

# New Hampshire Medicaid Annual Report

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*State Fiscal Year 2009*

**Office of Medicaid Business and Policy  
New Hampshire Department of Health and Human Services**

December 30, 2010

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

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# Introduction

New Hampshire's system of public assistance programs goes back to the early 1930's (along with other states), even pre-dating the Social Security system. These efforts were recognized and expanded to the federal level in 1965, with the creation of the joint state-federal Medicaid program as a companion to the new federal Medicare program.

The New Hampshire Medicaid program is a complex network that covered all or part of the health care costs of more than 153,000 people at some point during State Fiscal Year 2009. Those covered included low-income children, pregnant women, parents with children, elders, and people with disabilities. During the year, 1 out of every 11.6 people in New Hampshire received Medicaid services.

The purpose of this report is to provide a snapshot of the people covered, the services delivered and their associated costs, along with the quality of care provided over the 12-month period from July 1, 2008 through June 30, 2009.

Medicaid beneficiaries tend to have a higher burden of illness than privately insured individuals. They are twice as likely to have asthma, coronary artery disease, hypertension, depression, and mental health disorders (in children); three to four times more likely to suffer from a stroke or Chronic Obstructive Pulmonary Disease (COPD) or to use hospital emergency rooms; and five times as likely to have lung cancer or heart failure. Despite these health problems, NH Medicaid beneficiaries have higher rates of primary care visits and well-child visits and rate higher on effectiveness of care measures (such as receiving appropriate tests and taking prescribed medications) than beneficiaries across the US who are in Medicaid managed care service delivery systems.

New Hampshire state government spent a total of \$4.95 Billion in SFY 2009. Of this amount, \$1.36 Billion, or 27.5% of all state expenditures, was accounted for by Medicaid (Education was next highest at 27.2% of state spending). Just over half (50.5%) of Medicaid spending during this period was covered by the federal government through matching funds, not including American Recovery and Reinvestment Act of 2009 (ARRA) funding. The New Hampshire Department of Health and Human Services (DHHS) administers the broad array of Medicaid programs. Fifteen different units within DHHS are involved in this effort.

NH Medicaid spends an average of \$666 per month for each beneficiary, with average monthly costs ranging from \$254 for each low-income child covered up to \$2,810 for beneficiaries covered under Medicaid waiver programs and \$3,461 for long-term care for low-income seniors.

The Medicaid program deploys a robust constellation of utilization management and quality improvement strategies to contain costs and improve beneficiary health. Additionally, the Department's Office of Medicaid Business and Policy (OMBP) continuously monitors private sector managed care practices as well as other state Medicaid innovations for local application. Of particular interest are programs that demonstrate substantive improvements in the cost of care and member health. To the extent that Medicaid program constraints and internal resources allow, NH Medicaid has successfully adapted numerous managed care strategies to its fee-for-services world, thus realizing much of the promise of managed care without contracting with a managed care organization.

Delivery of Medicaid services during SFY 2009 resulted in 6,016,121 claims through 18,468 health care providers, including 4,000 community organizations.

Services provided to beneficiaries included the following:

- 26,695 inpatient hospital admissions,
- 473,073 outpatient hospital visits,
- 439,099 primary care visits,
- 4,566 births,
- 582,214 hours of home care,
- 122,381 dental visits by children,
- 31,722 complex radiology tests, and
- 1,321,990 prescriptions filled.

As rising unemployment, falling income, and decreased availability of job-based insurance left more people uninsured, more people turned to Medicaid for health care coverage. During SFY 2009, the nearly 10% increase in enrollment was the driving factor for increased Medicaid spending. By comparison, enrollment increased only 2.8% during SFY 2008. Total Medicaid spending rose by 4.7%, after a 6% increase during SFY 2008. Medicaid cost per patient declined by 2% in SFY 2009, following a 4% increase in the previous year.

While there was little increase in enrollment through December of SFY 2009, enrollment increased rapidly thereafter and continued its increase through the end of the fiscal year. At the same time New Hampshire's unemployment rate rose from 3.4% in December of

2007 to 6.4% by June 2009. Both enrollment and unemployment rates were expected to continue to increase into SFY 2010.

This report on the diverse populations and scope of services covered by NH Medicaid will promote a better understanding of the challenges faced and the accomplishments realized, while informing future policy considerations as issues and opportunities affecting NH Medicaid are addressed.

# New Hampshire Medicaid Overview

## The Medicaid Program

Established in 1965, Medicaid is a joint federal-state program providing health care to eligible needy persons. Medicaid is administered by the states within broad federal guidelines. Each state's Medicaid program is different, reflecting that state's priorities in designing program eligibility and benefits (some benefits are mandated by the federal government, while states have a choice of which optional benefits to offer). Each state operates its Medicaid program in accordance with a customized State Plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The State Plan describes the program's basic eligibility, coverage, reimbursement, and administrative policies.

The federal government and the states share responsibility for financing Medicaid. The federal government matches state Medicaid spending at rates that vary by state per capita income. For New Hampshire, the base federal matching rate is currently set at 50 percent, which means the State receives one federal dollar for each state dollar it spends. However, as explained below, NH received temporary increases in its federal match rate in SFY 2009, resulting in a federal matching rate of 61.59%

Just as the country has changed in many ways since 1965, Medicaid has evolved (utilizing state flexibility and guaranteed federal funding) in response to shifting economic and demographic conditions and changing needs. Medicaid has been transformed from providing medical assistance to individuals and families receiving cash assistance to a health, long-term care, and psycho-social support program for low-income populations, including working families, elderly people, foster children, women with breast and

cervical cancer, and individuals with diverse physical and mental disabilities. (Appendix 1 contains a complete listing of program expansions to the NH Medicaid programs since 1984.)

NH currently deploys a robust constellation of management strategies to maximize efficient use of state dollars. Currently utilization management strategies include benefit design, prior authorization, service limits, concurrent inpatient review, discharge planning, and care management. Current pharmacy utilization strategies include: prior authorization, mandatory generic utilization, a preferred drug list, quantity limits, a dose optimization program, a lock in program and new drug management.

Additionally, OMBP engages in a number of quality assurance and quality improvement activities. Beneficiary health is monitored using nationally recognized metrics and benchmarks. Results are reported in this annual review as well as the annual Children's Health Insurance Programs report and the annual CMS Drug utilization report. Quality improvement activities are undertaken as needed in accordance with report findings. Despite the fact that New Hampshire Medicaid does not contract with a managed care organization, Medicaid beneficiaries continued to match or outperform their counterparts in Medicaid managed care programs across the country in almost all clinical measures.

OMBP continuously monitors private sector managed care practice, particularly those which demonstrate substantive impact on the cost of care and member health. NH Medicaid has successfully applied numerous managed care strategies.

In the coming years, anticipated declining rates of employer-based health insurance, increasing numbers of uninsured, aging of the baby boomers, growing incidence of chronic disease in younger age groups, and rising health care costs will continue to affect the Medicaid program. Recent federal activity has presented new opportunities and challenges for states. The Deficit Reduction Act of 2005 (DRA) imposed new requirements for states along with options in the areas of benefits, cost sharing, and long-term care. The New Hampshire Department of Health and Human Services continues to evaluate these options and implement those that suit its mission in support of the needs of Medicaid recipients. The American Recovery and Reinvestment Act of 2009 (ARRA) provided temporary increases in FMAP rates starting in Oct. 2008 (a standard percentage increase for all states plus an additional increase based on each state's unemployment rate). States could not restrict their

eligibility standards, known as “maintenance of effort” requirement, or deposit these increases into their Rainy Day Funds. ARRA also increased disproportionate share hospital (DSH) allotments for SFY 2009 and 2010 and initiated major health information technology (HIT) efforts. The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) made programmatic and budgetary changes to this program. Implementation of these changes will impact NH Medicaid beginning in SFY 2010.

Beginning in 2007, CMS proposed regulations and issued guidance to implement several provisions of both the MMA (Medicare Modernization Act of 2003) and the DRA. Areas affected include citizenship documentation requirements, case management services, Graduate Medical Education for medical residents, rehabilitation services, and outpatient hospital services. CMS pursued these actions to ensure the programmatic and fiscal integrity of Medicaid. States, beneficiaries, and providers had concerns about possible negative consequences resulting from reducing the scope of services, limiting provider reimbursement and cost shifting to the states. Congress and the Obama Administration have imposed moratoriums on implementation of these actions and rescinded the implementation of several of them.

Given the proportion of states’ budgets dedicated to Medicaid and the continued increase in federal spend-

ing, much attention has been focused on Medicaid reform. There was heightened federal activity looking at broad reform of the health care system, including Medicaid. Across the country, states are exploring ways to control costs along with improving quality of care. Appendix 2 contains a list of efforts initiated by the NH Medicaid program with approval of the NH Legislature towards costs and program management. Appendix 3 describes changes to Medicaid providers’ rates initiated in 2009.

## NH Medicaid Covered Services

Medicaid may be viewed as four different coverage plans combined in one program. It provides:

- comprehensive and preventive child health coverage for low-income children up to the age of 21, following federal requirements of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program;
- acute care coverage for some parents of covered children;
- a complex range of acute and long-term care services for the frail elderly, people with physical and developmental disabilities, and those with mental illness; and
- “wraparound” coverage that supplements

**Table 1: NH Medicaid Covered Services (as of 6/30/2009)**

**Federal Mandates**

Intermediate Care Facility Nursing Home  
 Outpatient Hospital, General  
 Inpatient Hospital, General  
 Physicians Services  
 Rural Health Clinic  
 Home Health Services  
 Skilled Nursing Facility Nursing Home  
 Dental Service  
 SNF Nursing Home Atypical Care  
 ICF Nursing Home Atypical Care  
 Laboratory (Pathology)  
 I/P Hospital Swing Beds, SNF  
 I/P Hospital Swing Beds, ICF  
 Advanced Registered Nurse Practitioner  
 X-Ray Services  
 Family Planning Services

**State Mandates**

Home & Community Based Care:  
 Acquired Brain Disorder – Personal care services  
 Developmentally Disabled – Personal care services  
 Elderly and Chronically Ill – Personal care services  
 Home Care for Children with Severe Disabilities –  
 Personal care services  
 Medicaid Health Management Program – Chronic illness  
 disease management services

**Optional Services**

Prescribed Drugs  
 Optometric Services Eyeglasses  
 Mental Health Center  
 Ambulance Service  
 Private Non-Medical Institutional For Children  
 Adult Medical Day Care  
 Crisis Intervention  
 Furnished Medical Supplies & Durable Medical Equipment  
 Physical Therapy  
 Private Duty Nursing  
 Clinic Services (w/o School Services)  
 Day Habilitation Center  
 Medical Services Clinic  
 Psychology  
 Intensive Home and Community Services  
 Wheelchair Van  
 Podiatrist Services  
 Placement Services  
 Occupational Therapy  
 ICF Services for the Mentally Retarded  
 Chiropractic  
 Inpatient Psychiatric Facility Services Under Age 22  
 Speech Therapy  
 Home Based Therapy  
 Audiology Services  
 Child Health Support Service  
 Outpatient Hospital, Mental

and fills gaps in the Medicare benefit for low-income elders who are eligible for both Medicaid and Medicare, referred to as the “dually eligible” or “duals”.

The services used and the costs per person vary considerably across these populations. The specific medical services covered by the New Hampshire Medicaid program are included in Table 1 below and are grouped into federally mandated services, state mandated services, and optional services.

## NH Medicaid Coverage and Service Limits

Medicaid coverage depends on:

- the categories of services that are covered under the State plan;
- the applicable amount, duration, and scope of limitations on otherwise covered benefits (such as visit limits and day limits); and
- the standard of medical necessity that is used to determine whether otherwise covered services are medically appropriate for a particular individual in any specific case.
- NH Medicaid has established service limits on a number of covered services including physician, laboratory, X-ray, and outpatient hospital services. Specific limits on service use are defined in Table 2.

## Eligibility for the Medicaid Program

Medicaid serves five main groups of low-income individuals: children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly. There are two parts to Medicaid eligibility:

- *Categorical eligibility.* Federal law establishes many eligibility “categories,” and an individual will be determined eligible only if the detailed criteria are met for one of those categories. States are required to include certain “mandatory” eligibility groups; for example, all states must cover children and pregnant women with family incomes up to specified levels. Other eligibility pathways are optional and available only in those states that choose to cover them. Table 3 describes the eligibility groups covered by NH Medicaid.

**Table 2: NH Medicaid Limits on Covered Services\***

- Inpatient hospital services (*must be medically necessary*)
- Outpatient hospital services, including emergency room services (*12 visits per year*)
- Physician services (*18 visits per year*)
- Diagnostic x-rays (*15 per year*)
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21 (*must be medically necessary*)
- Dental Services (*for persons age 21 and over, limited to treatment of acute pain or infection*)
- Prescription drugs (*Pharmacy Benefit Management (PBM) limits*)
- Psychotherapy (*12 visits per year*)
- Podiatrist Services (*12 visits per year*)
- Chiropractic Services (*6 visits per year*)
- Durable medical equipment (*prior authorization required*)
- Medical supplies (*prior authorization required*)
- Physical, occupational, speech therapy (*80 15-minute units per year*)
- Eyeglasses (*examine every year to determine need for glasses, 1 repair per year, replacement with ½ diopter change*)

- *Financial eligibility.* Medicaid is a means-tested program. To qualify for Medicaid, a person must have a low-income expressed as a percentage of the Federal Poverty Level (FPL). CMS sets a minimum financial requirement, however, states have some flexibility in extending eligibility beyond the minimum for each categorical group. In NH Medicaid, income levels vary from 300% of FPL for infants to 40% FPL for parents as shown in Figure 1.

\* This list is not exhaustive. For example, Community Mental Health services are limited to \$1,800 per fiscal year for individuals who do not meet long-term care eligibility requirements and to \$4,000 per fiscal year for individuals with a serious mental illness or severe and persistent mental illness.

### Table 3: NH Medicaid Eligibility Categories

*Mandatory Eligibility Groups (all State Medicaid programs must cover)\**

- Low-income Medicare beneficiaries
- Individuals who would qualify for Temporary Assistance to Needy Families (TANF) today under the state’s 1996 AFDC eligibility requirements†
- Children under age six and pregnant women with family income at or below 133% of federal poverty level (FPL) guidelines
- Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level
- Infants born to Medicaid-enrolled pregnant women
- Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program
- Low-income aged, blind, and disabled receiving state supplemental assistance

*Optional Eligibility Groups (NH Medicaid has chosen to cover)‡*

- Children and pregnant women up to 185% of the FPL
- Individuals determined to be “medically needy” due to large medical expenses§
- Home Care for Children with Severe Disabilities (HC-CSD), commonly known as “Katie Beckett”; for severely disabled children up to age 19 whose medical disability qualifies them for institutional care but are cared for at home
- Medicaid for Employed Adults with Disabilities (MEAD) allows Medicaid-eligible disabled individuals between the ages of 18 and 64 who want to save money or work to increase their earnings while maintaining Medicaid coverage (up to 450% FPL)

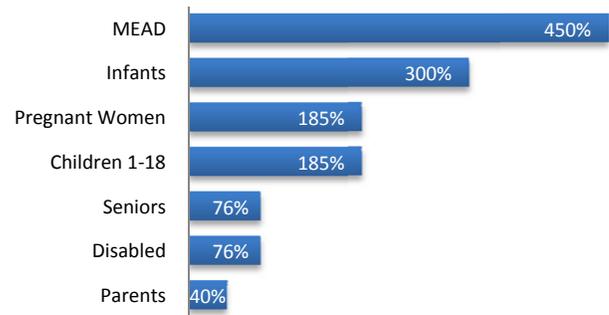
\* In 1974, New Hampshire, like over thirty other states at the time, elected for the “209(b)” status provided in the federal law that created the Supplemental Security Income (SSI) program (the federal income assistance program for disabled, blind, or aged individuals). When creating the SSI program, Congress hoped that SSI beneficiaries would also receive Medicaid. However, Congress was mindful of the increased expense for states to automatically cover all SSI beneficiaries. To provide states some financial flexibility, the 209(b) option was crafted which allowed a state to be more restrictive in its Medicaid eligibility than the SSI program eligibility guidelines, so long as those methodologies were no more restrictive than methodologies in place on January 1, 1972. Accordingly, New Hampshire does not automatically grant Medicaid to SSI beneficiaries. SSI beneficiaries who desire Medicaid must qualify for a state defined category of assistance.

