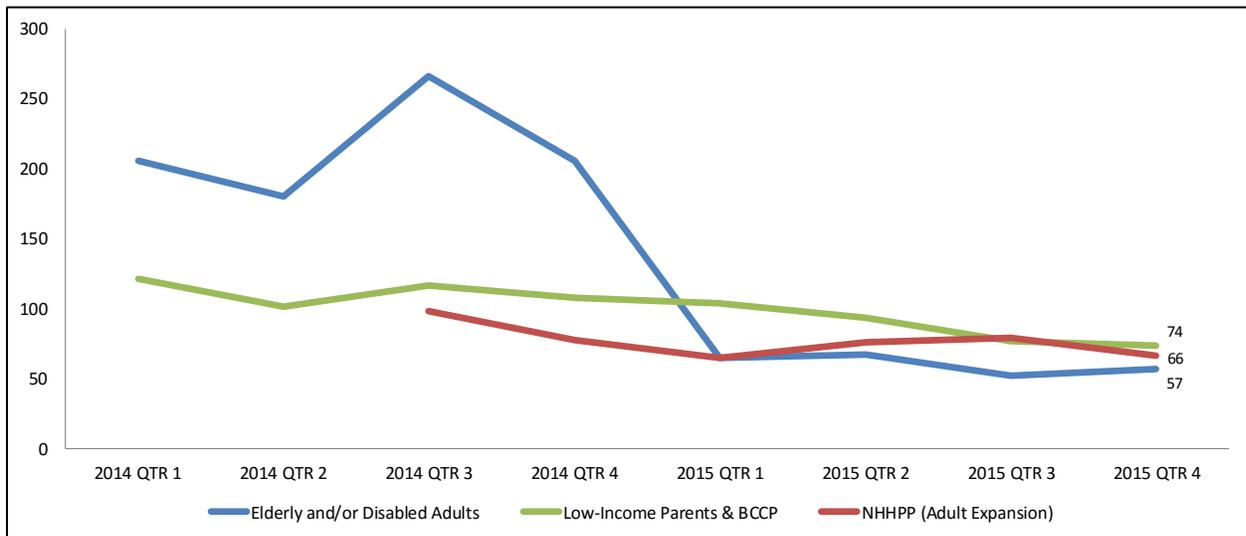


Figure 44. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014.

Figure 45. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

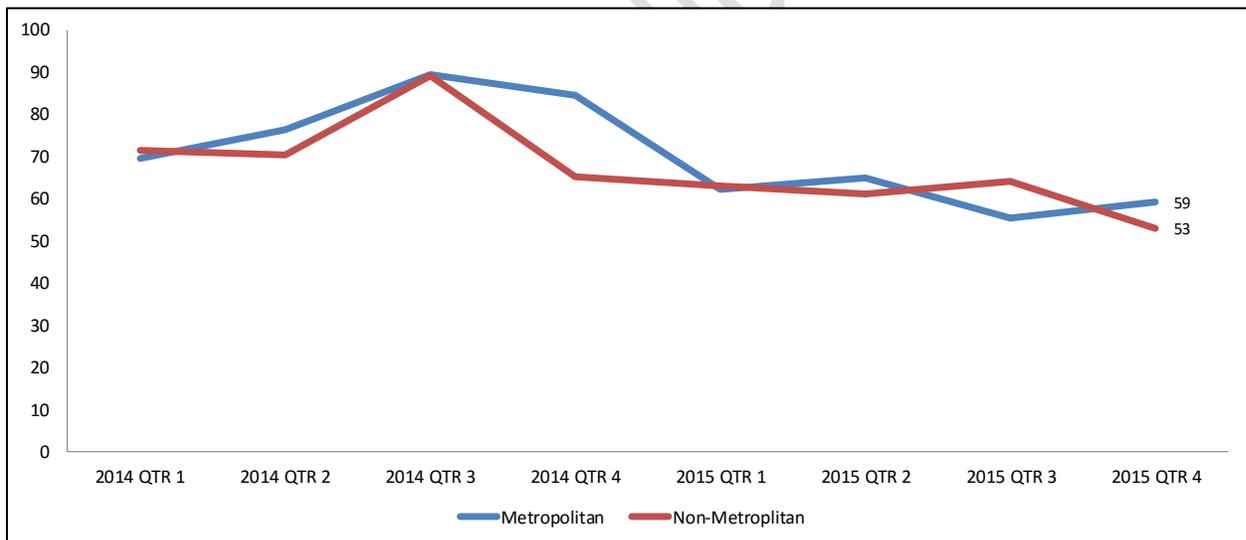
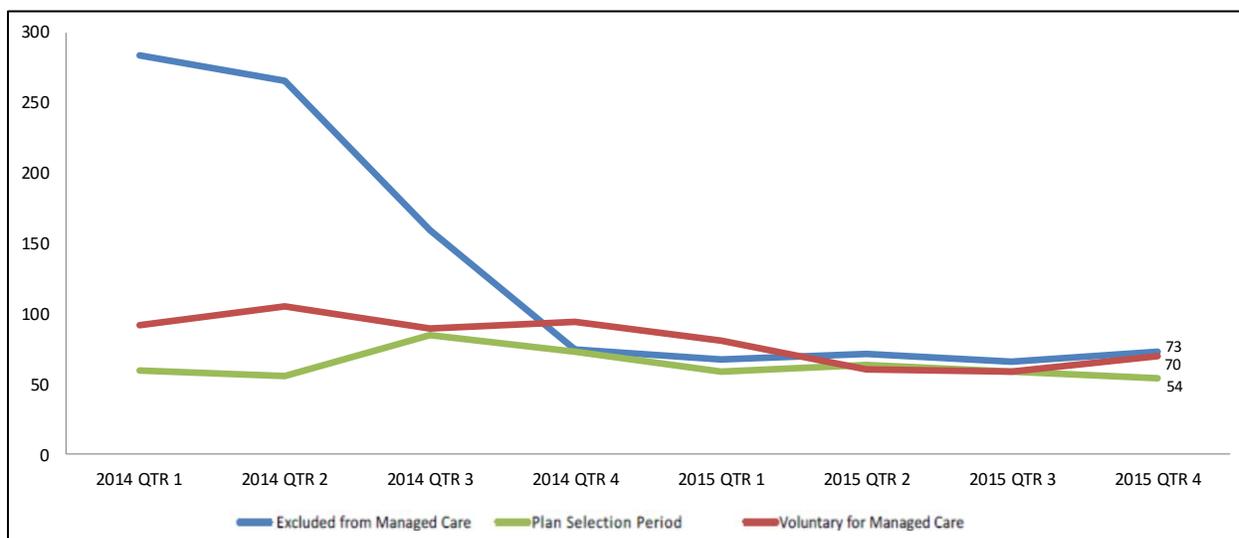


Figure 46. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



Utilization of Surgery Providers

Figures in this section show the trend in quarterly use of services from surgery providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the total Medicaid FFS population, broken out by age, eligibility groupings, and metropolitan and non-metropolitan areas of the state.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

Since this is the first time presenting these results, they will be treated as baseline data and will be used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- Due to frequent changes to the FFS population during 2014 and 2015, the utilization over time was not very stable and contained sudden changes.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 51.