† In 1996, federal policymakers severed the tie between medical and cash assistance when the AFDC program was replaced. The AFDC standard was retained in Title XIX to prevent the states from using the more restrictive eligibility requirements and time limits of AFDC’s successor - Temporary Assistance for Needy Families or TANF - when providing Medicaid coverage to needy children and families.

‡ ARRA required that eligibility had to be maintained by states (“maintenance of effort”) as a condition to receiving temporary increases in FMAP rates.

§ While Medically Needy is an optional category, as a 209(b) State, if New Hampshire does not elect to provide medically needy coverage, we must allow adult category individuals whose income exceeds the categorically needy income limit to spend down to the categorically needy income limit. Additionally, once a State opts to provide medically needy coverage, there are certain groups that must be covered as medically needy (e.g., pregnant women).

**Figure 1: NH Medicaid Eligibility by Percent of Poverty Level**



### Medicaid Waiver Programs

States can request approval to “waive” certain Medicaid requirements in order to provide a different mix of services or coverage and still receive federal matching funds. These waivers have standards for access and quality of care and can cost no more than what Medicaid would have paid absent the waiver (budget neutrality). Managed Care/Freedom of Choice waivers allow states to operate mandatory managed care programs for Medicaid beneficiaries. Home and Community Based Services (HCBS) waivers allow states to offer special services to Medicaid beneficiaries who would otherwise need institutional care.

New Hampshire has several waiver programs in operation (note: all participants in waiver programs utilize regular state plan services in addition to the waiver services):

- Home and Community Based Care for Acquired Brain Disorders (HCBC-ABD) services are available to individuals with traumatic brain injuries or neurological disorders who chose to remain in community settings in lieu of institutionalization.
- Home and Community Based Care for Developmentally Disabled (HCBC-DD) services are available to individuals with developmental disabilities and their families who chose to remain in community settings in lieu of institutionalization.
- Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI) services to provide options to eligible individuals who chose to remain in community settings in lieu of nursing home care.

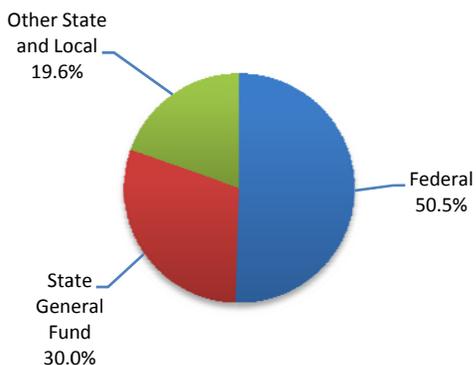
- In Home Supports Waiver (IHS) services provide in-home support to children with severe developmental disabilities, birth to age 21, living at home with their families.
- Medicaid Health Management Program (Disease Management) provides information, resources, and disease management services for individuals with chronic illnesses such as asthma, diabetes, heart failure, coronary artery disease, chronic obstructive pulmonary disease, chronic kidney disease, and end-stage renal disease (programs ended 6/30/2009).

## Medicaid Funding Sources

The NH Medicaid budget is comprised of federal, state general, and other state and local funds. The federal government covered just over 50% of New Hampshire's \$1.36 billion spent by the Medicaid program in State Fiscal Year (SFY) 2009.

**Figure 2: NH Medicaid Funding Sources, SFY 2009**

Total New Hampshire Medicaid Spending \$1.4 Billion



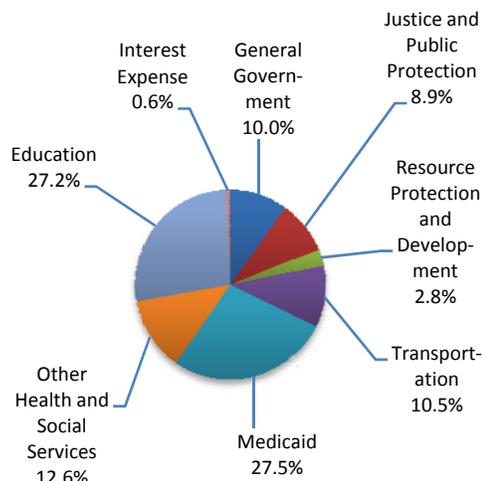
Total Medicaid funding increased by 4.7% (from \$1.30 to \$1.36 billion) from SFY 2008 to SFY 2009. While the amount of federal funds increased in 2009, the proportion decreased very slightly. The amount and proportion of state general funds decreased slightly and the amount and proportion of other state and local funds increased. Temporary FMAP increases under ARRA resulted in the receipt of an additional \$57.5 Million in federal funds during SFY 2009 that are not included in the NH Medicaid funding figures above. Although these funds were accepted and expended by NH Medicaid they supplanted previously appropriated State general and other funds.

## Medicaid and the New Hampshire State Budget

In SFY 2009, Medicaid accounted for the highest percentage of NH state budget expenses, barely exceeding education (27.5% to 27.2%). Note that for illustration purposes, the chart below separates Medicaid from the remainder of spending under the Health and Social Services budget category.

**Figure 3: NH State Budget by Category, SFY 2009**

Total New Hampshire State Budget \$5.0 Billion



Source: Schedule of Changes in Net Assets, Last Six Fiscal Years. State of New Hampshire Comprehensive Annual Financial Report for the Fiscal Year Ended June 30, 2009

Total spending for the NH state budget increased 6.0% from SFY 2008 to SFY 2009 (\$4.67 to \$4.95 billion). Total Medicaid spending also increased, by 4.7% (\$1.30 to \$1.36 billion). However, Medicaid spending as a proportion of the entire state budget declined slightly from 2008 (27.8%) to 2009 (27.5%).

## Medicaid Organization and Spending within NH DHHS

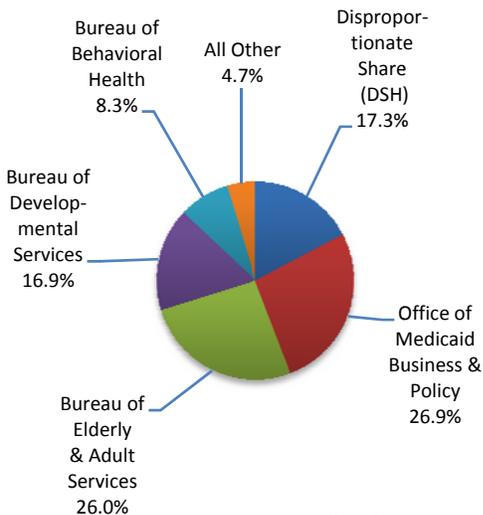
In New Hampshire, the Medicaid Program is administered within the Department of Health and Human Services (DHHS). Functional responsibility for the many components of the program is coordinated among several organizational units within DHHS. These include the Office of Medicaid Business and Policy (OMB: Medicaid Director, planning and policy, data and research, federal reporting, financial management, disproportionate share hospital), the Bureau of Behavioral Health (BBH: mental health), the Bureau of Developmental Services (BDS: developmental disabilities), and the Bureau of Elderly and Adult Services (BEAS: aged and long-term care).

Each of these units has programmatic responsibility for the Medicaid services that fall under their respective jurisdiction as well as the funding for those services.

The total spending by the NH Medicaid Program of \$1.36 billion can be broken down into activities or Department organizational units. The Bureau of Elderly and Adult Services (BEAS) accounted for 27% of Medicaid spending. The Office of Medicaid Business and Policy (OMBP) accounted for 26% and Disproportionate Share Hospital (DSH) payments made to hospitals accounted for 17% of Medicaid expenditures.\* Seventeen percent of Medicaid spending was through the Bureau of Developmental Services (BDS), 8% by the Bureau of Behavioral Health (BBH), and 5% was for “All Other”† activities.

**Figure 4: NH Medicaid Expenditures, SFY 2009**

Total NH Medicaid Spending \$1.4 Billion



## Medicaid Spending by Type

There are three general types of Medicaid spending. The bulk of Medicaid expenditures (76%) are for services to beneficiaries (provider payments). The second type of expenditures (18%) consists of Disproportionate Share payments to hospitals (certain general hospitals and NH Hospital) and ProShare pay-

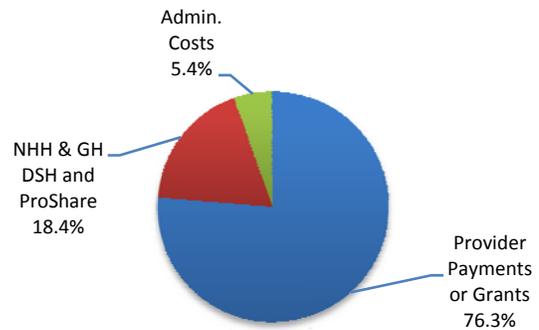
\* Certain hospitals are recognized by the State as serving a disproportionate share of Medicaid and uninsured patients. These hospitals receive additional Medicaid payments for providing inpatient and outpatient care to Medicaid enrollees.

† “All Other” units expending Medicaid funds include the Division of Children, Youth and Families, Division of Family Assistance, Department of Information Technology, Office of Operations Support and Program Integrity, Office of Administration, Division of Community Based Care Services, Office of the Commissioner, Division of Juvenile Justice Services, Division of Public Health Services, New Hampshire Hospital, and Division of Child Support Services.

ments to counties (covers the difference between actual NH Medicaid nursing home rates and the amount Medicare would reimburse). Administrative costs represent the smallest portion of expenditures (5%).

**Figure 5: NH Medicaid Spending by Type, SFY 2009**

Total NH Medicaid Spending \$1.4 Billion



Source: NH DHHS, Office of Business Operations

# Medicaid Enrollment and Expenditures

In state fiscal year 2009, New Hampshire Medicaid provided health care and psycho-social support coverage to an average of 122,258 persons each month, serving 153,158 unique persons over the year.‡ As noted above, the Medicaid program expended a total of \$1.36 billion in SFY 2009 of which \$1.05 billion (77%) was attributable to Medicaid provider payments. In order to accurately examine the relationship between those enrolled on Medicaid and the services they have used it is necessary to analyze the data not by what was paid for by NH Medicaid in SFY 2009, but the services that occurred during that year (totaling \$0.98 billion). Throughout the next sections the data presented is based on SFY 2009 service dates. Because this is based on service date, and not payment date, the total dollar amount differs slightly from the above.

Table 4 presents individuals enrolled and Medicaid expenditures for SFY 2009. Low-income children represent 56% of NH Medicaid members yet only

‡ Note average enrollment represents the average number of persons enrolled in the NH Medicaid program throughout SFY 2009 and not point in time statistics.

account for 22% of total program expenditures. Persons with disabilities (severely disabled children, physically and mentally disabled adults) represent 15% of the population and account for 44% total program expenditures. Elderly adults, who rely on Medicaid for their long-term care needs, accounted for the largest percentage of payments. Elderly adults are 7% of the Medicaid population and account for 25% of total expenditures. Low-income adults, while comprising 15% of the Medicaid population, only account for 8% of the expenditures.

**Table 4: NH Medicaid Enrollment\* and Medical Provider Expenditures for SFY 2009**

Eligibility Category <sup>†</sup>	Enrolled at any time during SFY 2009		Medicaid Expenditures	
	Number	Percent Enrolled	Amount	Percent of Cost
Low-income Child	90,881	56.1%	\$219,434,428	22.4%
Low-income Adult	24,524	15.2%	\$75,650,747	7.7%
Severely Disabled Child	1,760	1.1%	\$36,493,225	3.7%
Disabled Physical	10,227	6.3%	\$190,326,010	19.5%
Disabled Mental	12,385	7.7%	\$207,105,503	21.2%
Elderly	11,699	7.2%	\$243,738,217	24.9%
QMB/SLMB Only	10,385	6.4%	\$4,710,396	0.5%
<b>Total</b>	<b>161,861</b>	<b>100%</b>	<b>\$977,458,526</b>	<b>100%</b>

\*Difference from \$1.36 Billion due to provider spending for services with dates of services (7/1/2008-6/30/2009); does not reflect administrative, cost settlements, rebates or other off-claim payments.

## Medicaid Enrollment

From 2002 through 2008, Medicaid enrollment continued to show a modest increase. In 2009, monthly enrollment in Medicaid trended upward from 117,810 to 129,071, an increase of almost 10%. Nationally, Medicaid enrollment grew at a rate not seen since the late 1960s, when the program began<sup>‡</sup>. NH is one of thirteen states that exhibited double-digit growth in enrollment during the year. Figure 6 provides the monthly enrollment for SFY 2009. Beginning in De-

\* Enrollment figures in this table represent the number of persons enrolled at any time during the fiscal year 2009, regardless of the length of time enrolled.

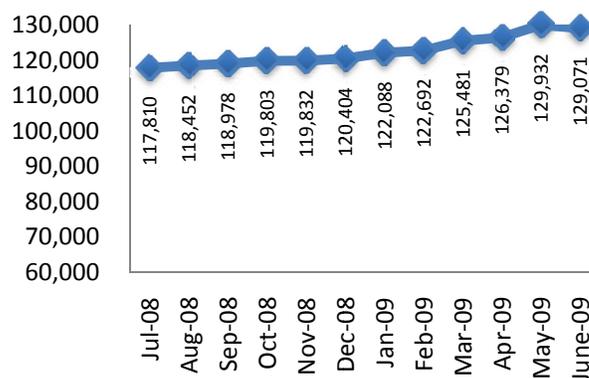
<sup>†</sup> Members were assigned to an Eligibility Group based on the Medicaid program they were eligible for as of June 2009. Families eligible under the Temporary Assistance for Needy Families (TANF) and related programs were categorized as “low-income” with age used to identify children (18 or less) and adults (greater than 18). Individuals in the elderly group were labeled by program even when age was less than 65. Similarly individuals in the disabled group were placed in “Disabled,” even when their ages were greater than 65. Individuals who are eligible for Medicare and have low-incomes may have their premiums, co-pays, co-insurance, and deductibles paid for by Medicaid and referred to as Qualified Medicare Beneficiary (QMB), or Specified Low-Income Medicare Beneficiary (SLMB).

<sup>‡</sup> Medicaid Enrollment: June 2009 Data Snapshot, Kaiser Family Foundation, February 2010, <http://www.kff.org/medicaid/8050.cfm>

ember, a rapid increase in members was observed through May, with a slight decline from May to June. Normally, new FPL guidelines are published the end of January, and account for the increased enrollment observed from February to March. However, the FPL levels did not change in 2009. In prior years, this growth was generally followed by a leveling off. However this fiscal year’s growth was indicative of the declining economy.

**Figure 6: NH Medicaid Enrollment by Month, SFY 2009**

Note: Includes retroactive enrollment



From June 2004 through June 2008, growth in the number of NH Medicaid enrollees was 6% or less. Between June 2008 and June 2009, NH Medicaid enrollment increased 9.6%. This 12 month period was also the first time since the early 1990’s that all states experienced a growth in enrollment<sup>§</sup>.

**Figure 7: NH Medicaid Enrollment for Month of June Over time, SFY 2004 - 2009**

Note: Includes retroactive enrollment



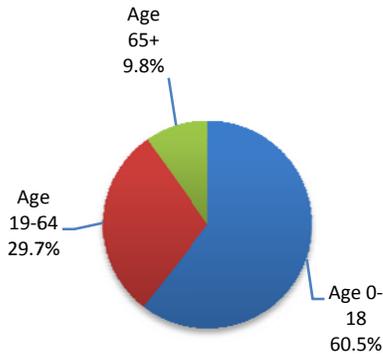
In SFY 2009, children (members 18 years or less) made up 61% of the NH Medicaid population (slightly more than shown in Table 4 due to looking at a point in time). As shown in Figure 8 members 19

<sup>§</sup> Ibid.

to 64 represented 30% of members and the remaining 10% were members aged 65 plus. While children make up the majority of the Medicaid population, they account for only 26% of spending.

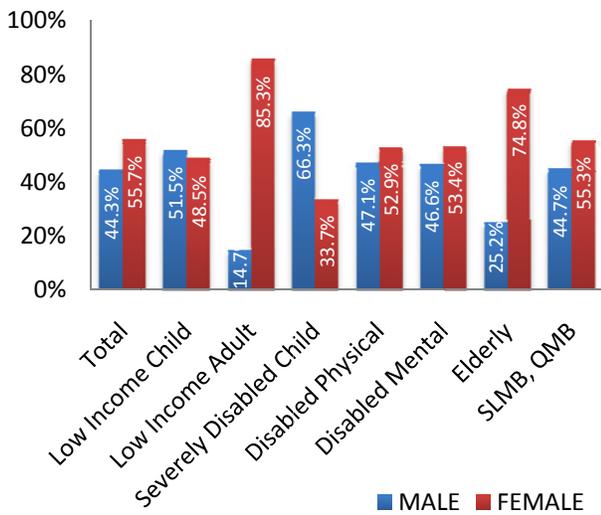
**Figure 8: NH Medicaid Enrollment by Age Categories, SFY 2009\***

Total Enrollment in June of 2009 = 129,071



Females account for over half of Medicaid enrollees. Gender differences were observed in all eligibility categories with females predominating low-income adults (85%, due to pregnant women eligibility category and greater likely of heading single parent low-income households) and the elderly (75%, due to longer lifespan and likelihood fewer resources than males). The only groups in which males made up a larger proportion of enrollees were the low-income child and severely disabled child groups.

**Figure 9: NH Medicaid Enrollment by Gender and Eligibility Category, June 2009**



\* Percentage based on end of SFY 2009 data (June 2009).

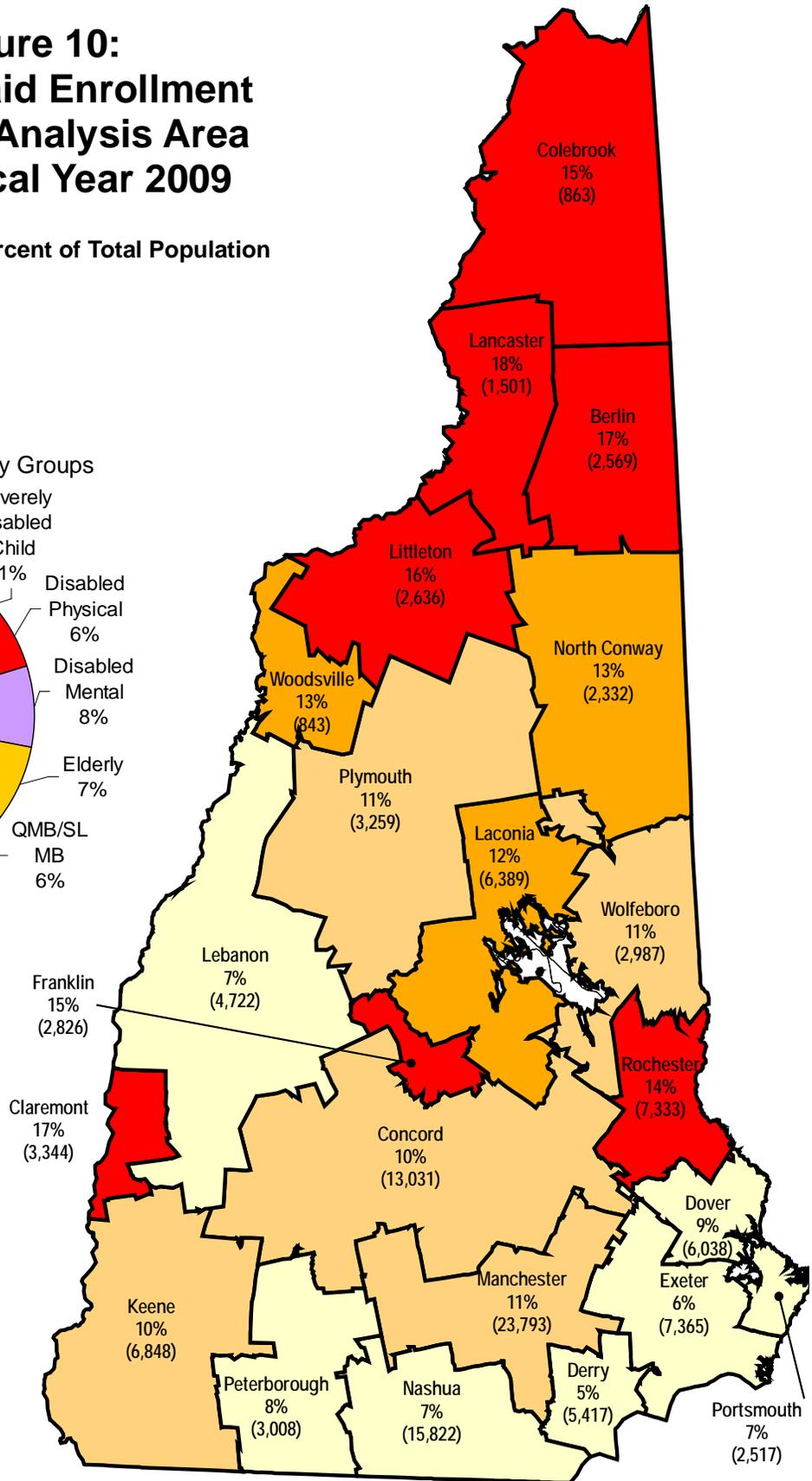
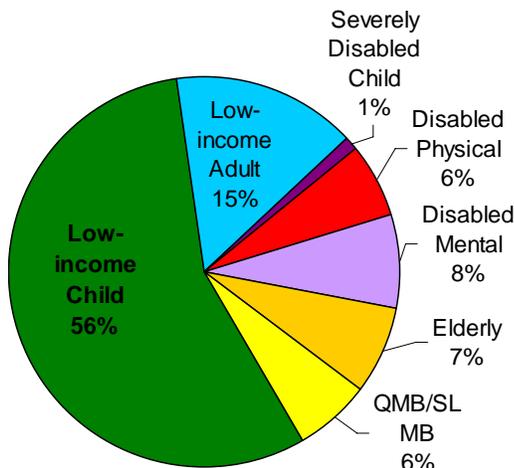
The percent of the population covered by NH Medicaid varies by Health Analysis Area (HAA) from a low of 5% in the Derry area to a high of 18% in Lancaster. On the following page, Figure 10 displays the percent of population enrolled in NH Medicaid for each of the HAAs. While the percent of population is not among the highest, the Manchester, Nashua, and Concord areas had the largest actual number of Medicaid members. These three areas account for 41% of the total NH Medicaid population. Figure 10 also displays the statewide distribution of Medicaid enrollees by eligibility group.

# Figure 10: NH Medicaid Enrollment by Health Analysis Area State Fiscal Year 2009

## Medicaid Enrollees as a Percent of Total Population



## NH Enrollees by Eligibility Groups



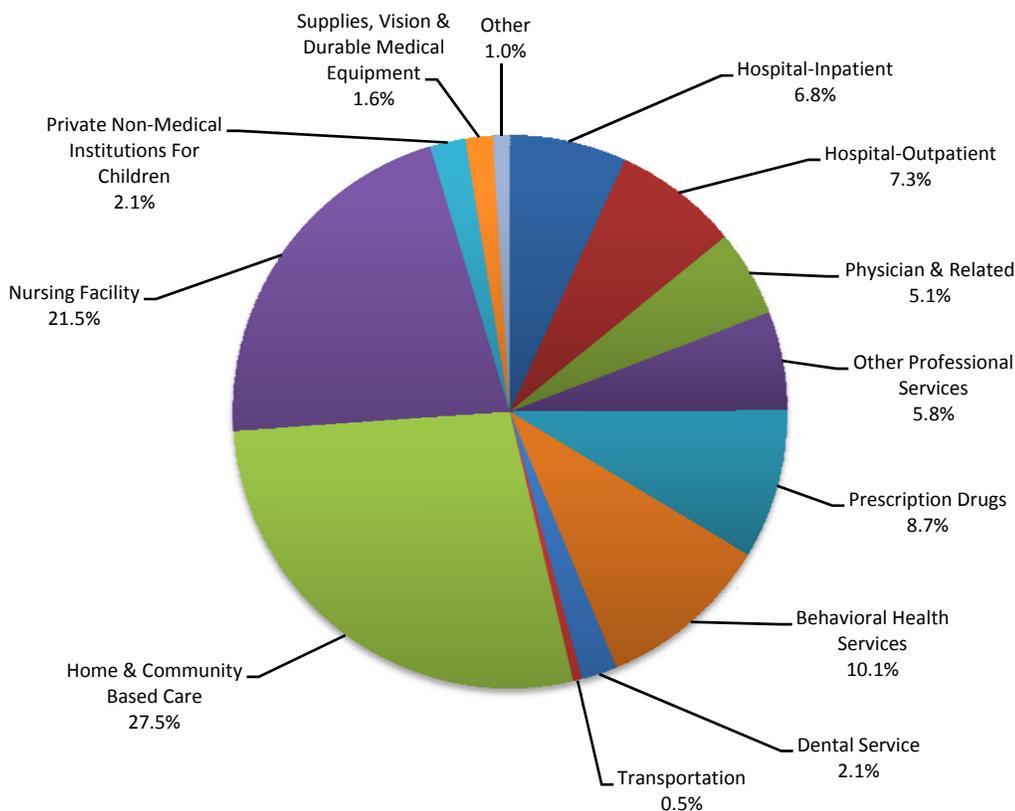
Notes:  
Data based on total enrollment of 129,071 enrolled at any time during the month of June, 2009.  
Data does not include Healthy Kids Silver.  
Health Analysis Areas defined by resident's hospital preference, based on non-specialty hospital services.  
Data current as of 1/31/10.

## Medicaid Expenditures: Provider Payments

In SFY 2009, the largest category of NH Medicaid spending was for long-term care services, including services provided at home and in institutions. As shown in Figure 11, approximately 51% of provider payments were associated with long-term care services (comprised of home and community-based care,

contributed another 10% of payments, other professional services\* accounted for 6% of spending, while dental, vision, transportation, mental retardation, and other services† each contributed 2% or less. Finally, prescription drugs accounted for 9% of payments.‡ (For a complete list of services and costs see Appendix Tables 4a and 4b.)

**Figure 11: Distribution of NH Medicaid Payments by Types of Service, SFY 2009**



nursing facility and private non-medical institutions for children). At over \$200 million dollars each, payments for home and community based care (HCBC) accounted for 28% of payments and nursing facilities another 21%. HCBC services for the developmentally impaired accounted for \$179 million (77%) of the total HCBC expenditures. Additionally, 2% of expenditures were for private non-medical treatment for children.

Acute care services including medical care and behavioral health accounted for 40% of NH Medicaid payments to providers. Hospital services contributed 14% (7% for outpatient and 7% for inpatient services), and physician and other related services another 5%. Additionally, behavioral health services

Table 5 provides expenditures and number of members using each service category. The most frequently used services were physician-related and prescription drugs. Over 110,000 members (72%) utilized physician-related services during SFY 2009 at an average yearly cost of \$453 per user. Prescription drugs were the next most frequently used service with over 94,000 members at an annual cost of \$899 per user. Additionally, over half (57%) of members used outpa-

\* Other professional services include therapies, lab, radiology, clinics and chiropractic.

† Other services include child health support, placement services and disability determination.

‡ Expenditures for prescription drugs are not adjusted for rebates from manufacturers. In SFY 2009, pharmacy rebates totaled \$26.8 million.

tient services with an average payment of \$805. While long-term care services represent the highest cost areas they served a small proportion of members—HCBC served 13,475 (9%) members and nursing homes provided services to 6,948 members (5%). At least one service was used by 89% of all Medicaid members leaving 11% of members enrolled during the year with no service use (mostly members with a short length of enrollment).

**Table 5: NH Medicaid Provider Claim Payments by Service Categories, SFY 2009**

Service Category	Total Claim Payments	Service Users	Service Users as a Percent of Members	Average Paid Per User Per Year
Home & Community Based Care	\$269,061,717	13,475	8.8%	\$19,967
Nursing Facility	\$208,150,917	6,948	4.5%	\$29,958
Behavioral Health Services	\$98,596,863	25,443	16.1%	\$3,875
Prescription Drugs	\$85,048,590	94,575	61.8%	\$899
Hospital-Outpatient	\$70,298,817	87,312	57.0%	\$805
Hospital-Inpatient	\$67,077,249	17,259	11.3%	\$3,887
Other Professional Services	\$58,573,497	52,456	34.3%	\$1,117
Physician & Related	\$50,074,097	110,472	72.1%	\$453
Dental Service	\$20,296,633	51,931	33.9%	\$391
Private Non-Medical Institutional For Children	\$20,005,787	1,103	0.7%	\$18,138
Vision & Other Durable Medical Equipment	\$15,649,936	31,707	20.7%	\$494
Other	\$6,538,846	605	0.4%	\$10,808
Transportation	\$5,232,911	10,976	7.2%	\$477
Mental Retardation Facility Services	\$3,028,496	42	<0.1%	\$72,107
<b>Total*</b>	<b>\$977,634,356</b>	<b>136,791</b>	<b>89.3%</b>	<b>\$7,147</b>

\* NH Medicaid expenditures totaled \$1.36 billion in SFY 2009. The figures in this table cover payments to providers based on dates of service from July 1, 2008 through June 30, 2009. The figures in this table do not include expenditures for administration, cost settlements, rebates, and other types of non-claim payments.

### Payments by Eligibility Category

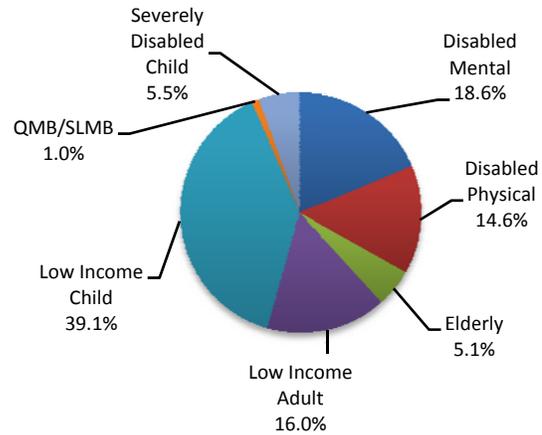
Spending on acute care\* services is driven by the health needs of children and members with disabilities. Children contribute 44% of spending on acute care services, with low-income children accounting for 39% and severely disabled children an additional 5% (Figure 12). Members with disabilities account for another 34% of acute care services, 19% for members with mental disabilities, and 15% for those with

\* Acute care includes behavioral health, inpatient and outpatient hospital, physician, other professional, dental, vision, DME, transportation and other services.

physical disabilities. Low-income adults (16%), the elderly (5%) and QMB/SLMB† (1%) account for the remainder.