Figure 47. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

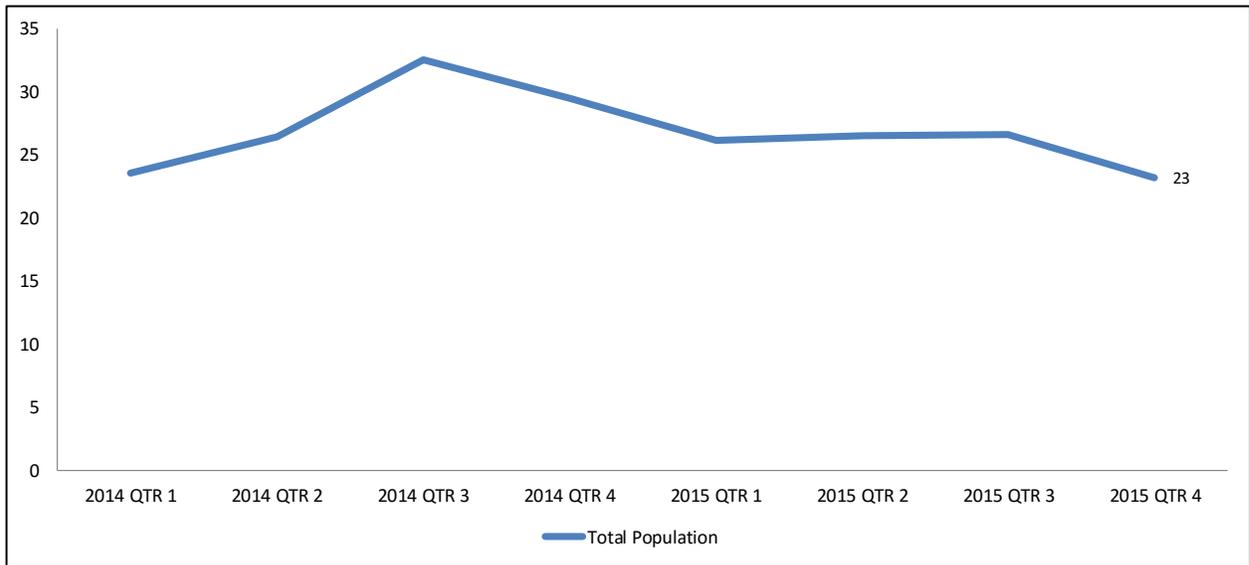


Figure 48. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

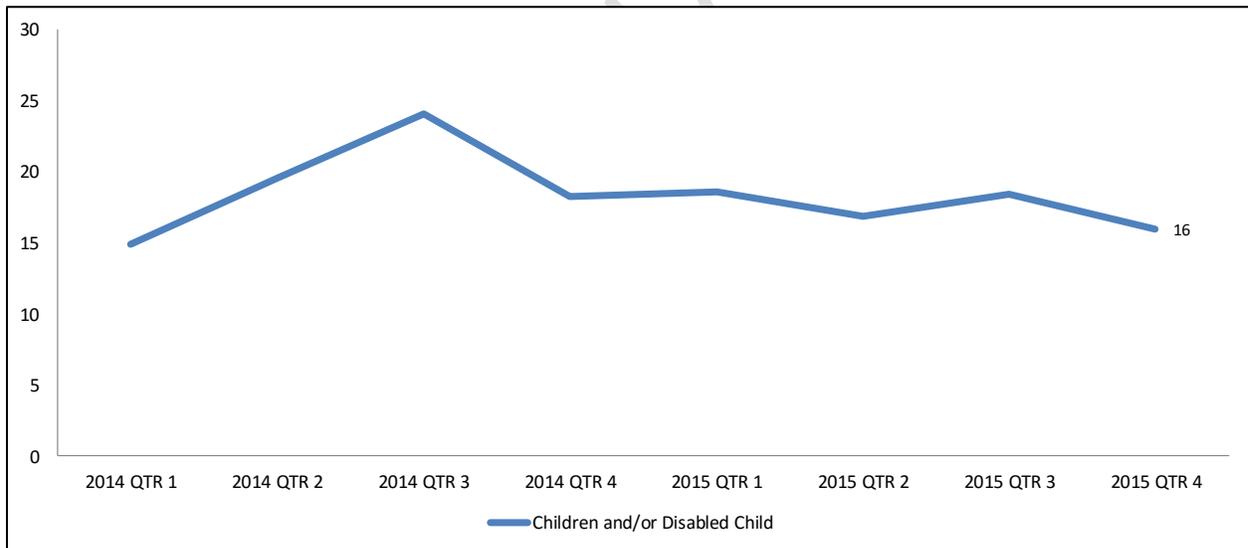
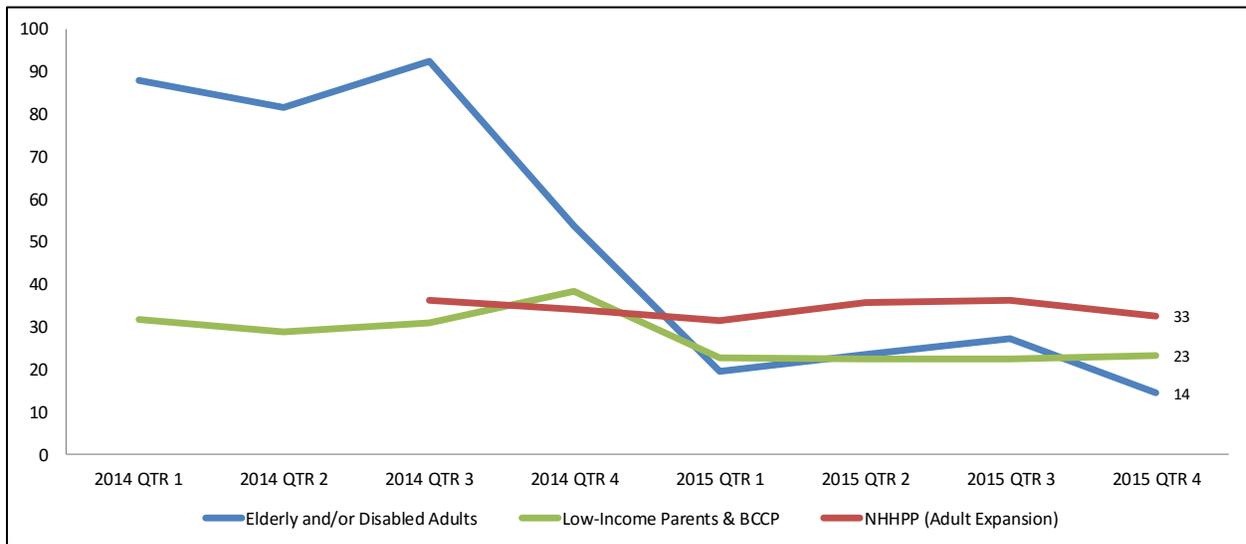


Figure 49. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, the visits from the elderly and/or disabled adults category were less than 30 for Quarters 1 and 4 of 2015. Please use caution when interpreting these results.

Figure 50. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

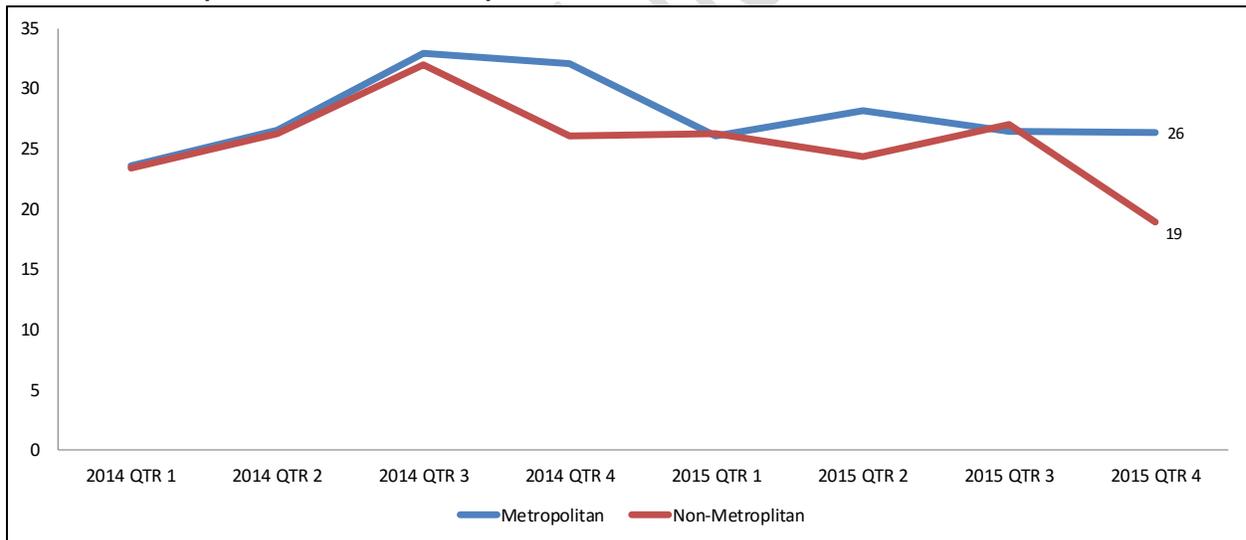
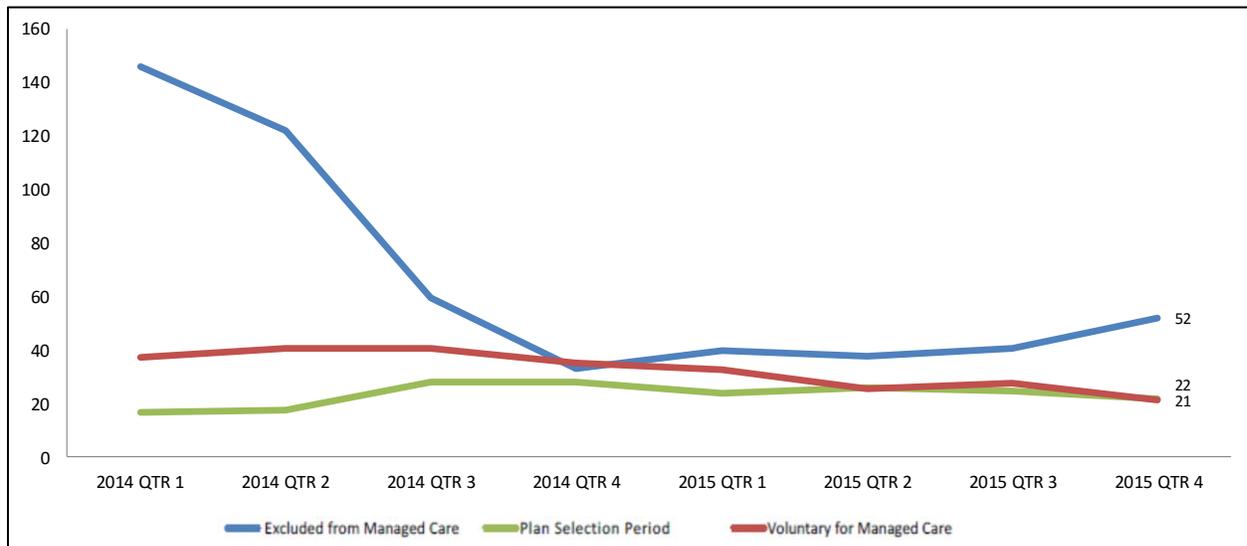


Figure 51. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



Utilization of Home Health Providers

Figures in this section show the trend in quarterly use of services from home health providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the total Medicaid FFS population, broken down by age, eligibility groupings, and metropolitan and non-metropolitan areas of the State.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

Since this is the first time presenting these results, they will be treated as baseline data and will be used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- The high utilization was primarily from the children and/or disabled child and voluntary groups.
- Due to frequent changes to the FFS population during 2014 and 2015, the utilization over time was not very stable and contained sudden changes.