**Figure 12: NH Medicaid Spending for Acute Care Services by Eligibility Category, SFY 2009**

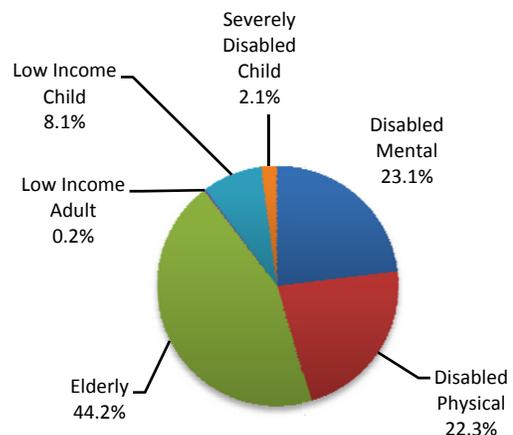
Total Acute Care Spending \$392,338,849



In contrast, spending on long-term care services‡ is driven by the elderly (45%) and members with disabilities (47%), 23% for those with mental disability, 22% for those with physical disability, and 2% for severely disabled children. Low-income children and adults account for 8% of long-term care spending (Figure 13).

**Figure 13: NH Medicaid Spending for Long-Term Care Services by Eligibility Category, SFY 2009**

Total Long-term Care Spending \$500,246,917



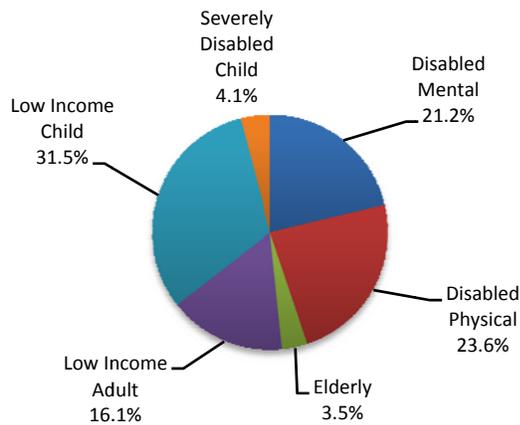
† “QMB” stands for Qualified Medicare Beneficiary and “SLMB” stands for Specified Low-income Medicare Beneficiary. See Glossary for definitions of these terms.

‡ Long-term care includes HCBC, nursing home, mental retardation services and PNMI for children.

Spending on prescription drugs is more broadly distributed; however, members with disabilities still constitute the largest proportion at 45%; 24% for those with physical disability and 21% for those with mental disability (Figure 14). The elderly account for 3% of prescription drug expenditures. Children contributed another 36%; 32% for low-income children and 4% for children with severe disabilities. Low-income adults accounted for the remaining 16%.

**Figure 14: NH Medicaid Spending for Prescription Drugs by Eligibility Category, SFY 2009**

Total Prescription Drugs \$85,048,590.



Medicare prescription drug coverage (Part D) began on January 1, 2006 and now pays for drugs for the elderly and some people with disabilities.\* In return for covering the drug costs for those who are receiving Medicaid and Medicare, all states are required to make State Phase Down Contributions back to Medicare. These “clawback” payments reflect the cost savings to Medicaid programs. In SFY 2009, New Hampshire paid almost \$30 million back to the federal government (up from \$28.5 million in SFY2008). Additionally, NH Medicaid receives rebates for prescription drugs†. In SFY 2009, NH Medicaid received almost \$36 million in rebates (up from \$26.8 million in SFY2008). These adjustments are not included in the Medicaid prescription drug payments shown here (the state share of the revenue from these rebates is deposited in the state unrestricted fund).

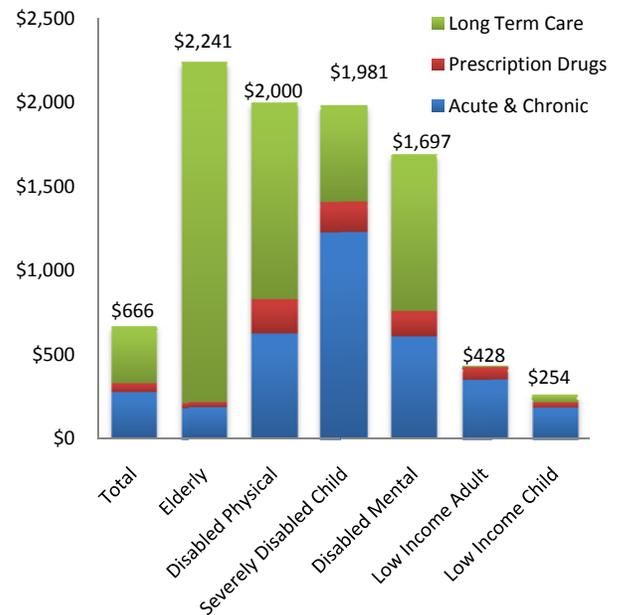
NH Medicaid spending varies widely by eligibility category. On average, NH Medicaid spent \$666 per

\* The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) resulted in the transition of prescription drug coverage from Medicaid to Medicare for those low-income seniors and individuals with disabilities who are dually eligible for Medicaid and Medicare.

† Created by the Omnibus Reconciliation Act of 1990 (OBRA’90), the Medicaid Drug rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with DHHS for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients.

member per month for services in SFY 2009. However, among the full benefit eligibility groups there is a ten-fold difference in spending per member per month (PMPM).‡ PMPM spending varies from \$254 for low-income children to \$2,241 for the elderly. Figure 15 displays PMPM spending for members. Low-income children and adults have the lowest PMPMs, with acute care being the primary care need of members in these two groups. The children with severe disabilities’ PMPM was \$1,981, whose health needs are both acute and long-term care. Long-term care services are the primary care need for adults with disabilities and the elderly. Adults with physical disabilities PMPM was \$2,000, while adults with mental disabilities PMPM was \$1,697. (For a complete listing of PMPM spending by service category for each eligibility category see Appendix 5. A complete listing of Medicaid provider payments, enrollment, and PMPMs by town is listed in Appendix 7.)

**Figure 15: NH Medicaid per Member per Month Spending by Eligibility Groups, SFY 2009**

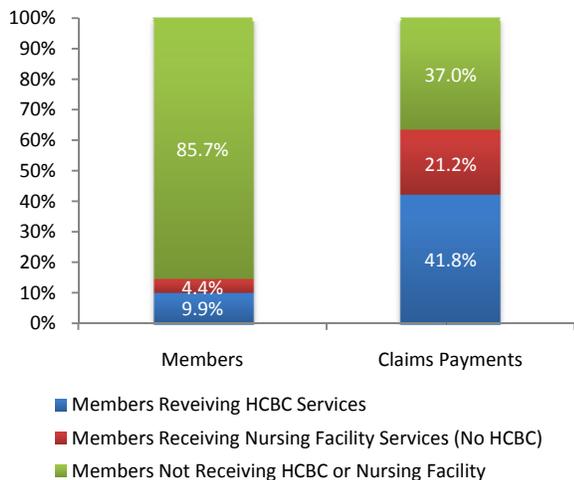


Overall average PMPMs decreased 2% between SFY 2008 (\$677) and 2009 (\$666). With the exception of the disabled physical (0.3%) and severely disabled child (2.4%) groups that experienced a slight increase in PMPM, all other groups declined slightly in 2009. See page 14 for a discussion of trends in spending by service type.

‡ Full benefit eligibility groups consist of those who meet the Medicaid eligibility criteria (low-income children and families, people with disabilities and the elderly) and are entitled to obtain coverage for the entire set of medically necessary services that are included in New Hampshire’s Medicaid benefit package (both mandatory and optional).

As described on page 5, home and community based care (HCBC) waiver programs are provided to NH Medicaid members who would otherwise need institutional services, allowing them to be cared for in the community. Ten percent of NH Medicaid members were on the HCBC waivers during SFY09, however these members accounted for 42% of the total claims payments during the year (Figure 16). Waivers services accounted for 66% of all claims payments for HCBC participants. Members in nursing homes accounted for 4% of members and 21% of claims payments. Given the significant level of care needs for HCBC participants and nursing home residents, the per member per month costs for HCBC waiver clients (\$2,810) and nursing home residents (\$3,461) are significantly higher than all other members (\$287). The HCBC participants had significantly higher non-long term care costs per member per month (\$873) than the members in nursing homes (\$159). A complete breakdown of costs for HCBC waiver and non-waiver participants is provided in Appendix Table 6a.

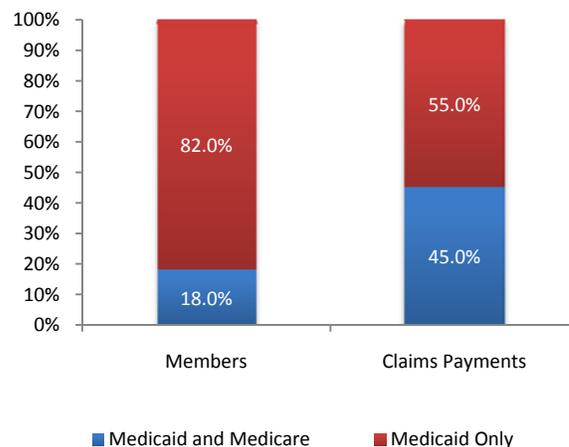
**Figure 16: Distribution of NH Medicaid Members and Costs by Members Using Home and Community Based Care Services (HCBC), in Nursing Facilities, and all Others, SFY 2009**



Medicaid members who are entitled to Medicare, often referred to as “dual eligibles” are another group that have extensive care needs. People with Medicare who also have limited income and resources may qualify for Medicaid. These members are older or have disabilities. About half of the dual eligibles are receiving HCBC or NF services. Medicaid will pay for services covered under the program, but not covered

by Medicare\*. About 18% of NH Medicaid members are dually eligible for Medicare, however they account for 45% of NH Medicaid payments (Figure 17). Medicaid PMPM for dual eligibles is \$1,777 compared with Medicaid only members PMPM of \$442. Removing long term care costs, the Medicaid only members PMPM of \$345 was higher than the dual eligibles PMPM of \$309. Spending on dual eligibles noted in this report does not include any services paid by Medicare. These are costs for the Medicaid program only. For a complete list of service use and costs by dual status see Appendix Table 6b.

**Figure 17: Distribution of NH Medicaid Members and Costs by Members Dually Eligible for Medicare, SFY 2009**

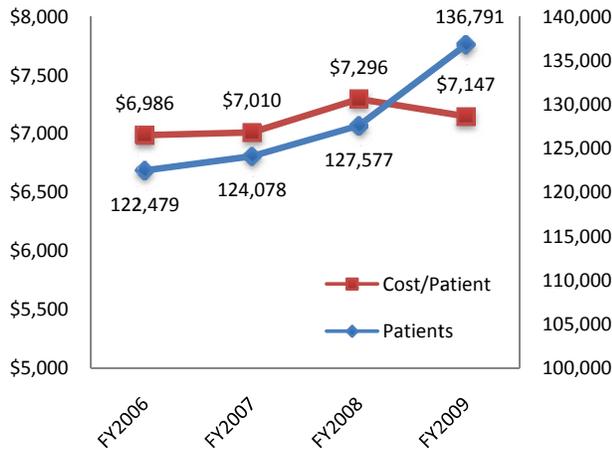


### Trends in Medicaid Service Spending

NH Medicaid services that drive most spending—long-term care, hospital inpatient, and outpatient—have increased in both utilization and unit costs. Additionally, total enrollment has increased. Overall total spending for NH Medicaid services increased 15% from 2006 to 2009, increasing each year. Per patient costs increased by 4.4% from SFY 2006 to SFY 2008, then dropped by 2.0% in SFY 2009, for an overall increase over this period of 2.3%. Cost trends are highlighted below (Appendix 4a contains a detailed listing of costs for services from SFY 2007 thru 2009).

\* Benefits for dual eligibles vary depending on how they qualify for Medicaid. For more information on dual eligibles see: <https://www.cms.gov/DualEligible/>

**Figure 18: NH Medicaid Costs per Patient and Number of Patients, per Member per Month Spending by Eligibility Groups, SFY 2006-2009**



*Long-Term Care Cost Trend:* Home and community based care (HCBC) services increased in 2009 compared to 2007, providing care to 14.4% more chronically ill and elderly, and 12.9% more developmentally disabled members. Accordingly, HCBC costs for these two groups increased 35.6% and 16% respectively. Private non-medical institution (PNMI) services for children saw a decrease in use of 12.4% and costs of 12.4%. As a result of increased use of HCBC services, nursing home intermediate care level facility (ICF) services decreased by 3.4% in the number of members served and 1.5% in total payments. However, ICF costs per person increased slightly by 2.0%.

*Hospital Cost Trend:* The number of members using general hospital inpatient and outpatient services increased 6.0% and 14.9% respectively from 2007 to 2009. Hospital inpatient (16.9%) and outpatient (5.6%) costs also increased, resulting in a 10.3% increase per patient for inpatient services but a decrease in spending per patient (8.1%) for outpatient services.

*Mental Health Center Cost Trend:* Mental health centers served 12.2% more members in 2009 compared with 2007, while total costs rose 13.8%, with a 1.4% increase in cost per patient.

*Physician Services Cost Trend:* Physicians served 13.9% more members in 2009 compared with 2007, while total costs rose 17.6%, or 3.2% per patient.

*Pharmacy Cost Trend:* Reimbursement for pharmacy moved to the fourth highest cost center for NH Medicaid in 2009, surpassing both hospital inpatient and outpatient spending. Members using prescription drugs increased (8.6%) and the total dollars spent

increased (21.3%), resulting in a 11.7% increase in spending per patient from 2007 to 2009.

*Dental Cost Trend:* From 2007 to 2009, members receiving dental services increased 22.5%, with a 31.4% increase in total spending, resulting in an increase of 7.4% per patient. The trend is indicative of the success New Hampshire has had in improving access and use of dental services by children.

## Tracking Access, Quality and Outcomes

The State of New Hampshire, through its Medicaid program, has made a significant impact on providing health care coverage to vulnerable populations, particularly low-income children. In 2009, 21% of NH's families had incomes of \$30,000 or less. Ten percent of NH's population remained uninsured in 2009, 7% less than the national rate of 17% uninsured\*. Along with providing coverage, NH Medicaid must assure that members have access to health services and are provided quality care. The Office of Medicaid Business and Policy, New Hampshire Comprehensive Health Care Information System (NH CHIS) project has developed a series of metrics based on Health Care Effectiveness Data and Information Set (HEDIS) specifications to assist NH Medicaid with monitoring access, quality, and outcomes of care. HEDIS measures can be compared to national HEDIS averages for Medicaid managed care programs compiled by the National Committee for Quality Assurance†. For this report, comparative data from the Medicaid HEDIS averages for 2008 are used‡.

Note: all measures in this section are calculated for members who do not have Medicare coverage, be-

\* Source: Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009) <http://www.statehealthfacts.kff.org/> (10/2010).

† NH CHIS quality metrics reported here are based on the NCQA HEDIS design specifications: HEDIS 2009, Technical Specifications, Volume 2. National Committee for Quality Assurance. 2009. [www.ncqa.org](http://www.ncqa.org). However, specifications for the NH CHIS quality metrics vary from those used to calculate the HEDIS National averages in that provider services billed under hospital outpatient services related to office or clinic based care are included, as are NH Medicaid codes for NH rural health centers, federally qualified health centers, and hospital-facility-based primary care clinics. Additionally, National metrics are based on calendar year reporting, while this report uses the State's fiscal year (7/1/08-6/30/09).

‡ No national data are available for fee for service Medicaid programs because there is no mandate to monitoring quality as there is with managed care organizations.

cause data on the Medicare portion of their claims is incomplete. Additionally, all measures are based only on those members continuously enrolled during the measurement period (no more than a one month gap in enrollment per year).

## Access

Primary care services are important to assuring access to appropriate medical care. Children and adolescents' access to primary care practitioners\* is a NCQA HEDIS measure. NCQA HEDIS measures the percentage of children age 12 through 24 months old and 25 months through 6 years old, with at least one primary care practitioner visit during the current year (one year measure), and the percentage of children 7 through 11 years old and 12 through 19 years old with at least one visit during the current or prior year (two year measure). Measures of use of primary care services for children, adolescents, and adults have been developed by NH CHIS. NH CHIS has added a measure for infants through 11 months of age and the age group 12-19 years was modified to 12-18 years for consistency with the definition of children (0-18) used in all other NH CHIS reporting. 54% of children were continuously enrolled in SFY 2009 and included in these measures. The HEDIS access to primary care practitioner measure is not a measure of just preventive services; the visits reported include both visits for preventive services and visits for medical illness and other problems.