Figure 52. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

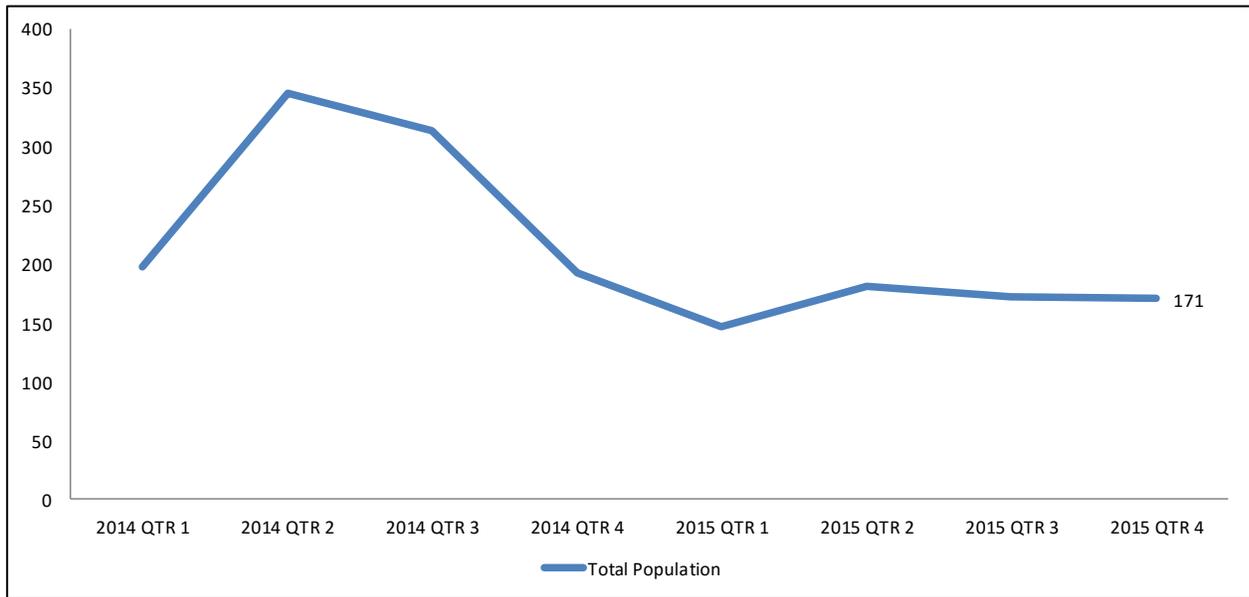


Figure 53. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

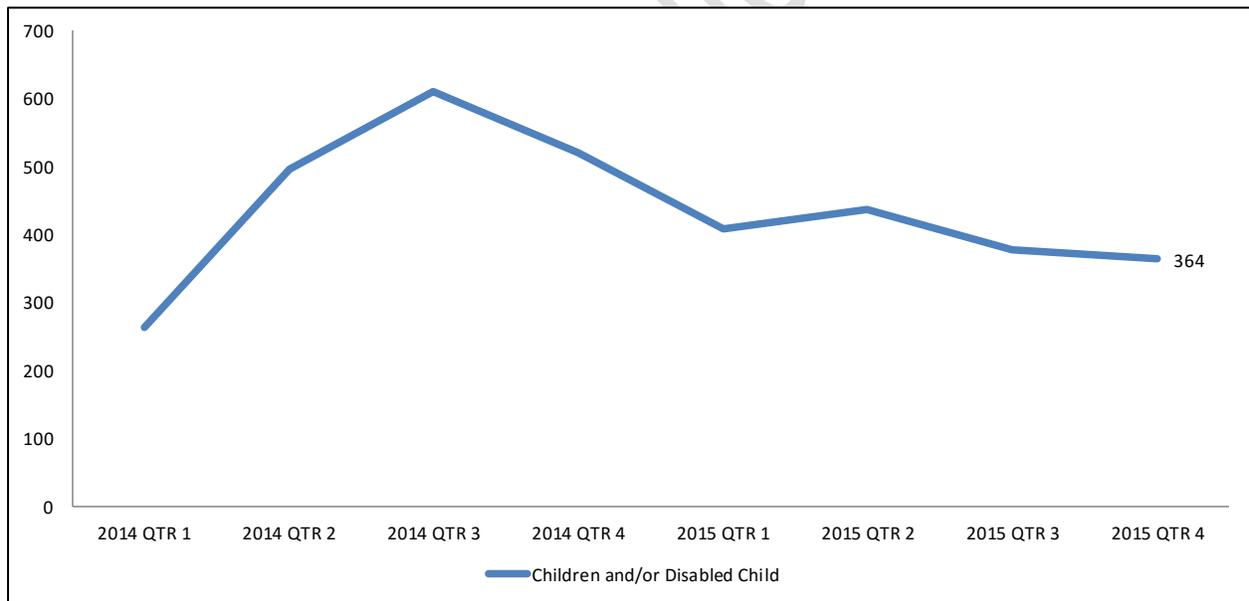
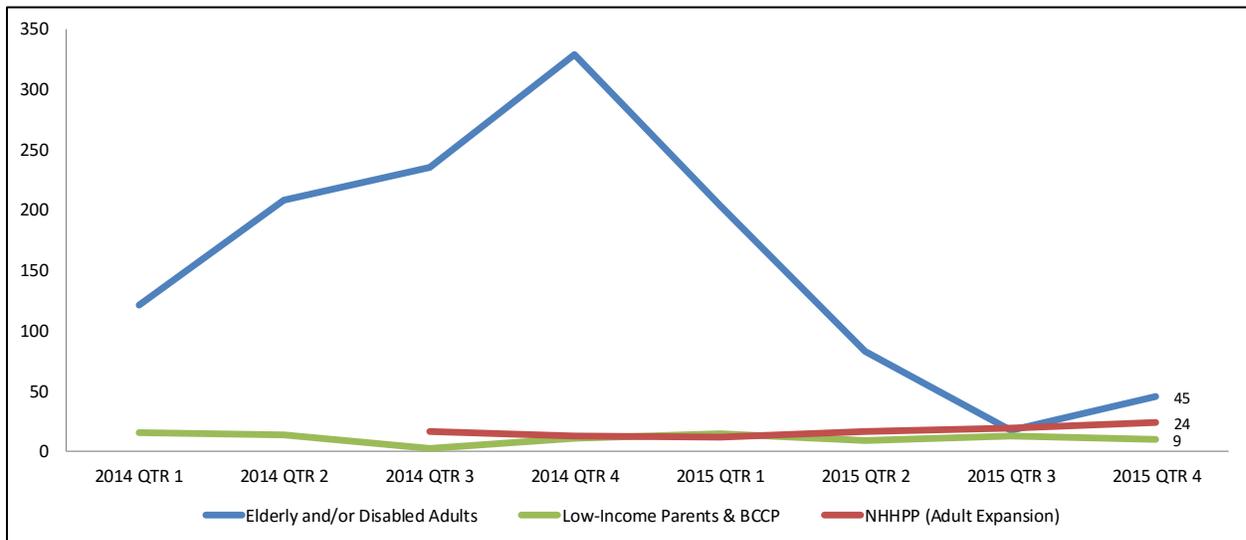


Figure 54. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, the visits from the elderly and/or disabled adults group were less than 30 for Quarter 3 of 2015. The visits from the low-income parents & BCCP group were less than 30 for Quarter 3 of 2014 and the last three quarters of 2015. Please use caution when interpreting these results.

Figure 55. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

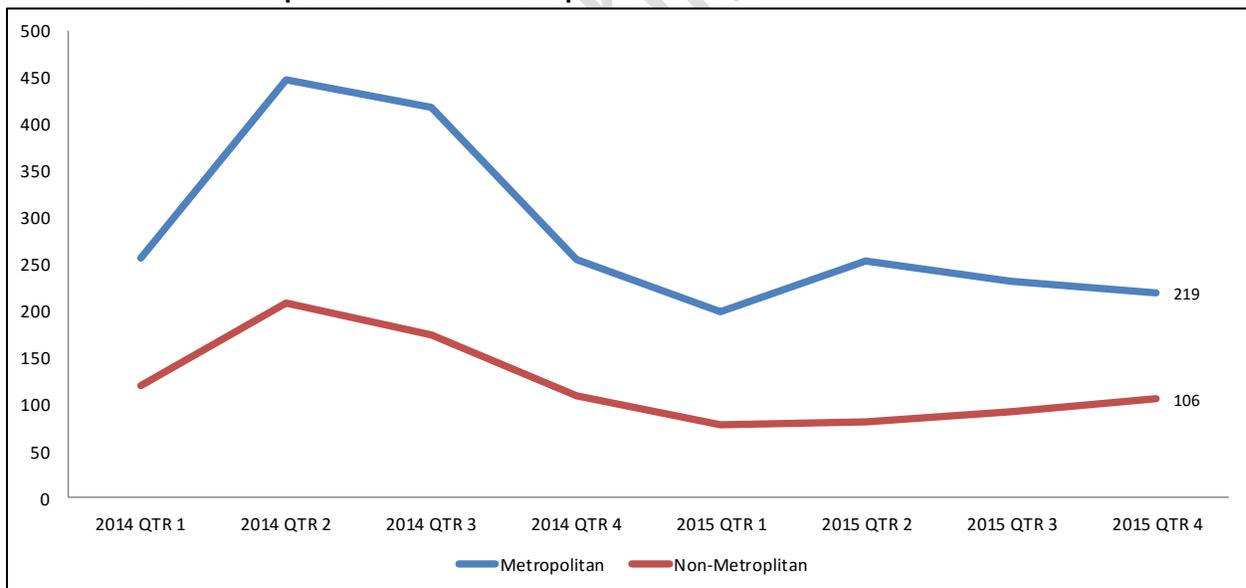
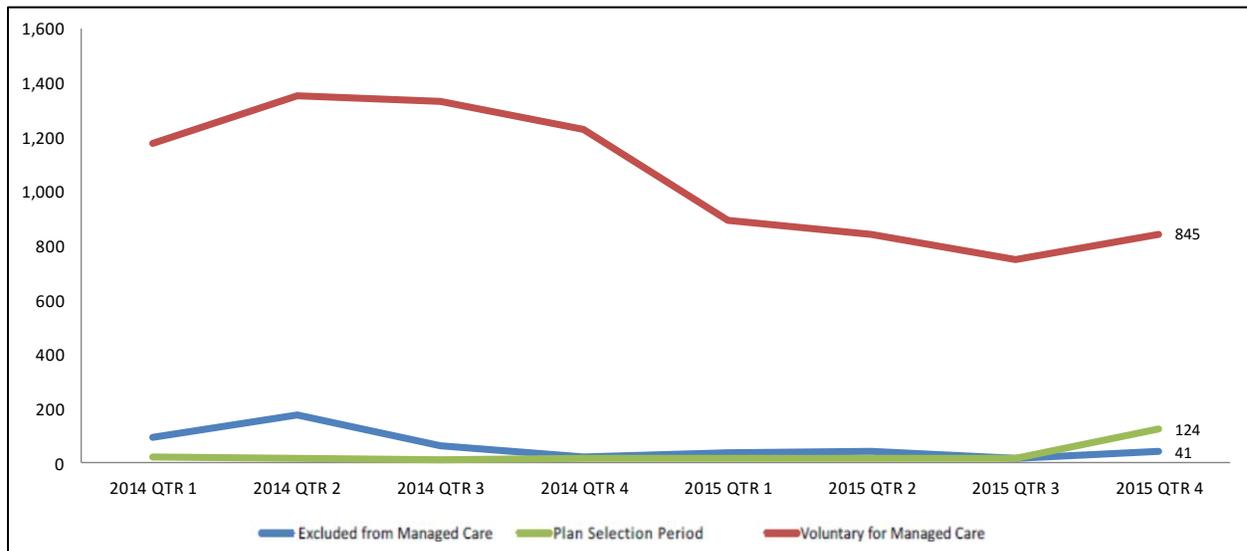


Figure 56. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



Note: The visits from the Excluded from Managed Care category were less than 30 for Quarter 3 of 2015. Please use caution when interpreting these results.

Mental Health Utilization

Figures in this section show the trend in quarterly use of mental health services by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data. The mental health services were defined based on the National Committee for Quality Assurance (NCQA) measure *Mental Health Utilization* from the Healthcare Effectiveness Data and Information Set (HEDIS[®]14) 2016.

Data are presented for the total Medicaid FFS population, broken down by age, eligibility groupings, and metropolitan versus non-metropolitan areas of the state.

Note: because the FFS population had changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

Since this is the first time presenting these results, they will be treated as baseline data and will be used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- Due to frequent changes to the FFS population during 2014 and 2015, the utilization over time was not very stable and contained sudden changes.

¹⁴ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Figure 57. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

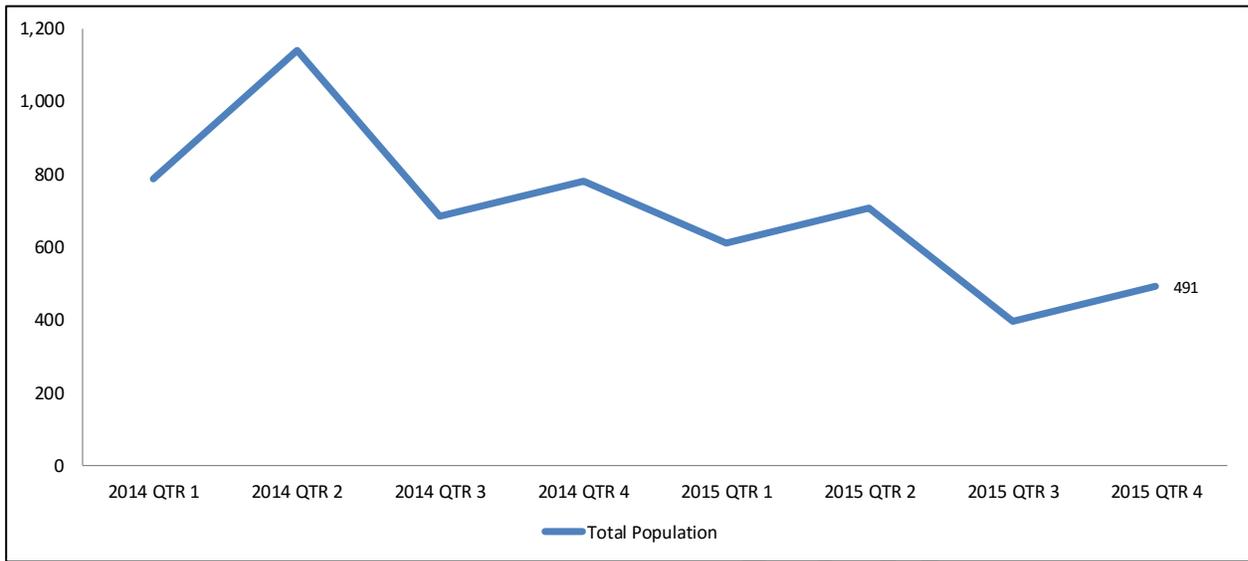


Figure 58. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

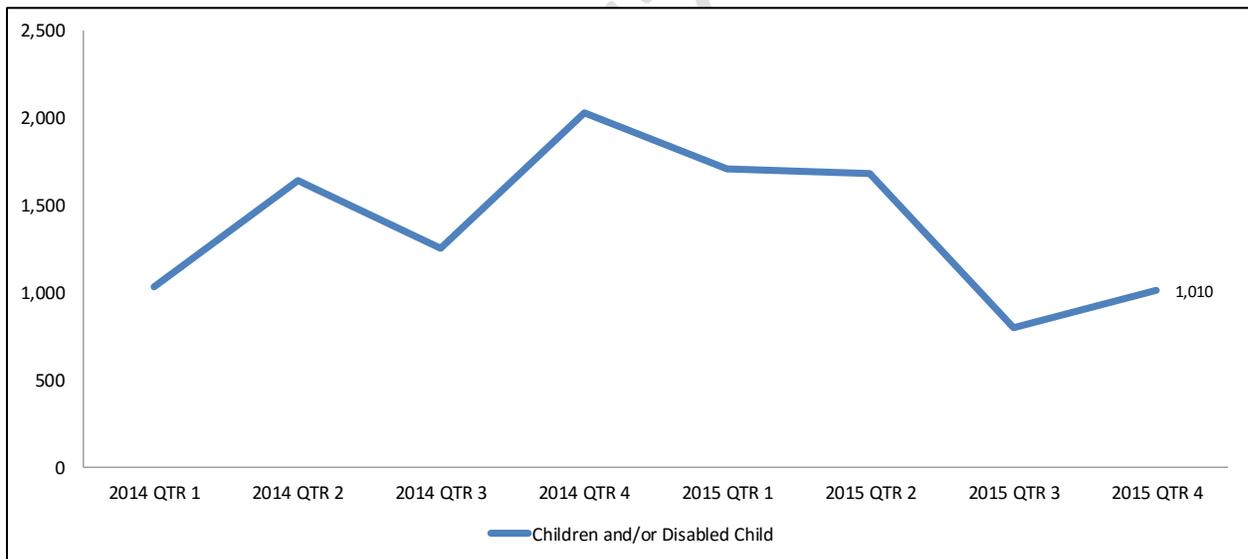
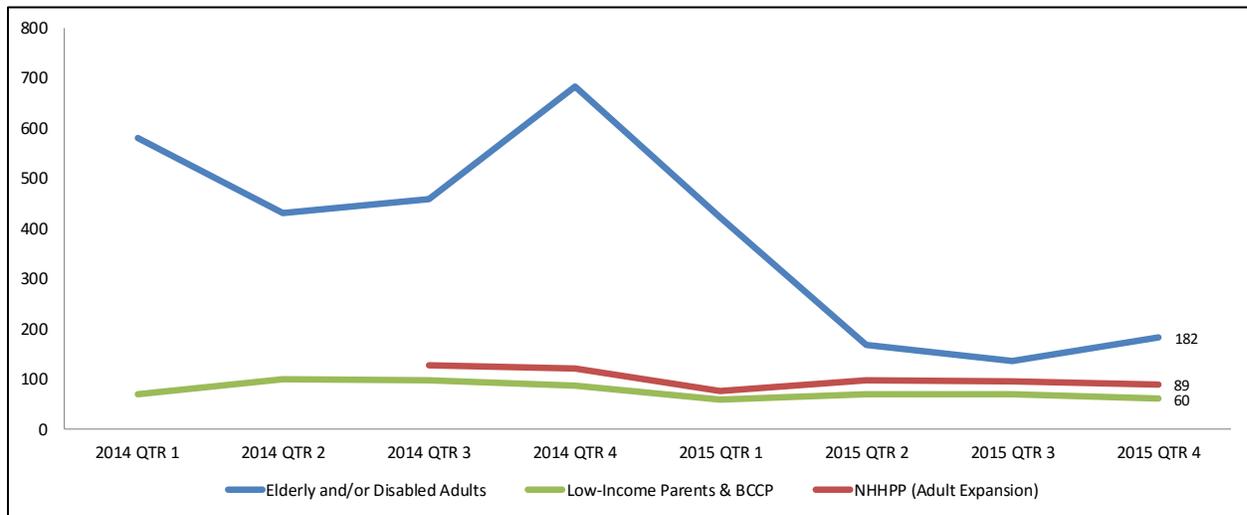


Figure 59. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group



Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014.