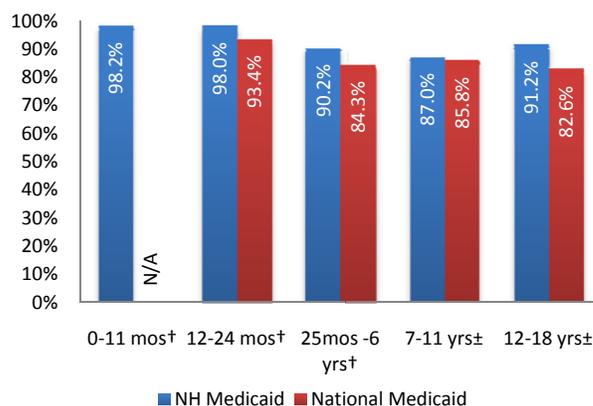
In SFY 2009, 98% of children in their first eleven months and in their second year had at least one visit to a primary care provider. Ninety percent of children from age 25 months to six years had at least one primary care visit (Figure 19).

For children age seven and older, the HEDIS measure criteria are at least one primary care visit in the past two years. Eighty-seven percent of children age 7 to 11 had at least one primary care visit in the past two years, while 91% of children age 12 to 18 had at least one primary care visit.

For age groups where there is a national HEDIS average, NH Medicaid children were above the 2008 national HEDIS average for children in all age groups.

\* Primary care includes clinics, rural health centers, physicians with specialties Family/General Practice, General Internal Medicine, Pediatrics, Nurses and Physician Assistants. Additionally for the Adolescent Well-care measures, Obstetricians and Gynecologists are also considered.

**Figure 19: Percent of Children Receiving a Primary Care Visit during the Year by Age Group, SFY 2009**

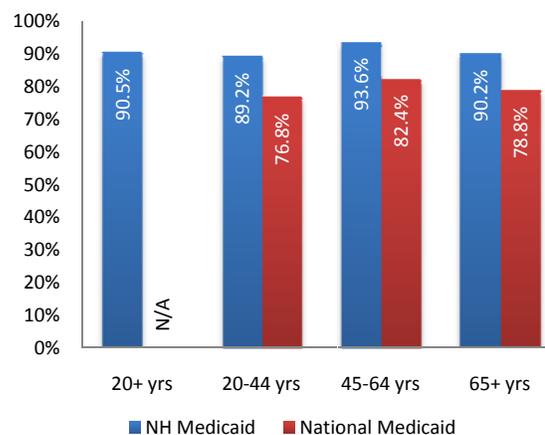


† Primary care visit in the past year.

± Primary care visit in the past two years.

Adult members also have better access to ambulatory health services than observed in the national averages, with 90% receiving an ambulatory health service during SFY 2009. Members age 45 and over had the highest access rate with 94% accessing care. Adults age 20 to 44 had the lowest percentage of access at 89%—however, all age groups exceeded the 2008 national Medicaid audited NCQA HEDIS rates (Figure 20).

**Figure 20: Adults' Access to Preventive/ Ambulatory Health Services by Age Group, SFY 2009**



A recent CHIS study released by OMBP assigned patients to different primary care provider types based on the care they had received in 2008.† The study found that 21% were assigned to part of the Dartmouth-Hitchcock Clinic system, 10% to a Feder-

† Source: Comparison of Primary Care Received by New Hampshire Medicaid Members at Different Practice Settings, 2008 (9/2010).

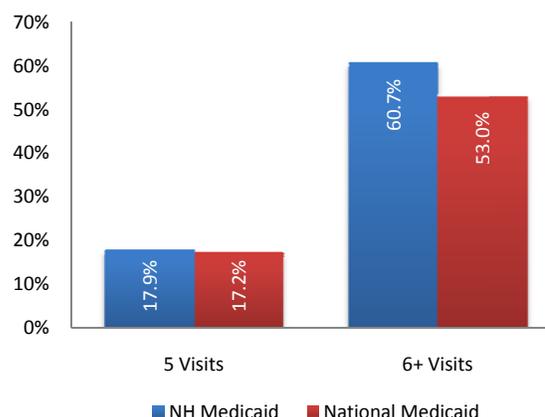
ally Qualified Health Center, 4% to a Rural Health Clinic, 41% to hospital-based and other independent primary care providers not falling into the other groups, and 23% of members with no assignment.\*

### Use of Preventive Services

Use of preventive services such as well-child visits, immunizations, and routine screenings for children, adolescents, and adults are designed to improve health status. Use of these services, particularly Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children is important to improving the overall health of NH Medicaid enrollees. Well-child visits are a NCQA HEDIS use of preventive service measure. These HEDIS measures are based on specific codes used to identify the visit as preventive in nature and, therefore, are distinguished from the access to primary care practitioner measure reported in the previous section. NCQA HEDIS reports a one-year measure for children age 3-6 years, a one-year measure for adolescent children age 12-19 years, and the distribution of visits during the first 1 to 15 months of life. To cover age groups where HEDIS does not have a measure, NH CHIS added well-child measures for children age 16-35 months and children age 7-11 years. Additionally, the age 12-19 years measure was modified to 12-18 years for consistency with the definition of children used in NH CHIS reporting and NH Medicaid.

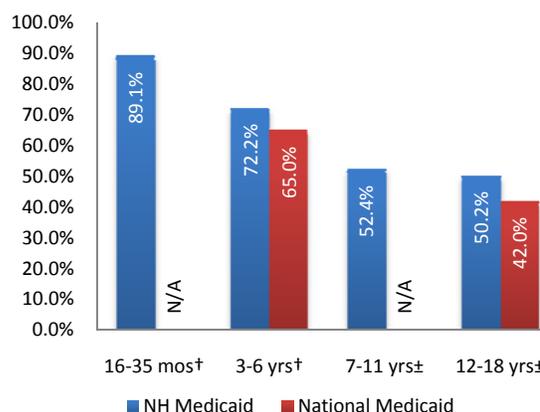
Sixty-one percent of infants between 1 and 15 months of age had the expected 6 or more well-child visits and an additional 18% had 5 during the period, both exceeding the 2008 national average (Figure 21).

**Figure 21: Percent of Infants 1 to 15 Months Old 5+ Well-Child Visits, SFY 2009**



Eighty-nine percent of children under the age of 3 in NH Medicaid received their scheduled well-child visit in SFY 2009. Seventy-two percent of children age 3 to 6 years and 52% of children age 7 to 11 years received their scheduled visits in the past two years, as did 50% of adolescents' age 12 to 18 years. Two national averages exist on these measures, one for children aged 3 to 6 and one for adolescents. Both of these NH Medicaid age groups exceed the 2008 national averages (Figure 22).

**Figure 22: Percent of Children with Well-Child Visits by Age Group, SFY 2009**



† Well-child visit in the past year.

± Well-child visit in the past two years.

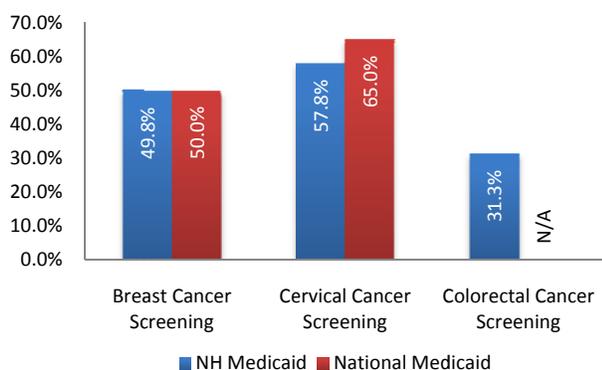
Adult screenings for breast cancer was consistent with National NCQA rates. Half (50%) of female members received a breast cancer screening. Screening provides women with earlier detection of breast cancer, allowing for more treatment options and bet-

\* Since the study used all members, not just those continuously enrolled like in the HEDIS measures, many members had short enrollment and no primary care. Other members received primary care at providers other than those typically identified as delivering primary care services.

ter chance of survival. Women age 42 to 69\* (N=2,761) are considered for this measure. Cervical cancer screening was slightly lower than the National NCQA rate with 58% received a cervical cancer screening. 2008 National NCQA average screening rates were 50% for breast cancer and 65% for cervical cancer (Figure 23). As with breast cancer, early detection of cervical cancer is important for treatment and survival. Women 21 to 64 are considered for this measure (N=8,831).

Colorectal cancer (CRC) is the second leading cause of cancer-related death in the United States. Unlike other screening tests that only detect disease, some methods can detect premalignant polyps and guide their removal, which may prevent the development of cancer. Colorectal screenings occurred in 31% of members. This measure assesses whether adults 50-80† years of age (N=2,431) with continuous enrollment had the appropriate screening for CRC.

**Figure 23: Adult Preventive Screenings, SFY 2009**

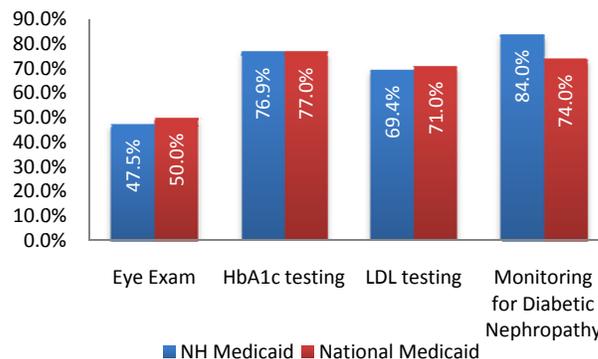


Diabetes accounts for nearly 20% of deaths in all persons over the age of 25. Diabetes is one of the most costly and highly preventable diseases. Complications, such as amputations, blindness, and kidney failure can be prevented with early detection. Adult members (age 18-75‡) with diabetes received comprehensive diabetic care at rates that were higher than that observed in the national Medicaid NCQA reporting§ (Figure 24). A high rate of monitoring for diabetic nephropathy was indicated; 84% of diabetics received this screening in 2009, higher than the national aver-

age of 74%. Glycosylated hemoglobin (HbA1c) testing at 77% was equal to the national average. Forty-eight percent of members with diabetes received an eye examination, while 69% received low-density lipoprotein (LDL) cholesterol testing; these were both comparable to the national averages.

**Figure 24: Comprehensive Diabetes Care, SFY 2009**

Diabetic Members (N=1,790)



## Discussion

The New Hampshire Medicaid program served more than 153,000 beneficiaries at some point during the 12-month period covered in this Annual Report. This State Fiscal Year 2009 (SFY 2009) report provided a snapshot of who those beneficiaries were, the types of services they received along with their associated costs and looked at some measures of access, quality, and outcomes of care that, where possible, were compared to national Medicaid managed care programs.

Medicaid continues to represent a significant percentage of state expenditures. In SFY 2009, for the first time, Medicaid accounted for the highest percentage of NH state budget expenses, barely exceeding education (27.5% to 27.2%). In SFY 2008 and 2007, education spending had exceeded Medicaid by 1%. From SFY 2007 to SFY 2009, total Medicaid spending increased 11%. During SFY 2009, the 7.2% increase in enrollment was the driving factor for increased Medicaid spending. By comparison, enrollment increased 2.8% during SFY 2008. Total Medicaid spending rose by 4.7%, after a 6% increase during SFY 2008. It is noteworthy that Medicaid cost per patient actually declined by 2% in SFY 2009, following a 4% increase in the previous year.

\* 42-69 is the HEDIS specification for this measure, although in practice nearly all Medicaid members 65-69 also have Medicare eligibility and are excluded from the measure.

† See previous note; same is true for this measure for 65-80 year olds.

‡ 18-75 is the HEDIS specification for this measure, although in practice nearly all Medicaid members 65-75 also have Medicare eligibility and are excluded from the measure.

§ HEDIS contains a list of nine different measures of comprehensive diabetes care. Test results are not available in NH CHIS claims data so measures that include test results cannot be reported.

As shown in this Annual Report, distribution of New Hampshire Medicaid spending varied by eligibility and service categories, with the largest category of expenditures being in long-term care services. Ten percent of Medicaid beneficiaries participated in the HCBC waivers that accounted for 28% of total claims payments. Members in nursing homes accounted for 5% of members and 21% of claims payments. Per member per month (PMPM) costs for clients using long-term care services were \$2,810 PMPM for waiver clients and \$3,461 PMPM for nursing home clients, compared to \$287 PMPM for non-long term care clients.

NH currently deploys a robust constellation of management strategies to assure the appropriate use of state dollars. Currently utilization management strategies include benefit design, prior authorization, service limits, concurrent inpatient review, discharge planning, and care management. Current pharmacy utilization strategies include: prior authorization, mandatory generic utilization, a preferred drug list, quantity limits, a dose optimization program, a lock in program and new drug management.

Additionally, OMBP engages in a number of quality assurance and quality improvement activities. Beneficiary health is monitored using HEDIS and AHRQ metrics and benchmarks. Results are reported in this annual review as well as the annual QCHIP report and the annual CMS Drug utilization report. Quality improvement activities are undertaken as needed in accordance with report findings. Despite the fact that New Hampshire Medicaid does not contract with a managed care organization, Medicaid beneficiaries continued to match or outperform their counterparts in Medicaid managed care programs across the country in almost all clinical measures.

OMBP continuously monitors private sector managed care practice, particularly those which demonstrate substantive impact on the cost of care and member health. NH Medicaid has successfully applied numerous managed care strategies, thus realizing much of the promise of managed care without contracting with a managed care organization.

Medicaid beneficiaries continued to outperform their counterparts in Medicaid managed care programs across the country in almost all measures used in this report. With increased emphasis on prevention, this was particularly noteworthy in use of preventive measures for children.

NH Medicaid experienced almost a 10% increase in enrollment during SFY 2009 as more NH citizens turned to Medicaid. This was accompanied by a corresponding increase in NH's unemployment rate - which went from 3.4% in December of 2007 to 6.4% by June 2009. Both enrollment and unemployment rates were expected to continue to increase into SFY 2010. New Hampshire's experience was not unique as national experts estimated that for every 1% increase in the unemployment rate, an additional 1 million Americans turned to Medicaid for coverage. The SFY 2010 New Hampshire Medicaid Annual Report will resume this story—describing the impact on enrollment and expenditures—during a period of what has been described as the most serious recession since the 1930's.