Figure 60. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

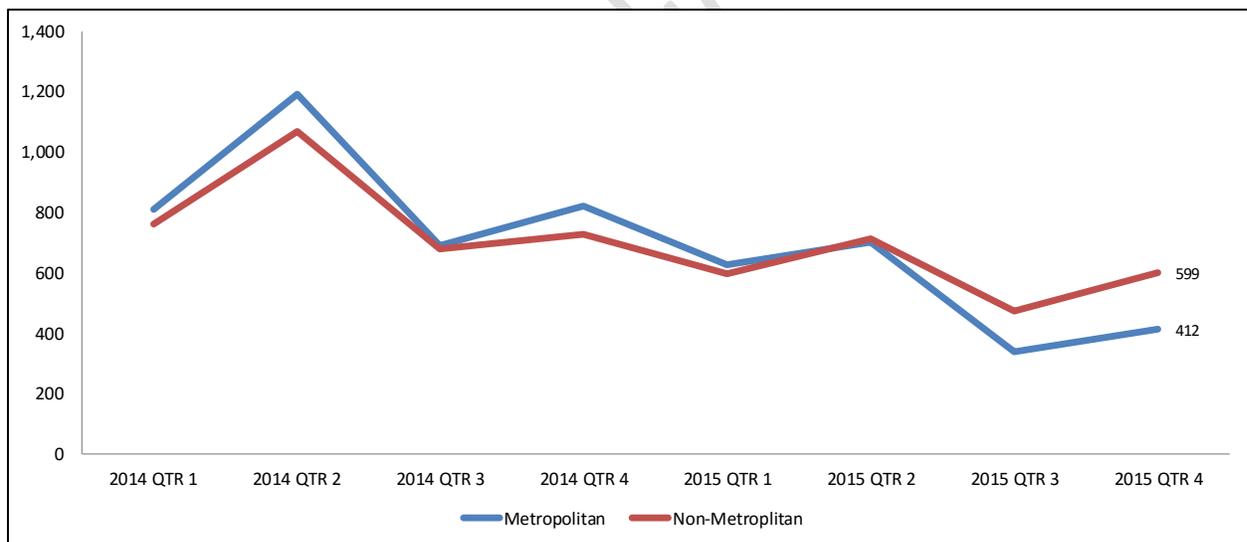
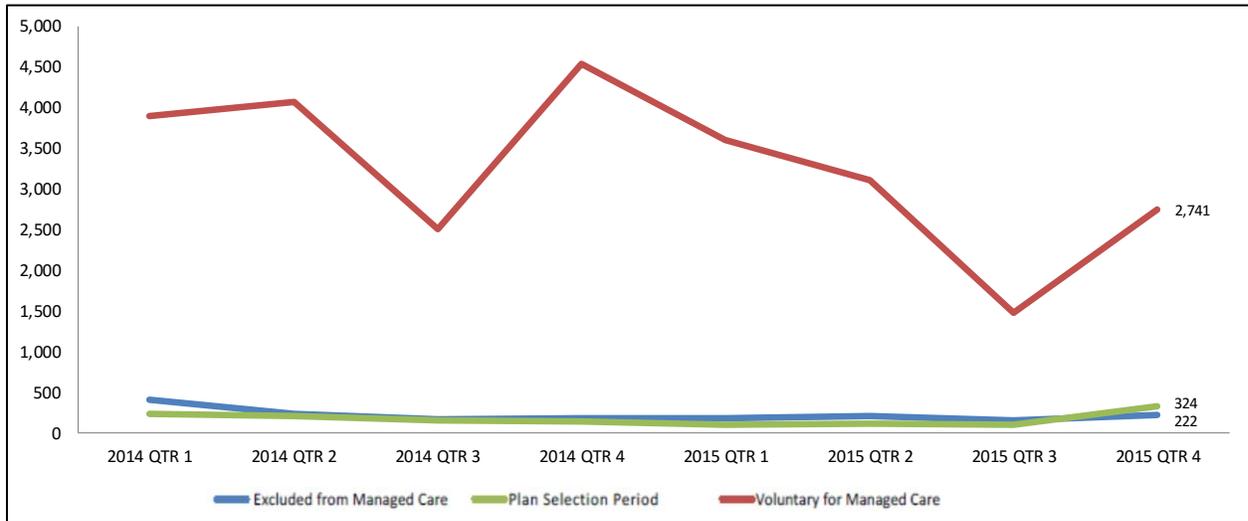


Figure 61. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary



DRAFT for Public Comment

6. Summary, Conclusion and Efforts to Improve Access

Ensuring access to care is a priority of the New Hampshire Medicaid program. The foregoing report provides specific data and analysis that establish the 2014 and 2015 access levels for physician services, inpatient and outpatient services, all of which establish the following:

New Hampshire Medicaid's systematic monitoring of access indicators help identify access problems for beneficiaries. Should access issues arise, New Hampshire Medicaid will take corrective actions, as set forth in Chapter 3 to resolve access issues for New Hampshire Medicaid beneficiaries.

New Hampshire Medicaid presented evidence, set forth in Chapter 4 of the report, that indicates that it has regular, ongoing engagement with Medicaid beneficiaries in order to assess the unique characteristics and needs of beneficiaries, to monitor access to healthcare and other issues of concern to beneficiaries and to intervene on the behalf of any beneficiary requesting assistance with provider availability and access, or with any other issue creating a barrier to access.

Analytic access monitoring plans and procedures, set forth in Chapter 4, indicate that New Hampshire is well positioned to systematically monitor beneficiary needs, the strength and availability of the provider network, and beneficiary utilization of healthcare services as follows:

- **Beneficiary enrollment:** After transitioning to the Medicaid managed care program in December 2013, the size of the FFS population became much smaller and continued to change in 2014 and 2015. This reduction in the FFS population, that continues into 2016 necessitates a new approach to access monitoring from New Hampshire's prior reports.
- **Provider network:** The majority (75%) of licensed practicing physicians were also New Hampshire Medicaid providers in 2015. In addition, while the FFS population became much smaller in size, one-third to two-thirds of the FFS providers were still servicing the FFS population (i.e., submit at least one claim in Quarter 4 of 2015) for the provider types evaluated in the report.
- **Time/distance analysis:** When applying MCO contract time/distance standards for the primary care providers to FFS beneficiaries as of May 1, 2016, all FFS beneficiaries met the standard.
- **Beneficiaries to active providers ratio:** The beneficiaries to active primary care providers and pediatricians ratios in CY 2014 and 2015 were much lower than the historical ratios and do not indicate any access to care concerns. These lower ratios are due to the large reduction in the FFS population.
- **Quarterly service utilization:** The 2014 and 2015 FFS population consisted of a considerable amount of Plan Selection Period beneficiaries who stayed in FFS temporarily for a few months and then transitioned to the Medicaid managed care program. These Plan Selection Period beneficiaries generally had lower physician/APRN/clinic utilization, but higher rates of emergency department utilization for conditions potentially treatable in primary care. However, this may not indicate potential issues

for access to care, but simply beneficiaries waiting until managed care enrollment before engaging with primary care.

- DHHS will continue monitoring the rates and will develop new control limits for the new FFS population as the FFS population stabilizes and sufficient data are collected in future access reports.
- Other measures included in this report are beneficiaries to active cardiology, radiology, surgery, and home health provider ratios; and quarterly service utilization from cardiology, radiology, surgery, and home health providers in addition to mental health utilization. Since this is the first time presenting these results, they were presented for informational purposes only and will be used to develop control limits as the FFS population stabilizes and sufficient data are collected in future reports.

New Hampshire Medicaid routinely monitors access indicators, i.e. beneficiary enrollment and demographics, provider enrollment and availability, and beneficiary utilization of health care services and will produce an annual report similar to the report set forth above to measure and monitor beneficiary access to healthcare in New Hampshire. With the ability to identify access issues as they arise comes the concomitant ability of New Hampshire Medicaid to respond effectively to correct those issues. Currently the data do not indicate existing or projected access problems, however, should an access issue be identified through these monitoring systems, DHHS is ready to take corrective action measures on both a localized and system-wide basis through the processes set forth in this report.

Furthermore, NH Medicaid will continue to review and refine its monitoring and response plans to assure that the report continues to add meaningful information and value to policy discussions and to the administration of the Medicaid Program.

Current Efforts to Improve Access to Care

In response to access monitoring and beneficiary needs assessment, effective July 1, 2016, all NH Medicaid beneficiaries, including the FFS population, have access to substance use disorder treatment services as part of their benefit package. This benefit will include screening and brief intervention, outpatient treatment, residential treatment, medication assisted treatment and recovery support services.

Additionally, New Hampshire has begun a concerted effort to build capacity to deliver care for substance use disorders as part of the Section 1115 Medicaid waiver “Building Capacity for Transformation” awarded by CMS in January 2016. This waiver will allow the state to invest \$150 million over five years to transform the state’s behavioral health delivery system. The primary goal of this effort is to provide, better more cost-effective support to Medicaid beneficiaries, by building capacity, integrating physical and behavioral health care and ensuring smooth transitions of care.

Recognizing issues surrounding the workforce shortage of health care professionals, including personnel providing substance use disorder services, the Governor created the Commission on Health Care Workforce in April 2016. The Commission brings together experts from nursing, child and elderly care, developmental and long-term services, the broader health care community, and education to make short- and long-term recommendations on how to resolve the workforce shortage. As part of the Governor’s Commission, the Healthcare Task Force will work to engage providers and health systems to prevent and address substance misuse.

Legislation passed in June 2016 will play an important role in attracting and retaining substance misuse providers to New Hampshire. In addition, new resources were provided in June 2016 to the state's Primary Care Association to bolster their efforts to recruit substance use disorder professionals, as well as primary care, dental and behavioral health providers.

DRAFT for Public Comment

7. Appendices

DRAFT for Public Comment

Appendix A: Definitions

Bridge to Marketplace Program - A transition program that enrolled New Hampshire Health Protection Program beneficiaries into New Hampshire's Medicaid managed care program beginning in August 2014. The program ended on December 31, 2015 and the majority of the members enrolled transitioned to the Premium Assistance Program.

Excluded from Managed Care - Beneficiaries who will never be mandatory for Medicaid Managed Care such as members receiving medical benefits from the Office of Veterans Affairs

Fee-for-Service only (FFS) - New Hampshire Medicaid beneficiaries who are in a managed care plan selection period, excluded from managed care or voluntary for managed care.

Health Insurance Premium Payment Program (HIPP) - An early program beginning in August of 2014 that enrolled New Hampshire Health Protection Program beneficiaries into employee sponsored health care. Beneficiaries were enrolled after an assessment of access to cost-effective employer sponsored coverage.

New Hampshire Health Protection Program (NHHPP) - A program to expand NH Medicaid to Adults age 19 to 64 beginning in August of 2014. The NHHPP program consisted of three parts: the Health Insurance Premium Program; a Bridge to Marketplace Premium Assistance Program; and the Premium Assistance Program.

Premium Assistance Program (PAP) – A program beginning on January 1, 2016, for non-medically frail New Hampshire Health Protection Program beneficiaries transitioned from the Bridge to Marketplace program. Under the PAP program, beneficiaries receive premium assistance to purchase health coverage from Qualified Health Plans (QHPs) in the health insurance marketplace.

Plan Selection Period - Beneficiaries in their plan selection period who will shortly move to Medicaid managed care program or Qualified Health Plans within the next two months.

Voluntary for Managed Care - Beneficiaries who initially opted out of Medicaid managed care program before February 1, 2016 and who transition into Medicaid managed care program in February 1, 2016 due to the implementation of New Hampshire's 1915b waiver (subsequent reporting will remove this category).

Appendix B: Tabular Version of Data in Trend Charts

Figure 6. NH Medicaid Enrollment: Total Population

Time Period	Average Members
2014 QTR 1	10,068
2014 QTR 2	6,089
2014 QTR 3	6,656
2014 QTR 4	10,486
2015 QTR 1	11,325
2015 QTR 2	8,927
2015 QTR 3	7,594
2015 QTR 4	7,655

Figure 7. NH Medicaid Enrollment: Children and/or Disabled Child

Time Period	Average Members
2014 QTR 1	7,159
2014 QTR 2	4,029
2014 QTR 3	3,224
2014 QTR 4	3,577
2015 QTR 1	3,655
2015 QTR 2	3,431
2015 QTR 3	3,254
2015 QTR 4	3,312

Figure 8. NH Medicaid Enrollment: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults	Low-Income Parents & BCCP	NHHP (Adult Expansion)
2014 QTR 1	672	2,237	0
2014 QTR 2	421	1,639	0
2014 QTR 3	375	1,230	1,826
2014 QTR 4	236	1,025	5,648
2015 QTR 1	391	942	6,337
2015 QTR 2	540	803	4,153
2015 QTR 3	516	714	3,110
2015 QTR 4	533	760	3,050

Figure 9. NH Medicaid Enrollment: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan	Non-Metropolitan
2014 QTR 1	5,717	4,351
2014 QTR 2	3,497	2,592
2014 QTR 3	3,799	2,856
2014 QTR 4	5,964	4,522
2015 QTR 1	6,427	4,898
2015 QTR 2	5,193	3,734
2015 QTR 3	4,330	3,263
2015 QTR 4	4,412	3,243

Figure 10. NH Medicaid Enrollment: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care	Plan Selection Period	Voluntary
2014 QTR 1	274	8,264	1,531
2014 QTR 2	183	4,431	1,475
2014 QTR 3	324	4,818	1,513
2014 QTR 4	749	8,214	1,523
2015 QTR 1	640	9,028	1,657
2015 QTR 2	477	6,698	1,752
2015 QTR 3	600	5,364	1,630
2015 QTR 4	373	6,737	545

Figure 11. Active NH Medicaid In-State Physician Providers Compared to Licensed Providers With NH Billing Address, 2015

Geographic Area	Active Medicaid Providers	Active Non-Medicaid Providers
Total In-State	3,081	1,028
Metropolitan	1,652	515
Non-Metropolitan	1,429	513

Figure 12. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians) , CY 2014-2015

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	1,352	10,068	7	770	5,717	7	582	4,351	7
2014 QTR 2	1,154	6,089	5	669	3,497	5	485	2,592	5
2014 QTR 3	1,307	6,656	5	748	3,799	5	559	2,856	5
2014 QTR 4	1,450	10,486	7	827	5,964	7	623	4,522	7
2015 QTR 1	1,410	11,325	8	796	6,427	8	614	4,898	8
2015 QTR 2	1,324	8,927	7	770	5,193	7	554	3,734	7
2015 QTR 3	1,184	7,594	6	679	4,330	6	505	3,263	6
2015 QTR 4	1,180	7,655	6	693	4,412	6	487	3,243	7

Figure 13. Ratio of NH Medicaid FFS Child Beneficiaries to Active In-State Pediatricians, CY 2014-2015

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	0 to 18 Members	Ratio	Providers	0 to 18 Members	Ratio	Providers	0 to 18 Members	Ratio
2014 QTR 1	229	7,159	31	138	4,126	30	91	3,033	33
2014 QTR 2	224	4,029	18	134	2,362	18	90	1,667	19
2014 QTR 3	216	3,224	15	132	1,877	14	84	1,348	16
2014 QTR 4	227	3,577	16	140	2,110	15	87	1,467	17
2015 QTR 1	228	3,655	16	140	2,152	15	88	1,504	17
2015 QTR 2	224	3,431	15	139	2,016	15	85	1,415	17
2015 QTR 3	219	3,254	15	136	1,879	14	83	1,374	17
2015 QTR 4	214	3,312	15	130	1,920	15	84	1,392	17

Figure 14. Ratio of FFS Deliveries to Active Delivery FFS Providers, CY 2014-2015

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Deliveries	Ratio	Providers	Deliveries	Ratio	Providers	Deliveries	Ratio
2014 QTR 1	54	72	1.3	32	45	1.4	22	27	1.2
2014 QTR 2	28	34	1.2	16	22	1.4	12	12	1.0
2014 QTR 3	26	33	1.3	14	18	1.3	12	15	1.3
2014 QTR 4	18	20	1.1	8	9	1.1	10	11	1.1
2015 QTR 1	32	36	1.1	12	15	1.3	20	21	1.1
2015 QTR 2	17	18	1.1	7	7	1.0	10	11	1.1
2015 QTR 3	30	34	1.1	22	25	1.1	8	9	1.1
2015 QTR 4	19	19	1.0	4	4	1.0	15	15	1.0

Figure 15. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Cardiology Providers, CY 2014-2015

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	252	10,068	40	134	5,717	43	118	4,351	37
2014 QTR 2	207	6,089	29	111	3,497	32	96	2,592	27
2014 QTR 3	248	6,656	27	130	3,799	29	118	2,856	24
2014 QTR 4	285	10,486	37	151	5,964	39	134	4,522	34
2015 QTR 1	282	11,325	40	149	6,427	43	133	4,898	37
2015 QTR 2	269	8,927	33	149	5,193	35	120	3,734	31
2015 QTR 3	258	7,594	29	137	4,330	32	121	3,263	27
2015 QTR 4	242	7,655	32	138	4,412	32	104	3,243	31

Figure 16. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Radiology Providers, CY 2014-2015

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	55	10,068	183	28	5,717	204	27	4,351	161
2014 QTR 2	54	6,089	113	28	3,497	125	26	2,592	100
2014 QTR 3	54	6,656	123	27	3,799	141	27	2,856	106
2014 QTR 4	56	10,486	187	29	5,964	206	27	4,522	167
2015 QTR 1	58	11,325	195	29	6,427	222	29	4,898	169
2015 QTR 2	59	8,927	151	30	5,193	173	29	3,734	129
2015 QTR 3	59	7,594	129	33	4,330	131	26	3,263	126
2015 QTR 4	59	7,655	130	31	4,412	142	28	3,243	116

Figure 17. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Surgery Providers, CY 2014-2015

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	107	10,068	94	38	5,717	150	69	4,351	63
2014 QTR 2	77	6,089	79	25	3,497	140	52	2,592	50
2014 QTR 3	101	6,656	66	39	3,799	97	62	2,856	46
2014 QTR 4	128	10,486	82	46	5,964	130	82	4,522	55
2015 QTR 1	126	11,325	90	45	6,427	143	81	4,898	60
2015 QTR 2	110	8,927	81	44	5,193	118	66	3,734	57
2015 QTR 3	110	7,594	69	40	4,330	108	70	3,263	47
2015 QTR 4	94	7,655	81	38	4,412	116	56	3,243	58

Figure 18. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Home Health Providers, CY 2014-2015

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	7	10,068	1,438	4	5,717	1,429	3	4,351	1,450
2014 QTR 2	5	6,089	1,218	3	3,497	1,166	2	2,592	1,296
2014 QTR 3	6	6,656	1,109	4	3,799	950	2	2,856	1,428
2014 QTR 4	8	10,486	1,311	5	5,964	1,193	3	4,522	1,507
2015 QTR 1	14	11,325	809	9	6,427	714	5	4,898	980
2015 QTR 2	16	8,927	558	11	5,193	472	5	3,734	747
2015 QTR 3	14	7,594	542	10	4,330	433	4	3,263	816
2015 QTR 4	20	7,655	383	15	4,412	294	5	3,243	649

Figure 19. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	10,827	30,205	358
2014 QTR 2	6,762	18,267	370
2014 QTR 3	7,089	19,967	355
2014 QTR 4	9,911	31,459	315
2015 QTR 1	9,356	33,975	275
2015 QTR 2	8,138	26,781	304

Time Period	Visits	Member Months	Rate per 1,000
2015 QTR 3	5,697	22,781	250
2015 QTR 4	5,308	22,966	231

Figure 20. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	6,762	21,478	315
2014 QTR 2	4,203	12,088	348
2014 QTR 3	3,424	9,673	354
2014 QTR 4	3,751	10,731	350
2015 QTR 1	3,825	10,966	349
2015 QTR 2	3,664	10,292	356
2015 QTR 3	2,626	9,761	269
2015 QTR 4	2,820	9,936	284

Figure 21. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,233	2,015	612	2,832	6,712	422	0	0	—
2014 QTR 2	716	1,262	567	1,843	4,917	375	0	0	—
2014 QTR 3	665	1,125	591	1,373	3,690	372	1,627	5,479	297
2014 QTR 4	348	709	491	1,105	3,075	359	4,707	16,944	278
2015 QTR 1	276	1,173	235	1,060	2,825	375	4,195	19,011	221
2015 QTR 2	371	1,621	229	917	2,410	380	3,186	12,458	256
2015 QTR 3	223	1,547	144	639	2,143	298	2,209	9,330	237
2015 QTR 4	223	1,600	139	525	2,279	230	1,740	9,151	190

Figure 22. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	6,649	17,151	388	4,178	13,054	320
2014 QTR 2	4,159	10,492	396	2,603	7,775	335
2014 QTR 3	4,335	11,398	380	2,754	8,569	321
2014 QTR 4	6,146	17,892	344	3,765	13,567	278
2015 QTR 1	5,648	19,282	293	3,708	14,693	252
2015 QTR 2	5,124	15,579	329	3,014	11,202	269
2015 QTR 3	3,433	12,991	264	2,264	9,790	231
2015 QTR 4	3,216	13,237	243	2,092	9,729	215