More studies of the New Hampshire Medicaid Program are available at [www.dhhs.nh.gov/ombp/publications.htm](http://www.dhhs.nh.gov/ombp/publications.htm)

Topics include:

- Payment rates compared with those of other states, Medicare, and commercial insurance
- Children's access, prevention, care management, utilization, and payment costs
- Chronic disease
- Emergency department use
- Primary and preventive care

Detailed data reports are available at the Comprehensive Healthcare Information System website [www.nhchis.org](http://www.nhchis.org) by selecting the Standard Reports link



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## Appendix 1: Key Developments in Medicaid—Milestones and Program Expansion Since 1984

Implementation Date	Program Expansion	Reason
10/1/84	Establishment of a mandatory group of qualified pregnant women and children under age 5 whose coverage was to be phased in over a 5 year period and a mandatory eligibility group of newborn children of Medicaid-eligible women.	Federal Mandate - Deficit Reduction Act of 1984 (DEFRA 84)
7/1/86	Amended the qualified pregnant women eligibility group by requiring States to provide Medicaid to any pregnant woman who met the AFDC income and resource requirements regardless of family structure.	Federal Mandate - Consolidated Omnibus Reconciliation Act of 1985 (COBRA 85)
7/1/87	Individuals who are approved under the provisions of Section 1916 of the SSA and who are eligible for Medicaid the month prior to such approval, remain automatically eligible for Medicaid until SSA changes their status.	Federal Mandate - Employment Opportunities for Disabled Americans Act (EODAA)
1/1/89	New coverage group - children with severe disabilities	State Mandate (RSA 167:3-c VI)
1/2/89	Payment of co-insurance, deductibles and Medicare premiums for qualified Medicare beneficiaries (QMB)	Federal Mandate Medicare Catastrophic Coverage Act of 1988 (MCCA)
5/31/89	Change In & Out spend down period from six months to one month. Result is smaller spend downs that are easier for clients to meet	State Initiative - settlement re: Bishop v. Mongan
7/1/89	Medical Assistance (MA) for pregnant women and infants under one year of age with income at 75% of the FPL	Federal Mandate MCCA
7/3/89	New coverage group - home care for children with severe disabilities (Katie Beckett)	State Mandate (RSA 167:3-c IV)
9/30/89	Protection of income and resources of the spouse of an institutionalized individual.	Federal Mandate MCCA
10/1/89	Elimination of eligibility penalty for property transfers of less than fair market value - for MAO cases.	Federal Mandate MCCA, Family Support Act of 1988 (FSA)
1/1/90	Use SSI income and resource methodology for QMB cases	Federal Mandate (OBRA 89)
1/1/90	Cover services provided by Federally Qualified Health Centers (FQHCs)	Federal Mandate (OBRA 90)
4/1/90	Allow old medical expenses as deductions in determining eligibility for In & Out medical assistance	Federal Mandate - existing (compliance issue)
4/1/90	Increase in income limit for pregnant women and children under the age of six to 133% FPL	Federal Mandate (OBRA 89)
4/1/90	Twelve month extended medical assistance for AFDC cases that lose eligibility due to employment	Federal Mandate (FSA)
7/1/90	Buy-in of Medicare Part A premium for working disabled with income under 200% FPL	Federal Mandate (OBRA 90)
10/1/91	New coverage group, AFDC unemployed parent	Federal Mandate: 45 CFR 233.101, Social Security Act, Section 407
1/1/91	Medical assistance for one year to a child born to a woman who is eligible for and receiving MA at the time of birth if the child continues to live with the mother and the mother remains eligible or would remain eligible for MA if still pregnant	Federal Mandate (OBRA 90)
1/1/91	Provide medical assistance to children under the age of 22 who are residing in designated receiving facilities	State initiative - to enhance state dollars by obtaining 50% federal financial participation

<b>Implementation Date</b>	<b>Program Expansion</b>	<b>Reason</b>
4/1/91	Reduction in VA benefits to a maximum of \$90 for individuals in nursing homes who have no dependents	Federal Mandate (OBRA 90)
7/1/91	Coverage of children born after 9/30/83 with income up to 100% federal poverty level. To be phased in up to age 19	Federal Mandate (OBRA 90)
10/21/91	Exclude SSA income and resource accounts set up under Plan for Achieving Self Support	State initiative - out of court settlement with NH Legal Assistance
5/11/92	Resource offset for life insurance. Adult categories of financial and medical assistance	State initiative - Favreau v. Department of Human Services Consent Decree
7/1/92	Increase income limit for poverty level pregnant women and children under age one from 133% federal poverty level to 150% federal poverty level	State Mandate (SB 319)
12/1/92	Allow a one month - six month option for In & Out spend down cases	State Initiative (to avoid litigation)
1/1/93	Payment of Medicare Part B premiums for specified low-income Medicare beneficiaries (SLMBs)	Federal Mandate (OBRA 90)
8/10/93	Certain trusts established for the benefit of disabled individuals are exempt resources for Medicaid eligibility determinations.	Federal Mandate (OBRA 93)
12/1/93	Use SSI earned income disregards for APTD applicants and beneficiaries. Use SSI definition of disability to determine medical eligibility for APTD applicants and beneficiaries	State Mandate (HB-2-FN)
1/1/94	Increase income limits for poverty level groups (pregnant women, children born after 9/30/83) to 170% federal poverty level, initial processing of MA cases through clinics expanded	State Mandate (SB 209)
7/1/94	Use of shortened application form, presumptive eligibility for poverty level pregnant women who apply through prenatal clinics	State Initiative
7/1/94	Increase income limits for poverty level groups to 185% of the federal poverty level. Also expand coverage of children to through age 18	State Mandate (SB 774)
1/1/95	Increase income limits for specified low-income Medicare beneficiaries to 120% federal poverty level	Federal Mandate (OBRA 90)
5/1/96	Conversion from "full-month" Medicaid coverage (if the individual is eligible at anytime during the month, the individual is eligible for the whole month) to date specific eligibility.	State Initiative
2/1/97	Welfare Reform - For TANF-related MA: except for PL cases, change employment expense disregard from \$90/mo to 20% of gross income; exclude one vehicle per household; elimination of the equity value of life insurance as a resource; and elimination of the "3 of the last 6 month" criterion for EMA eligibility any time financial assistance closes due to increased earned income.	State Initiative
1/1/98	Payment of Medicare Part B premiums for specified low-income Medicare beneficiaries whose income is higher than 120% of the Federal poverty level but less than or equal to 135% of the Federal poverty level and who are not receiving MA.	Federal Mandate (Balanced Budget Act of 1997)
1/1/98	Increase in the nursing facility income cap to \$1,250. The change in income limit effected nursing facility eligibility and eligibility for all home and community-based care programs.	Mandated by the language in the HCBC-ECI waiver, which stated that the income limit for the HCBC-ECI was a certain percentage of the State Supplementary Income maximum payment level.

<b>Implementation Date</b>	<b>Program Expansion</b>	<b>Reason</b>
5/1/98	Increase the income limit for infants under age one who are not covered by other health insurance and whose family income is higher than 185% of the Federal poverty level but less than or equal to 300% of the Federal poverty level.	State Initiative
7/1/99	Increase in the substantial gainful activity (SGA) income criterion from \$500 to \$700 per month. The State is required to use SSI earned income disregards for APTD applicants and beneficiaries.	State Mandate (Chp. 225, NH laws of 1999; and 20 CFR 404.1574(b)(2), (3), and (4), and 416.974(b)(2), (3), and (4))
8/1/99	Increase in the monthly personal needs allowance from \$40 to \$50 for residents of nursing facilities, community residences and residential care facilities.	State Mandate (RSA 167:27-a)
8/1/99	Increase in the NHEP/FAP maximum shelter allowance from \$243 to \$268 subsequently changed the NHEP/FAP SON as well as the PIL for group sizes 2 or more by \$25.	State Initiative
4/1/00	Increase in the NHEP/FAP maximum shelter allowance subsequently changed the NHEP/FAP SON by \$25.	State Initiative
8/1/00	Allow 50% earned income disregard for TANF cat needy; increase cat needy resource limit to \$2000	State Initiative
8/1/00	Extend 12 month EMA to TANF cat needy cases closed due to increased income or hours of employment	State Initiative
10/1/00	Revised earned income computation for OAA, QMB, SLMB, SLMB135, SLMB175, and QWDI to use the SSI methodology. Eliminated the employment expense disregard for all adult eligibility determinations.	State Initiative
1/1/01	Formula established to automatically increase the significant gainful activity (SGA) level annually. As a result of the formula, the SGA level was increased from \$700 to \$740.	Federal Mandate (20 CFR 416.974 (b)(2)(ii)(B))
1/1/01	Removed language, which made spouses legally liable for their spouses and parents legally liable for their children in determining Medicaid eligibility. Federal mandates still apply.	State Mandate (RSA 167:3-b)
3/1/01	New coverage group - Women diagnosed with breast or cervical cancer (or a pre-cancerous condition) by the Breast and Cervical Cancer Prevention program.	State Initiative
2/1/02	New Coverage group - Medicaid for Employed Adults with Disabilities – MEAD	State Mandate (RSA 167:6; TWWIIA)
4/03 - 6/03	State Medicaid matching rates raised by 2.95 % from 4/03 thru 6/04 as temporary federal fiscal relief for the states due to an economic downturn, to counteract declines in state revenue collections at the same time Medicaid program were facing increased enrollments.	Federal Mandate (Jobs and Growth Tax Relief Reconciliation Act of 2003)
2003	Established new Medicare Part D prescription drug program. Medicaid drug coverage for dual eligibles, those who qualify for both Medicaid and Medicare, transferred to Medicare as of Jan. 1, 2006. States are required to make monthly “clawback” payments to Medicare, reflecting savings in Medicaid drug expenditures.	Federal Mandate Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
2004	Implemented Preferred Drug List (PDL) and supplemental rebate program for Medicaid prescription drug program.	State Initiative
2004	Developed and implemented Medicaid Decision Support System (MDSS).	State Initiative

<b>Implementation Date</b>	<b>Program Expansion</b>	<b>Reason</b>
3/2005	Implemented Medicaid Health Management Program to provide high quality, cost-effective disease management care for Medicaid participants with chronic illnesses.	State Initiative
5/2005	Secretary of HHS appoints advisory Medicaid Commission to recommend ways to modernize Medicaid. The Commission is charged with preparing a report on cost savings and another report on longer-term sustainability recommendations.	Federal Initiative
7/2005	Medicaid will provide wraparound coverage for the several classes of drugs excluded from Medicare Part D coverage.	State Initiative (Chp. 294:2, NH Laws of 2005)
7/2005	Enactment of care management pilot program to support the efficient and effective delivery of primary and specialty care services focused on prevention and each client having a medical home.	State Initiative (Chp. 177:123, NH Laws of 2005)
8/2005	Medicaid Commission releases first report, with recommendations to reduce Medicaid spending growth by \$11 billion over the next five years while working toward longer-term program changes to better serve beneficiaries.	Federal Initiative
2005-2006	Developed and implemented plan for preparation and start-up of Medicare Part D prescription drug program, covering all education, outreach and systems activities to transition all duals eligibles (had both Medicaid and Medicare) to new program.	State Initiative - see MMA above
2/2006	Federal provisions to reduce the rate of federal and state Medicaid spending growth through new flexibility on Medicaid premiums, cost sharing and benefits, along with tighter controls on asset transfers to qualify for long-term care.	Federal Initiative & Mandate - Deficit Reduction Act of 2005 (DRA)
11/2006	Medicaid Commission releases second report, with recommendations for long-term Medicaid reforms. Focused on improving health of beneficiaries through a more efficient Medicaid system.	Federal Initiative
7/2008	Required State Medicaid Agencies to accept and process as applications for Medicare Savings Programs (MSP) information received by the Social Security Administration by applicants for the low-income subsidy under Medicare Part D, increased MSP resource limits to match those for LIS, and exempted Medicare cost sharing benefits paid under MSPs from Medicaid estate recovery.	Federal Initiative & Mandate - Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
2/2009	Programmatic and budgetary changes to the Children's Health Insurance Program.	Federal Initiative & Mandate – Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
2/2009	Temporary increases in FMAP rates and DSH allotments along with HIT enhancements, including incentives to adopt electronic health records (EHRs)	Federal Initiative – American Recovery and Reinvestment Act of 2009 (ARRA)

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## Appendix 2. Recent New Hampshire Laws Relative to Medicaid

The following recently enacted laws impacted NH Medicaid during SFY 2009.

- Extended the moratoriums on nursing home beds and rehabilitation until June 30, 2009, asserted the right of individuals to use person-centered planning to develop support plans for their Medicaid-funded nursing home services, maintained eligibility criteria for nursing facility services which were scheduled to change on July 1, 2007, required DHHS to submit accurate cost estimates of the full state cost to adequately fund long-term care services as part of its budget request, and authorized establishment of a presumptive eligibility process for applicants seeking Medicaid or Medicaid-waiver coverage for long-term care services. (Chp. 330, NH Laws of 2007).
- Enacted package including the following provisions (Chp. 263, NH Laws of 2007):
  - Limited the ability of DHHS to change program eligibility standards and rates in the biennium ending June 30, 2009;
  - Authorized the Commissioners of Health and Human Services and Revenue Administration to extend an information sharing agreement for determining and reviewing eligibility for Medicaid and Temporary Assistance to Needy Families (TANF) through June 30, 2009;
  - Reduced the Medicaid enhancement tax and the nursing facility quality assessment fee from 6 percent to 5.5 percent.
- Established certain additional criteria for administration of the Medicaid for employed adults with disabilities (MEAD) program, permitting individuals who are eligible for home and community-based care waiver services and who qualify for a special income limit, to receive medical assistance through the MEAD program. (Chapter 76, NH laws of 2008).
- Clarified the Medicaid long-term care determination process by requiring a nurse to obtain medical records only if the nurse is unable to determine that an applicant is eligible following the required clinical assessment. (Chapter 168, NH Laws of 2008).
- Limited recovery of assistance to property interests created on or after July 1, 2005 and also limited recovery to the value of the interest held by the recipient of the assistance. Further required DHHS to provide written notice of the procedure for obtaining a hardship waiver and those persons who are exempt from recovery by state and federal law. (Chapter 253, NH Laws of 2008).
- Permitted a prior appropriation to DHHS for nursing services to lapse on June 30, 2009, provided that the total county reimbursement obligation be reduced by the amount of the credit counties receive for nursing home and HCBC-ECI care, and limited county obligations for certain nursing home and juvenile service costs to the maximum obligation the county would have incurred under the methodology used prior to July 1, 2008. (Chapter 296:18-20, NH Laws of 2008).
- Repealed and reenacted the Medicaid to Schools Program with more detailed explanation of services provided. (Chapter 302:25-26, NH Laws of 2008).
- Prohibited insurers from refusing to enroll or pay for services for persons eligible for Medicaid. Also made changes to third party liability and recovery of public assistance (TPL) as required by the federal Deficit Reduction Act of 2005 to clarify that insurers must allow the State to recover payment from them when Medicaid has paid for medical services for an individual under their coverage. (Chapter 342, NH Laws of 2008).