Figure 23. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	690	822	839	7,669	24,791	309	2,468	4,592	537
2014 QTR 2	392	550	713	3,968	13,293	299	2,402	4,424	543
2014 QTR 3	496	972	510	4,390	14,455	304	2,203	4,540	485
2014 QTR 4	635	2,248	282	7,014	24,642	285	2,262	4,569	495
2015 QTR 1	520	1,920	271	6,558	27,084	242	2,278	4,971	458
2015 QTR 2	425	1,432	297	5,446	20,093	271	2,267	5,256	431
2015 QTR 3	490	1,799	272	3,631	16,091	226	1,576	4,891	322
2015 QTR 4	274	1,118	245	4,384	20,212	217	650	1,636	397

Figure 24. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	453	30,205	15

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 2	233	18,267	13
2014 QTR 3	339	19,967	17
2014 QTR 4	414	31,459	13
2015 QTR 1	385	33,975	11
2015 QTR 2	298	26,781	11
2015 QTR 3	226	22,781	10
2015 QTR 4	196	22,966	9

Figure 25. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	274	21,478	13
2014 QTR 2	121	12,088	10
2014 QTR 3	110	9,673	11
2014 QTR 4	139	10,731	13
2015 QTR 1	134	10,966	12
2015 QTR 2	111	10,292	11
2015 QTR 3	68	9,761	7
2015 QTR 4	84	9,936	8

Figure 26. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	61	2,015	30	118	6,712	18	0	0	—
2014 QTR 2	30	1,262	24	82	4,917	17	0	0	—
2014 QTR 3	38	1,125	34	76	3,690	21	115	5,479	21
2014 QTR 4	13	709	18	41	3,075	13	221	16,944	13
2015 QTR 1	17	1,173	14	31	2,825	11	203	19,011	11
2015 QTR 2	17	1,621	10	28	2,410	12	142	12,458	11
2015 QTR 3	10	1,547	6	22	2,143	10	126	9,330	14
2015 QTR 4	10	1,600	6	25	2,279	11	77	9,151	8

Figure 27. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	254	17,151	15	199	13,054	15
2014 QTR 2	147	10,492	14	86	7,775	11
2014 QTR 3	208	11,398	18	131	8,569	15
2014 QTR 4	251	17,892	14	163	13,567	12
2015 QTR 1	240	19,282	12	145	14,693	10
2015 QTR 2	194	15,579	12	104	11,202	9
2015 QTR 3	128	12,991	10	98	9,790	10
2015 QTR 4	122	13,237	9	74	9,729	8

Figure 28. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	24	822	29	367	24,791	15	62	4,592	14
2014 QTR 2	13	550	24	170	13,293	13	50	4,424	11
2014 QTR 3	17	972	17	268	14,455	19	54	4,540	12
2014 QTR 4	25	2,248	11	335	24,642	14	54	4,569	12
2015 QTR 1	19	1,920	10	303	27,084	11	63	4,971	13
2015 QTR 2	9	1,432	6	241	20,093	12	48	5,256	9
2015 QTR 3	17	1,799	9	172	16,091	11	37	4,891	8
2015 QTR 4	8	1,118	7	180	20,212	9	8	1,636	5

Figure 29. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	2,000	30,205	66
2014 QTR 2	1,210	18,267	66
2014 QTR 3	1,672	19,967	84
2014 QTR 4	2,356	31,459	75
2015 QTR 1	1,964	33,975	58
2015 QTR 2	1,869	26,781	70
2015 QTR 3	1,473	22,781	65
2015 QTR 4	1,321	22,966	58

Figure 30. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,002	21,478	47
2014 QTR 2	564	12,088	47
2014 QTR 3	469	9,673	48
2014 QTR 4	586	10,731	55
2015 QTR 1	562	10,966	51
2015 QTR 2	534	10,292	52
2015 QTR 3	407	9,761	42
2015 QTR 4	423	9,936	43

Figure 31. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	325	2,015	161	673	6,712	100	0	0	—
2014 QTR 2	176	1,262	139	470	4,917	96	0	0	—

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 3	203	1,125	180	422	3,690	114	578	5,479	105
2014 QTR 4	107	709	151	299	3,075	97	1,364	16,944	81
2015 QTR 1	95	1,173	81	233	2,825	82	1,074	19,011	56
2015 QTR 2	140	1,621	86	231	2,410	96	964	12,458	77
2015 QTR 3	94	1,547	61	213	2,143	99	759	9,330	81
2015 QTR 4	79	1,600	49	197	2,279	86	622	9,151	68

Figure 32. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,115	17,151	65	885	13,054	68
2014 QTR 2	739	10,492	70	471	7,775	61
2014 QTR 3	1,002	11,398	88	670	8,569	78
2014 QTR 4	1,457	17,892	81	899	13,567	66
2015 QTR 1	1,209	19,282	63	755	14,693	51
2015 QTR 2	1,135	15,579	73	734	11,202	66
2015 QTR 3	821	12,991	63	652	9,790	67
2015 QTR 4	802	13,237	61	519	9,729	53

Figure 33. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	133	822	162	1,557	24,791	63	310	4,592	68
2014 QTR 2	73	550	133	852	13,293	64	285	4,424	64
2014 QTR 3	86	972	88	1,308	14,455	90	278	4,540	61
2014 QTR 4	113	2,248	50	1,935	24,642	79	308	4,569	67
2015 QTR 1	89	1,920	46	1,560	27,084	58	315	4,971	63
2015 QTR 2	79	1,432	55	1,500	20,093	75	290	5,256	55
2015 QTR 3	98	1,799	54	1,140	16,091	71	235	4,891	48
2015 QTR 4	75	1,118	67	1,164	20,212	58	82	1,636	50

Figure 34. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	24	30,205	0.8
2014 QTR 2	15	18,267	0.8
2014 QTR 3	12	19,967	0.6
2014 QTR 4	17	31,459	0.5
2015 QTR 1	15	33,975	0.4
2015 QTR 2	10	26,781	0.4
2015 QTR 3	7	22,781	0.3
2015 QTR 4	14	22,966	0.6

Figure 35. Inpatient Hospital Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	279	30,205	9
2014 QTR 2	163	18,267	9
2014 QTR 3	242	19,967	12
2014 QTR 4	349	31,459	11
2015 QTR 1	306	33,975	9
2015 QTR 2	266	26,781	10
2015 QTR 3	219	22,781	10
2015 QTR 4	237	22,966	10

Note: excludes maternity and newborns

Figure 36. Inpatient Hospital Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	47	822	57	162	24,791	7	70	4,592	15
2014 QTR 2	21	550	38	68	13,293	5	74	4,424	17
2014 QTR 3	25	972	26	144	14,455	10	73	4,540	16
2014 QTR 4	24	2,248	11	253	24,642	10	72	4,569	16
2015 QTR 1	17	1,920	9	207	27,084	8	82	4,971	16
2015 QTR 2	16	1,432	11	184	20,093	9	66	5,256	13
2015 QTR 3	23	1,799	13	142	16,091	9	54	4,891	11
2015 QTR 4	28	1,118	25	187	20,212	9	22	1,636	13

Figure 37. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	345	30,205	11
2014 QTR 2	258	18,267	14
2014 QTR 3	359	19,967	18
2014 QTR 4	572	31,459	18
2015 QTR 1	553	33,975	16
2015 QTR 2	401	26,781	15
2015 QTR 3	352	22,781	15
2015 QTR 4	281	22,966	12

Figure 38. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	124	21,478	6
2014 QTR 2	136	12,088	11
2014 QTR 3	101	9,673	10
2014 QTR 4	136	10,731	13
2015 QTR 1	164	10,966	15
2015 QTR 2	87	10,292	8
2015 QTR 3	57	9,761	6
2015 QTR 4	71	9,936	7

Figure 39. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	141	2,015	70	80	6,712	12	0	0	—
2014 QTR 2	64	1,262	51	58	4,917	12	0	0	—
2014 QTR 3	59	1,125	52	76	3,690	21	123	5,479	22
2014 QTR 4	39	709	55	34	3,075	11	363	16,944	21
2015 QTR 1	36	1,173	31	39	2,825	14	314	19,011	17
2015 QTR 2	47	1,621	29	37	2,410	15	230	12,458	18
2015 QTR 3	47	1,547	30	27	2,143	13	221	9,330	24
2015 QTR 4	38	1,600	24	26	2,279	11	146	9,151	16

Figure 40. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	184	17,151	11	161	13,054	12
2014 QTR 2	141	10,492	13	117	7,775	15
2014 QTR 3	178	11,398	16	181	8,569	21
2014 QTR 4	315	17,892	18	257	13,567	19

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2015 QTR 1	274	19,282	14	279	14,693	19
2015 QTR 2	237	15,579	15	164	11,202	15
2015 QTR 3	145	12,991	11	207	9,790	21
2015 QTR 4	158	13,237	12	123	9,729	13

Figure 41. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	61	822	74	194	24,791	8	90	4,592	20
2014 QTR 2	37	550	67	108	13,293	8	113	4,424	26
2014 QTR 3	53	972	55	218	14,455	15	88	4,540	19
2014 QTR 4	33	2,248	15	422	24,642	17	117	4,569	26
2015 QTR 1	45	1,920	23	372	27,084	14	136	4,971	27
2015 QTR 2	27	1,432	19	306	20,093	15	68	5,256	13
2015 QTR 3	48	1,799	27	256	16,091	16	48	4,891	10
2015 QTR 4	38	1,118	34	209	20,212	10	34	1,636	21

Figure 42. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	2,124	30,205	70
2014 QTR 2	1,349	18,267	74
2014 QTR 3	1,782	19,967	89
2014 QTR 4	2,394	31,459	76
2015 QTR 1	2,127	33,975	63
2015 QTR 2	1,693	26,781	63
2015 QTR 3	1,347	22,781	59
2015 QTR 4	1,297	22,966	56

Figure 43. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	894	21,478	42
2014 QTR 2	623	12,088	52
2014 QTR 3	513	9,673	53
2014 QTR 4	598	10,731	56
2015 QTR 1	526	10,966	48
2015 QTR 2	411	10,292	40
2015 QTR 3	362	9,761	37
2015 QTR 4	430	9,936	43

Figure 44. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	415	2,015	206	815	6,712	121	0	0	—
2014 QTR 2	227	1,262	180	499	4,917	101	0	0	—
2014 QTR 3	299	1,125	266	430	3,690	117	540	5,479	99
2014 QTR 4	146	709	206	332	3,075	108	1,318	16,944	78
2015 QTR 1	76	1,173	65	293	2,825	104	1,232	19,011	65
2015 QTR 2	109	1,621	67	225	2,410	93	948	12,458	76
2015 QTR 3	81	1,547	52	164	2,143	77	740	9,330	79
2015 QTR 4	91	1,600	57	168	2,279	74	608	9,151	66

Figure 45. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,191	17,151	69	933	13,054	71
2014 QTR 2	802	10,492	76	547	7,775	70
2014 QTR 3	1,019	11,398	89	763	8,569	89
2014 QTR 4	1,511	17,892	84	883	13,567	65
2015 QTR 1	1,200	19,282	62	927	14,693	63
2015 QTR 2	1,010	15,579	65	683	11,202	61
2015 QTR 3	720	12,991	55	627	9,790	64
2015 QTR 4	782	13,237	59	515	9,729	53

Figure 46. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	233	822	283	1,470	24,791	59	421	4,592	92
2014 QTR 2	146	550	265	737	13,293	55	466	4,424	105
2014 QTR 3	155	972	159	1,220	14,455	84	407	4,540	90
2014 QTR 4	167	2,248	74	1,796	24,642	73	431	4,569	94
2015 QTR 1	129	1,920	67	1,598	27,084	59	400	4,971	80
2015 QTR 2	102	1,432	71	1,272	20,093	63	319	5,256	61
2015 QTR 3	118	1,799	66	943	16,091	59	286	4,891	58
2015 QTR 4	82	1,118	73	1,101	20,212	54	114	1,636	70

Figure 47. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	710	30,205	24
2014 QTR 2	482	18,267	26
2014 QTR 3	649	19,967	33
2014 QTR 4	927	31,459	29
2015 QTR 1	888	33,975	26
2015 QTR 2	711	26,781	27
2015 QTR 3	607	22,781	27
2015 QTR 4	533	22,966	23

Figure 48. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	321	21,478	15
2014 QTR 2	237	12,088	20
2014 QTR 3	233	9,673	24
2014 QTR 4	196	10,731	18
2015 QTR 1	204	10,966	19
2015 QTR 2	174	10,292	17
2015 QTR 3	180	9,761	18
2015 QTR 4	159	9,936	16

Figure 49. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	177	2,015	88	212	6,712	32	0	0	—
2014 QTR 2	103	1,262	82	142	4,917	29	0	0	—
2014 QTR 3	104	1,125	92	114	3,690	31	198	5,479	36
2014 QTR 4	38	709	54	118	3,075	38	575	16,944	34
2015 QTR 1	23	1,173	20	64	2,825	23	597	19,011	31

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2015 QTR 2	38	1,621	23	54	2,410	22	445	12,458	36
2015 QTR 3	42	1,547	27	48	2,143	22	337	9,330	36
2015 QTR 4	23	1,600	14	53	2,279	23	298	9,151	33

Figure 50. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	405	17,151	24	305	13,054	23
2014 QTR 2	278	10,492	26	204	7,775	26
2014 QTR 3	375	11,398	33	274	8,569	32
2014 QTR 4	574	17,892	32	353	13,567	26
2015 QTR 1	503	19,282	26	385	14,693	26
2015 QTR 2	438	15,579	28	273	11,202	24
2015 QTR 3	343	12,991	26	264	9,790	27
2015 QTR 4	349	13,237	26	184	9,729	19

Figure 51. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	120	822	146	418	24,791	17	172	4,592	37
2014 QTR 2	67	550	122	235	13,293	18	180	4,424	41
2014 QTR 3	58	972	60	407	14,455	28	184	4,540	41
2014 QTR 4	74	2,248	33	693	24,642	28	160	4,569	35
2015 QTR 1	76	1,920	40	649	27,084	24	163	4,971	33
2015 QTR 2	54	1,432	38	522	20,093	26	135	5,256	26
2015 QTR 3	73	1,799	41	398	16,091	25	136	4,891	28
2015 QTR 4	58	1,118	52	440	20,212	22	35	1,636	21

Figure 52. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	5,984	30,205	198
2014 QTR 2	6,319	18,267	346
2014 QTR 3	6,254	19,967	313
2014 QTR 4	6,053	31,459	192
2015 QTR 1	4,979	33,975	147
2015 QTR 2	4,856	26,781	181
2015 QTR 3	3,922	22,781	172
2015 QTR 4	3,927	22,966	171

Figure 53. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	5,636	21,478	262
2014 QTR 2	5,992	12,088	496
2014 QTR 3	5,896	9,673	610
2014 QTR 4	5,577	10,731	520
2015 QTR 1	4,478	10,966	408
2015 QTR 2	4,495	10,292	437
2015 QTR 3	3,689	9,761	378
2015 QTR 4	3,618	9,936	364

Figure 54. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	244	2,015	121	104	6,712	15	0	0	—
2014 QTR 2	263	1,262	208	64	4,917	13	0	0	—
2014 QTR 3	265	1,125	236	6	3,690	2	87	5,479	16
2014 QTR 4	233	709	329	33	3,075	11	210	16,944	12
2015 QTR 1	239	1,173	204	39	2,825	14	223	19,011	12
2015 QTR 2	134	1,621	83	21	2,410	9	206	12,458	17
2015 QTR 3	26	1,547	17	26	2,143	12	181	9,330	19
2015 QTR 4	72	1,600	45	21	2,279	9	216	9,151	24

Figure 55. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	4,411	17,151	257	1,573	13,054	120
2014 QTR 2	4,695	10,492	447	1,624	7,775	209
2014 QTR 3	4,757	11,398	417	1,497	8,569	175
2014 QTR 4	4,563	17,892	255	1,490	13,567	110
2015 QTR 1	3,842	19,282	199	1,137	14,693	77
2015 QTR 2	3,948	15,579	253	908	11,202	81
2015 QTR 3	3,016	12,991	232	906	9,790	93
2015 QTR 4	2,899	13,237	219	1,028	9,729	106

Figure 56. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	75	822	91	488	24,791	20	5,421	4,592	1,181
2014 QTR 2	98	550	178	230	13,293	17	5,991	4,424	1,354
2014 QTR 3	59	972	61	149	14,455	10	6,046	4,540	1,332
2014 QTR 4	52	2,248	23	385	24,642	16	5,616	4,569	1,229
2015 QTR 1	69	1,920	36	455	27,084	17	4,455	4,971	896
2015 QTR 2	58	1,432	41	363	20,093	18	4,435	5,256	844
2015 QTR 3	25	1,799	14	233	16,091	14	3,664	4,891	749
2015 QTR 4	46	1,118	41	2,499	20,212	124	1,382	1,636	845

Figure 57. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Total Population

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	23,830	30,205	789
2014 QTR 2	20,829	18,267	1,140
2014 QTR 3	13,666	19,967	684
2014 QTR 4	24,545	31,459	780
2015 QTR 1	20,805	33,975	612
2015 QTR 2	18,919	26,781	706
2015 QTR 3	9,018	22,781	396
2015 QTR 4	11,274	22,966	491

Figure 58. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Children and/or Disabled Child

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	22,200	21,478	1,034
2014 QTR 2	19,797	12,088	1,638
2014 QTR 3	12,107	9,673	1,252

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 4	21,744	10,731	2,026
2015 QTR 1	18,713	10,966	1,706
2015 QTR 2	17,274	10,292	1,678
2015 QTR 3	7,778	9,761	797
2015 QTR 4	10,034	9,936	1,010

Figure 59. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Adults by Eligibility Group

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,172	2,015	582	458	6,712	68	0	0	—
2014 QTR 2	544	1,262	431	488	4,917	99	0	0	—
2014 QTR 3	516	1,125	459	354	3,690	96	689	5,479	126
2014 QTR 4	484	709	683	263	3,075	86	2,054	16,944	121
2015 QTR 1	495	1,173	422	164	2,825	58	1,433	19,011	75
2015 QTR 2	270	1,621	167	167	2,410	69	1,208	12,458	97
2015 QTR 3	211	1,547	136	150	2,143	70	879	9,330	94
2015 QTR 4	291	1,600	182	136	2,279	60	813	9,151	89

Figure 60. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Metropolitan and Non-Metropolitan Counties

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	13,881	17,151	809	9,949	13,054	762
2014 QTR 2	12,508	10,492	1,192	8,321	7,775	1,070
2014 QTR 3	7,854	11,398	689	5,812	8,569	678
2014 QTR 4	14,678	17,892	820	9,867	13,567	727
2015 QTR 1	12,064	19,282	626	8,741	14,693	595
2015 QTR 2	10,942	15,579	702	7,977	11,202	712
2015 QTR 3	4,383	12,991	337	4,635	9,790	473
2015 QTR 4	5,450	13,237	412	5,824	9,729	599

Figure 61. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiaries, CY 2014-2015: Excluded from Managed Care, Plan Selection Period, and Voluntary

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	335	822	408	5,610	24,791	226	17,885	4,592	3,895
2014 QTR 2	129	550	235	2,671	13,293	201	18,029	4,424	4,075
2014 QTR 3	162	972	167	2,105	14,455	146	11,399	4,540	2,511
2014 QTR 4	386	2,248	172	3,432	24,642	139	20,727	4,569	4,536
2015 QTR 1	332	1,920	173	2,572	27,084	95	17,901	4,971	3,601
2015 QTR 2	297	1,432	207	2,267	20,093	113	16,355	5,256	3,112
2015 QTR 3	264	1,799	147	1,509	16,091	94	7,245	4,891	1,481
2015 QTR 4	248	1,118	222	6,541	20,212	324	4,485	1,636	2,741