### Appendix 3: Provider Payment Rate Changes in SFY 2009

Description	Old Rate	New Rate	Authority	Effective Date	DHHS Unit
Ultra Violet Light Therapy Systems	\$0.00 - \$0.00	\$74.14 - \$959.11	Medicaid program review	07/01/2008	OMBP
Rate for K0738– Portable Gaseous	\$0.00	\$30.97	Medicaid program review	08/01/2008	OMBP
Hearing Aid Increases	\$0.00 - \$0.00	\$0.00 - \$1275.00	Medicaid program review	10/01/2008	OMBP
Gel Pressure Pad for Mattress & Gel Pressure Mattress	\$0.00 - \$60.00	\$24.86 - \$255.89	Medicaid program review	07/01/2008	OMBP
Set Rate for L2005	\$0.00	\$2,254.34	Medicaid program review	07/31/2008	OMBP
Kindred Hospital - Waltham	\$850.00	\$900.00	Medicaid program review	11/06/2008	OMBP
Personal Care Services - 2 % decrease	\$4.47	\$4.38	Executive Order 2008-10	12/01/2008	OMBP
Personal Care Services - 2 % Increase	\$4.38	\$4.47	SFY 2008-2009 Budget	01/01/2009	OMBP
Ambulance Ground Mileage - 13.7% decrease	\$2.96	\$2.60	Executive Order 2008-10	12/01/2008	OMBP
Ambulance Ground Mileage - 13.7% Increase	\$2.60	\$2.96	SFY 2008-2009 Budget	01/01/2009	OMBP
Wheelchair Van Services - 2 % decrease	\$2.51 - \$27.90	\$2.46 - \$27.35	Executive Order 2008-10	12/01/2008	OMBP
Wheelchair Van Services - 2 % increase	\$2.46 - \$27.35	\$2.51 - \$27.90	SFY 2008-2009 Budget	01/01/2009	OMBP
Adult Medical Day Care Services - 2% decrease	\$11.16 - \$50.22	\$10.94 - \$ 49.24	Executive Order 2008-10	12/01/2008	OMBP
Adult Medical Day Care Services - 2% increase	\$10.94 - \$ 49.24	\$11.16 - \$50.22	SFY 2008-2009 Budget	01/01/2009	OMBP
Inpatient DRG Point Rate Changes - 10% decrease - 5 groups	\$3,147.61 - \$16,127.76	\$2,832.85 - \$14,514.98	Executive Order 2008-10	12/01/2008	OMBP
Physician Services - 2% Decrease	2% decrease	2% decrease	Executive Order 2008-10	12/01/2008	OMBP
Physician Services - 2% Increase	2% increase	2% increase	SFY 2008-2009 Budget	01/01/2009	OMBP
Dental - Increase for 25 procedure codes	\$29.00 - \$552.00	\$30.50 - \$625.00	SFY 2008-2009 Budget	01/01/2009	OMBP
Outpatient Interim Rate Changes	81.24%	54.04%	RSA 126-A:3, VII SFY 2008-2009 Budget	07/01/2008	OMBP
Home Health Services Rate Change	\$5.96 - \$21.50	\$6.14 - \$22.18	Adopted rules	01/01/2009	OMBP
County Bill rate change for 2009 (Medicare Part D)	\$140.23	\$150.27	State Phase Down Contribution	01/01/2009	OMBP
FQHC/RHC Encounter Rates	\$72.18 - \$156.16	\$76.84 - \$158.66	National Government Services periodic notice	04/01/2009	OMBP
Changing Procedure Codes to a PAC 9 with a rate of zero.	\$13.45 - \$924.94	\$0.00	Medicaid program review	01/01/2009	OMBP
Put up Procedure Code S0515	\$0.00	\$1,800.00	Medicaid program review	01/01/2009	OMBP
Choices for Independence (HCBC) rate changes	\$1.67 - \$61.20	\$1.70 - \$62.40	SFY 2008-2009 Budget	01/01/2009	BEAS
Changes to HCBC-ECI Level 1 Pricing for Supportive Housing	\$50.00	\$50.00	Contract change	03/01/2009	BEAS
Rate Increase for Supported Housing	\$35.00	\$36.00	BEAS program review	01/01/2009	BEAS

Description	Old Rate	New Rate	Authority	Effective Date	DHHS Unit
BBH Rate Change	provider specific	provider specific	BBH initiative	10/01/2008	BBH
BBH Rate Change	2% decrease	2% decrease	Executive Order 2008-10	12/01/2008	BBH
BBH Rate Change	2% increase	2% increase	SFY 2008-2009 Budget	12/01/2008	BBH
Medicaid Rate Change – NFI – Riverside School	\$100.10	\$97.49	Annual review	07/01/2008	DCYF
Medicaid Rate Change – NFI - North Midway Shelter Care Facility	\$136.54	\$127.47	Governor and Executive Council approved a new contract	07/01/2008	DCYF
Medicaid Rate Change – Tobey School	\$146.42	\$207.77	Annual review	07/01/2008	DCYF
Medicaid Rate Change – Germaine Lawrence	\$158.30	\$170.23	Annual review	07/01/2008	DCYF
PNMI Rate Change - Eckerd Youth Services	\$72.42	\$62.48	Governor and Executive Council approved new contract	07/01/2008	DCYF
PNMI Rate Change - Eckerd Youth Services	\$62.48	\$74.45	Governor and Executive Council revised contract	07/01/2008	DCYF
Medicaid Rate Change – Stetson School	\$107.22	\$90.02	Governor and Executive Council approved new contract	07/01/2008	DCYF
Medicaid Rate Request – ISN - ISO Foster Care	\$0.00	\$98.45	Provider number changed due to corporate change	03/01/2008	DCYF
Medicaid Rate Change – Lake Grove at Maple Valley	\$78.60	\$79.97	Annual review	03/01/2008	DCYF
St. Charles Children’s Home Medicaid Rate	\$32.83	\$61.92	SFY 2009 DHHS budget	07/01/2008	DCYF
Medicaid Rate Change – Brandon Residential Treatment Center	\$0.00	\$142.70	Annual review	10/01/2008	DCYF
Medicaid Rate Request – NE Salem ISO Foster Care	\$0.00	\$95.08	NE Salem certified August 6, 2008	08/06/2008	DCYF
Home-Based Therapeutic Service Rate – Lutheran Community Services (LCS)	\$0.00	\$57.36	LCS certified October 1, 2008	10/01/2008	DCYF
Home-Based Therapeutic Service Rate Change - 10 Providers	\$57.36	\$56.24	Executive Order 2008-10	12/01/2008	DCYF
Child Health Support Rate Change	\$9.98	\$9.78	Executive Order 2008-10	12/01/2008	DCYF
Intensive Home and Community Rate Change - 2% decrease - 5 providers	\$55.51 - \$87.08	\$54.42 - \$85.37	Executive Order 2008-10	12/01/2008	DCYF
ISO In Home Programs - 2% decrease - 9 providers	\$107.88-\$151.84	\$105.72-\$148.80	Executive Order 2008-10	12/01/2008	DCYF
ISO Foster Care - 2% decrease - 11 providers	\$78.89 - \$191.87	\$77.31 - \$188.03	Executive Order 2008-10	12/01/2008	DCYF
NFI North ISO Foster Care	\$0.00	\$96.20	NFI North certified October 19, 2008	10/19/2008	DCYF
NFI North ISO In Home Programs	\$0.00	\$112.00	NFI North certified October 19, 2008	10/19/2008	DCYF

Description Abbreviations

ISO - individualized service option

PNMI - Private Non-Medical Institution

Executive Order 2008-10 - Required DHHS reductions were met in part by decreases in several NH Medicaid rates.

DHHS Unit acronyms

OMBP - Office of Medicaid Business & Policy

BEAS - Bureau of Elderly & Adult Services

BBH - Bureau of Behavioral Health

DCYF - Division for Children, Youth & Families

## Appendix 4a: NH Medicaid Expenditures by Service Categories, SFY 2009 Service Dates

Note: Sorted by SFY 2009 Total Cost

Category of Service	FY 2007			FY 2008			FY 2009			Percent Change 2007 to 2009		
	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient
Intermediate Care Facility Nursing Home	6,419	\$192,405,238	\$29,974	6,211	\$195,401,675	\$31,461	6,199	\$189,523,897	\$30,573	-3.43%	-1.50%	2.00%
Home & Community Based Care, Developmentally Impaired	3,514	\$154,957,332	\$44,097	3,735	\$169,396,774	\$45,354	3,968	\$179,699,021	\$45,287	12.92%	15.97%	2.70%
Mental Health Center	18,224	\$83,128,982	\$4,562	18,868	\$87,686,372	\$4,647	20,449	\$94,605,787	\$4,626	12.21%	13.81%	1.41%
Dispense Prescribed Drugs	87,075	\$70,133,412	\$805	88,224	\$76,002,311	\$861	94,575	\$85,048,590	\$899	8.61%	21.27%	11.71%
Outpatient Hospital, General	75,970	\$66,574,057	\$876	79,046	\$76,059,046	\$962	87,310	\$70,297,301	\$805	14.93%	5.59%	-8.09%
Inpatient Hospital, General	16,011	\$54,065,977	\$3,377	16,102	\$55,145,635	\$3,425	16,968	\$63,180,266	\$3,723	5.98%	16.86%	10.26%
Home & Community Based Care, Elderly & Chronically Ill	3,269	\$38,546,944	\$11,792	3,675	\$46,031,921	\$12,526	3,740	\$52,285,151	\$13,980	14.41%	35.64%	18.55%
Physicians Services	96,796	\$42,181,488	\$436	99,311	\$45,153,684	\$455	110,249	\$49,591,372	\$450	13.90%	17.57%	3.17%
Clinic Services	8,745	\$31,956,840	\$3,654	8,473	\$36,609,792	\$4,321	8,526	\$37,758,961	\$4,429	-2.50%	18.16%	21.20%
Dental Service	42,411	\$15,445,986	\$364	46,334	\$17,996,705	\$388	51,931	\$20,296,633	\$391	22.45%	31.40%	7.37%
Private Non-Medical Institutional For Children	1,259	\$22,846,207	\$18,146	1,191	\$21,159,382	\$17,766	1,103	\$20,005,787	\$18,138	-12.39%	-12.43%	-0.05%
Furnished Medical Supplies Or Durable Medical Equipment	12,801	\$10,191,935	\$796	13,676	\$11,794,098	\$862	15,281	\$13,970,228	\$914	19.37%	37.07%	14.85%
Rural Health Clinic	21,817	\$10,789,841	\$495	22,075	\$11,211,447	\$508	24,509	\$12,742,094	\$520	12.34%	18.09%	5.03%
Skilled Nursing Facility Nursing Home	2,778	\$8,782,242	\$3,161	2,774	\$8,950,399	\$3,227	3,362	\$10,490,604	\$3,120	21.02%	19.45%	-1.29%
Day Habilitation Center	2,400	\$7,716,872	\$3,215	2,636	\$8,445,452	\$3,204	2,956	\$9,097,498	\$3,078	23.17%	17.89%	-4.27%
Private Duty Nursing	122	\$6,960,712	\$57,055	137	\$7,076,336	\$51,652	151	\$8,128,111	\$53,829	23.77%	16.77%	-5.65%
Home Health Services	2,836	\$7,087,274	\$2,499	2,809	\$7,131,144	\$2,539	3,154	\$7,564,443	\$2,398	11.21%	6.73%	-4.03%
Personal Care	176	\$5,246,505	\$29,810	168	\$5,196,565	\$30,932	183	\$6,026,997	\$32,934	3.98%	14.88%	10.48%
Placement Services	196	\$4,155,045	\$21,199	213	\$4,885,066	\$22,935	223	\$5,121,297	\$22,965	13.78%	23.25%	8.33%
SNF Nursing Home Atypical Care	56	\$4,675,267	\$83,487	55	\$5,071,266	\$92,205	51	\$4,832,384	\$94,753	-8.93%	3.36%	13.49%
Inpatient Psychiatric Facility Services Under Age 22	354	\$3,185,235	\$8,998	315	\$3,196,689	\$10,148	327	\$3,895,915	\$11,914	-7.63%	22.31%	32.41%
Psychology	5,890	\$3,631,132	\$616	6,065	\$3,444,986	\$568	6,376	\$3,667,994	\$575	8.25%	1.02%	-6.61%
Intensive Home And Community Services	186	\$2,315,238	\$12,448	234	\$2,985,082	\$12,757	421	\$3,580,431	\$8,505	126.34%	54.65%	-31.68%

Category of Service	FY 2007			FY 2008			FY 2009			Percent Change 2007 to 2009		
	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient
Medical Services Clinic	1,789	\$2,043,178	\$1,142	1,881	\$2,826,452	\$1,503	1,843	\$3,325,670	\$1,804	3.02%	62.77%	58.01%
Wheelchair Van	2,651	\$2,869,407	\$1,082	2,493	\$3,005,047	\$1,205	2,826	\$3,170,243	\$1,122	6.60%	10.48%	3.68%
ICF Services For The Mentally Retarded	39	\$2,468,361	\$63,291	38	\$3,058,029	\$80,474	42	\$3,028,496	\$72,107	7.69%	22.69%	13.93%
ICF Nursing Home Atypical Care	74	\$3,926,226	\$53,057	77	\$2,932,777	\$38,088	70	\$2,964,634	\$42,352	-5.41%	-24.49%	-20.18%
Ambulance Service	7,976	\$1,568,675	\$197	8,041	\$1,690,686	\$210	9,570	\$2,062,668	\$216	19.98%	31.49%	9.41%
Home Based Therapy	585	\$2,176,328	\$3,720	556	\$2,059,841	\$3,705	501	\$1,719,866	\$3,433	-14.36%	-20.97%	-7.72%
Optometric Services Eyeglasses	17,180	\$1,046,251	\$61	16,610	\$1,320,050	\$79	19,386	\$1,679,708	\$87	12.84%	60.55%	42.04%
Laboratory (Pathology)	17,368	\$1,294,690	\$75	17,072	\$1,476,689	\$86	17,646	\$1,596,345	\$90	1.60%	23.30%	20.62%
Child Health Support Service	378	\$1,182,847	\$3,129	433	\$1,571,028	\$3,628	400	\$1,417,132	\$3,543	5.82%	19.81%	13.23%
Physical Therapy	1,665	\$902,721	\$542	1,665	\$1,008,877	\$606	1,944	\$1,216,670	\$626	16.76%	34.78%	15.47%
Adult Medical Day Care	185	\$885,258	\$4,785	194	\$933,542	\$4,812	207	\$960,198	\$4,639	11.89%	8.47%	-3.06%
Family Planning Services	1,785	\$537,555	\$301	1,818	\$581,489	\$320	1,762	\$557,982	\$317	-1.29%	3.80%	5.21%
X-Ray Services	2,328	\$283,783	\$122	3,171	\$379,016	\$120	4,896	\$493,628	\$101	110.31%	73.95%	-17.36%
Occupational Therapy	423	\$217,564	\$514	482	\$281,828	\$585	452	\$419,940	\$929	6.86%	93.02%	80.75%
Advanced Registered Nurse Practitioner	2,053	\$435,885	\$212	2,460	\$486,682	\$198	2,012	\$385,769	\$192	-2.00%	-11.50%	-9.56%
Crisis Intervention	11	\$120,686	\$10,971	13	\$225,476	\$17,344	12	\$323,082	\$26,924	9.09%	167.70%	145.41%
I/P Hospital Swing Beds, SNF	76	\$367,149	\$4,831	79	\$424,645	\$5,375	85	\$234,414	\$2,758	11.84%	-36.15%	-42.91%
Podiatrist Services	3,320	\$194,892	\$59	3,289	\$196,677	\$60	3,393	\$205,199	\$60	2.20%	5.29%	2.50%
Speech Therapy	133	\$92,320	\$694	229	\$102,805	\$449	308	\$157,697	\$512	131.58%	70.82%	-26.22%
I/P Hospital Swing Beds, Icf	11	\$14,544	\$1,322	12	\$43,663	\$3,639	16	\$104,984	\$6,561	45.45%	621.83%	396.33%
Certified Midwife (Non-Nurse)	80	\$68,650	\$858	93	\$87,414	\$940	107	\$96,957	\$906	33.75%	41.23%	5.61%
Chiropractic	970	\$62,136	\$64	1,073	\$66,249	\$62	1,103	\$69,716	\$63	13.71%	12.20%	-1.24%
Audiology Services	669	\$34,160	\$51	586	\$32,594	\$56	618	\$29,593	\$48	-7.62%	-13.37%	-6.11%
Outpatient Hospital, Mental	13	\$3,275	\$252	28	\$3,442	\$123	27	\$1,516	\$56	107.69%	-53.70%	-77.71%
Inpatient Hospital, Mental							1	\$1,068	\$1,068	-	-	-
Other							2	\$247	\$124	-	-	-
<b>Total</b>	<b>124,078</b>	<b>\$869,776,299</b>	<b>\$7,010</b>	<b>127,577</b>	<b>\$930,826,825</b>	<b>\$7,296</b>	<b>136,791</b>	<b>\$977,634,356</b>	<b>\$7,147</b>	<b>10.25%</b>	<b>12.40%</b>	<b>1.95%</b>

\*Difference from \$1.36 Billion for SFY 2009 due to provider spending for services with dates of services (7/1/2008-6/30/2009); does not reflect administrative, cost settlements, rebates or other off-claim payments

## Appendix 4b: NH Medicaid Expenditures by Service Categories, SFY 2009 Paid Dates

Category of Service	Total Cost of Coverage
Intermediate Care Facility Nursing Home	\$190,691,566
Home & Community Based Care, Developmentally Impaired	\$180,538,151
Mental Health Center	\$95,439,185
Dispense Prescribed Drugs	\$84,077,354
Outpatient Hospital, General	\$69,137,172
Inpatient Hospital, General	\$64,410,849
Home & Community Based Care, Elderly & Chronically Ill	\$51,552,374
Physicians Services	\$49,777,896
Clinic Services	\$40,324,890
Private Non-Medical Institutional for Children	\$20,444,404
Dental Service	\$20,238,867
Furnished Medical Supplies or Durable Medical Equipment	\$14,195,896
Rural Health Clinic	\$12,812,303
Skilled Nursing Facility Nursing Home	\$11,708,246
Day Habilitation Center	\$9,113,302
Private Duty Nursing	\$7,661,854
Home Health Services	\$7,332,617
Personal Care	\$6,121,694
SNF Nursing Home Atypical Care	\$5,438,185
Placement Services	\$5,288,016
Inpatient Psychiatric Facility Services Under Age 22	\$4,256,032
Psychology	\$3,693,913
Intensive Home and Community Services	\$3,566,174
Medical Services Clinic	\$3,561,675
Wheelchair Van	\$3,206,252
ICF Services for the Mentally Retarded	\$3,059,195
ICF Nursing Home Atypical Care	\$3,009,545
Ambulance Service	\$1,979,520
Home Based Therapy	\$1,782,855
Optometric Services Eyeglasses	\$1,649,889
Laboratory (Pathology)	\$1,581,764
Child Health Support Service	\$1,418,461
Physical Therapy	\$1,228,269
Adult Medical Day Care	\$968,674
Family Planning Services	\$581,851
X-Ray Services	\$561,962
Occupational Therapy	\$409,496
I/P Hospital Swing Beds, SNF	\$376,026
Advanced Registered Nurse Practitioners	\$375,178
Crisis Intervention	\$297,304
Podiatrist Services	\$208,910
Speech Therapy	\$145,771
I/P Hospital Swing Beds, ICF	\$132,988
Certified Midwife (Non-Nurse)	\$85,966
Chiropractic	\$70,361
Audiology Services	\$29,948
Outpatient Hospital, Mental	\$1,607
Other	\$247
<b>Subtotal - Provider Payments</b>	<b>\$984,544,786</b>

<b>Category of Service</b>	<b>Total Cost of Coverage</b>
Nursing Facility Supplemental	\$68,678,682
Provider System Payout Non-Claim Specific	\$13,859,897
Insurance Premium Carrier System Payout	\$557,761
Provider Refund Claim Specific	-\$67,914
Provider Recoupment Non-Claim Specific	-\$742,289
Third Party Liability Carrier Refund Non-Claim Specific	-\$1,031,379
Recipient Refund Non-Claim Specific	-\$1,937,367
Provider Refund Non-Claim Specific	-\$13,314,169
<b>Subtotal - Non Claim Payments, Recoupments, Refunds</b>	<b>\$66,003,221</b>
<b>Total*</b>	<b>\$1,050,548,007</b>

\* Total NH Medicaid expenditures totaled \$1.36 billion in SFY 2009. The figures in this table cover payments to providers and cost settlements, rebates, and other types of non-claim payments, based on payment dates from July 1, 2007 through June 30, 2009. The figures in this table do not include expenditures for administration, disproportionate share hospital, and other payments that take place outside the Medicaid Management Information System.

## Appendix 5: NH Medicaid Per Member Per Month Expenditures by Service Categories for Eligibility Groups, SFY 2009

Category of Service Groups	Total Medicaid Enrollment	Low-income Adult	Low-income Child	Severely Disabled Child	Disabled Mental	Disabled Physical	Elderly
HCBC	\$183.40	\$5.63	\$20.43	\$559.08	\$860.28	\$976.08	\$388.39
Nursing Facility	\$141.88	\$0.68	\$0.83	\$1.20	\$78.43	\$196.65	\$1,644.67
Behavioral Health	\$67.21	\$25.96	\$36.76	\$175.20	\$391.16	\$67.96	\$43.82
Prescription Drugs	\$57.97	\$77.26	\$31.09	\$187.10	\$148.06	\$210.86	\$27.40
Hospital-Outpatient	\$47.92	\$104.43	\$24.30	\$65.31	\$70.21	\$156.08	\$39.37
Hospital-Inpatient	\$45.72	\$75.85	\$27.49	\$78.76	\$56.63	\$169.45	\$42.25
Other Professional	\$39.92	\$46.47	\$31.21	\$757.66	\$25.79	\$59.15	\$4.46
Physician & Related	\$34.13	\$78.63	\$23.54	\$20.75	\$36.26	\$82.61	\$19.28
PNMI For Children	\$13.83	\$5.95	\$20.73	\$10.42	\$4.76	\$4.07	\$0.72
Dental Service	\$13.64	\$0.00	\$22.31	\$0.89	\$5.92	\$0.27	\$0.00
Vision & DME	\$10.67	\$4.99	\$4.81	\$107.42	\$12.37	\$55.36	\$14.66
Other	\$4.46	\$0.00	\$7.09	\$5.09	\$2.34	\$0.44	\$0.00
Transportation	\$3.57	\$1.78	\$0.67	\$2.24	\$4.34	\$19.90	\$16.23
Intermediate Care Facility - MR	\$2.06	\$0.00	\$3.18	\$10.16	\$0.22	\$0.81	\$0.00
<b>Total</b>	<b>\$666.38</b>	<b>\$427.62</b>	<b>\$254.45</b>	<b>\$1,981.28</b>	<b>\$1,696.77</b>	<b>\$1,999.68</b>	<b>\$2,241.25</b>

**Appendix 6a: Comparison of NH Medicaid Members Cost and Service Use by Members Using Home and Community Based Care Services (HCBC), Nursing Facilities, and all Others, SFY 2009**

Service Categories	Members Receiving Home & Community Based Care Services in Year				Members Using Nursing Facilities and No HCBC Use				Member Not Receiving Home and Community Based Care Services or Nursing Facility			
	Total Claims Payment	Service Users	Service Users as a % of Members	PMPM	Total Claims Payment	Service Users	Service Users as a % of Members	PMPM	Total Claims Payment	Service users	Service Users as a % of Members	PMPM
Hospital-Inpatient	\$27,993,366	3,777	28.03%	\$191.59	\$3,012,451	1,059	17.44%	\$50.97	\$36,071,432	12,423	10.60%	\$28.59
Hospital-Outpatient	\$15,285,195	10,192	75.64%	\$104.61	\$1,384,699	2,527	41.62%	\$23.43	\$53,628,923	74,593	63.62%	\$42.50
Physician & Related	\$9,318,523	11,620	86.23%	\$63.78	\$956,151	4,562	75.13%	\$16.18	\$39,799,424	94,290	80.42%	\$31.54
Other Professional Services	\$21,311,043	6,477	48.07%	\$145.85	\$291,801	2,852	46.97%	\$4.94	\$36,970,653	43,127	36.78%	\$29.30
Prescription Drugs	\$20,028,497	10,175	75.51%	\$137.08	\$1,738,411	5,100	83.99%	\$29.42	\$63,281,682	79,300	67.64%	\$50.15
Behavioral Health Services	\$13,656,039	3,114	23.11%	\$93.46	\$646,901	514	8.47%	\$10.95	\$84,293,923	21,815	18.61%	\$66.80
Transportation	\$3,053,602	3,148	23.36%	\$20.90	\$930,982	2,490	41.01%	\$15.75	\$1,248,327	5,338	4.55%	\$0.99
Dental Service	\$901,817	2,873	21.32%	\$6.17	\$13,957	28	0.46%	\$0.24	\$19,380,860	49,030	41.82%	\$15.36
Home & Community Based Care	\$269,061,717	13,475	100.00%	\$1,841.48	\$0	0	0.00%	\$0.00	\$0	0	0.00%	\$0.00
Nursing Facility	\$13,038,463	876	6.50%	\$89.24	\$195,112,454	6,072	100.00%	\$3,302	\$0	0	0.00%	\$0.00
Vision & Other Durable Medical Equipment	\$9,147,567	6,434	47.75%	\$62.61	\$432,336	1,910	31.46%	\$7.32	\$6,070,033	23,363	19.93%	\$4.81
Private Non-Medical Institutions For Children	\$5,112,155	337	2.50%	\$34.99	\$0	0	0.00%	\$0.00	\$14,893,632	766	0.65%	\$11.80
Mental Retardation Facility Services	\$850,303	24	0.18%	\$5.82	\$9,222	1	0.02%	\$0.16	\$2,168,971	17	0.01%	\$1.72
Other	\$1,744,493	223	1.65%	\$11.94	0	0	0.00%	0	\$4,794,354	382	0.33%	\$3.80
<b>Total</b>	<b>\$410,502,779</b>	<b>13,475</b>		<b>\$2,810</b>	<b>\$204,529,366</b>	<b>6,072</b>		<b>\$3,461</b>	<b>\$362,602,212</b>	<b>117,244</b>		<b>\$287</b>

## Appendix 6b: Comparison of NH Medicaid Members Cost and Service Use by Dual Eligible Status, SFY 2009

Service Categories	Dual Eligible			Medicaid Only		
	Total Claims Payment	Service Users	PMPM	Total Claims Payment	Service Users	PMPM
Hospital-Inpatient	\$8,223,564	4,735	\$31.88	\$58,853,685	12,585	\$48.67
Hospital-Outpatient	\$11,889,339	17,580	\$46.10	\$58,409,478	70,655	\$48.31
Physician & Related	\$5,210,669	21,034	\$20.20	\$44,863,429	90,471	\$37.10
Other Professional Services	\$1,962,718	10,058	\$7.61	\$56,610,778	42,775	\$46.82
Prescription Drugs	\$3,996,038	13,609	\$15.49	\$81,052,552	81,949	\$67.03
Behavioral Health Services	\$40,238,096	7,193	\$156.01	\$58,358,767	18,809	\$48.26
Transportation	\$3,012,549	6,264	\$11.68	\$2,220,361	4,762	\$1.84
Dental Service	\$562,734	1,444	\$2.18	\$19,733,899	50,521	\$16.32
Home & Community Based Care	\$169,409,187	5,644	\$656.82	\$99,652,529	7,997	\$82.41
Nursing Facility	\$193,826,288	6,539	\$751.49	\$14,324,629	460	\$12
Vision & Other Durable Medical Equipment	\$4,241,287	10,452	\$16.44	\$11,408,649	21,473	\$9.44
Private Non-Medical Institutions For Children	\$196,983	7	\$0.76	\$19,808,804	1,101	\$16.38
Mental Retardation Services	\$21,477	1	\$0.08	\$3,007,019	42	\$2.49
Other	\$82,910	6	\$0.32	6455936.49	602	\$5.34
<b>Total</b>	<b>\$442,873,838</b>	<b>25,378</b>	<b>\$1,717.08</b>	<b>\$534,760,518</b>	<b>113,108</b>	<b>\$442.25</b>

## Appendix 7: New Hampshire Medicaid Enrollment and Total Expenditures by New Hampshire Cities and Towns – SFY 2009 Service Dates

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Acworth	683	57	\$374,214	\$547.90
Albany	498	42	\$234,328	\$470.54
Alexandria	1,391	116	\$575,347	\$413.62
Allenstown	6,329	527	\$2,956,776	\$467.18
Alstead	1,801	150	\$890,175	\$494.27
Alton	4,403	367	\$2,470,435	\$561.08
Amherst	3,071	256	\$2,464,346	\$802.46
Andover	1,678	140	\$988,203	\$588.92
Antrim	2,941	245	\$1,491,997	\$507.31
Ashland	2,921	243	\$1,230,111	\$421.13
Atkinson	2,443	204	\$6,700,078	\$2,742.56
Auburn	2,290	191	\$1,708,399	\$746.03
Barnstead	4,665	389	\$1,851,195	\$396.83
Barrington	6,322	527	\$3,166,173	\$500.82
Bartlett	1,775	148	\$799,036	\$450.16
Bath	1,096	91	\$334,621	\$305.31
Bedford	6,072	506	\$9,047,628	\$1,490.06
Belmont	8,660	722	\$4,894,577	\$565.19
Bennington	1,619	135	\$862,085	\$532.48
Benton	178	15	\$113,992	\$640.40
Berlin	23,145	1,929	\$17,944,073	\$775.29
Bethlehem	3,084	257	\$1,413,247	\$458.25
Boscawen	5,994	500	\$10,249,048	\$1,709.88
Bow	2,565	214	\$2,989,042	\$1,165.32
Bradford	1,469	122	\$863,575	\$587.87
Brentwood	2,809	234	\$5,952,723	\$2,119.16
Bridgewater	360	30	\$128,776	\$357.71
Bristol	5,294	441	\$2,042,943	\$385.90
Brookfield	357	30	\$131,732	\$369.00
Brookline	1,688	141	\$1,109,817	\$657.47
Cambridge	27	2	*	*
Campton	4,770	398	\$1,968,345	\$412.65
Canaan	2,669	222	\$1,337,231	\$501.02
Candia	2,370	198	\$1,344,538	\$567.32
Canterbury	1,296	108	\$633,727	\$488.99
Carroll	1,087	91	\$931,378	\$856.83
Center Harbor	1,309	109	\$907,108	\$692.98
Charlestown	7,344	612	\$3,631,478	\$494.48
Chatham	262	22	\$52,752	\$201.34
Chester	2,200	183	\$1,626,158	\$739.16
Chesterfield	2,072	173	\$1,207,971	\$583.00
Chichester	1,430	119	\$994,695	\$695.59
Claremont	27,955	2,330	\$21,180,118	\$757.65
Clarksville	284	24	\$59,846	\$210.73
Colebrook	5,131	428	\$3,165,676	\$616.97
Columbia	540	45	\$446,516	\$826.88
Concord	62,054	5,171	\$76,326,366	\$1,230.00
Conway	18,312	1,526	\$13,413,897	\$732.52

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Cornish	916	76	\$484,180	\$528.58
Croydon	499	42	\$337,367	\$676.09
Dalton	1,440	120	\$581,105	\$403.55
Danbury	1,554	130	\$720,481	\$463.63
Danville	2,601	217	\$1,111,113	\$427.19
Deerfield	2,882	240	\$1,779,873	\$617.58
Deering	1,332	111	\$587,969	\$441.42
Derry	27,824	2,319	\$17,423,230	\$626.19
Dixville	12	1	*	*
Dorchester	487	41	\$108,275	\$222.33
Dover	30,124	2,510	\$21,458,093	\$712.33
Dublin	1,041	87	\$310,445	\$298.22
Dummer	309	26	\$216,871	\$701.85
Dunbarton	1,340	112	\$892,281	\$665.88
Durham	1,438	120	\$1,154,748	\$803.02
East Kingston	1,054	88	\$538,381	\$510.80
Easton	64	5	*	*
Eaton	178	15	\$124,613	\$700.08
Effingham	1,882	157	\$1,243,092	\$660.52
Ellsworth*	12	1	*	*
Enfield	3,862	322	\$2,175,697	\$563.36
Epping	5,636	470	\$2,853,324	\$506.27
Epsom	4,914	410	\$3,348,375	\$681.40
Errol	338	28	\$177,262	\$524.44
Exeter	9,606	801	\$6,280,038	\$653.76
Farmington	12,000	1,000	\$5,329,349	\$444.11
Fitzwilliam	2108	176	\$978,408	\$464.14
Francestown	748	62	\$380,230	\$508.33
Franconia	917	76	\$883,189	\$963.13
Franklin	18,625	1,552	\$9,983,687	\$536.04
Freedom	1,143	95	\$454,012	\$397.21
Fremont	2,311	193	\$2,168,170	\$938.20
Gilford	5,837	486	\$3,319,206	\$568.65
Gilmanton	3,232	269	\$1,635,342	\$505.98
Gilsum	789	66	\$298,350	\$378.14
Goffstown	8,525	710	\$7,947,083	\$932.21
Gorham	3,958	330	\$2,251,333	\$568.81
Goshen	953	79	\$773,903	\$812.07
Grafton	1,820	152	\$909,187	\$499.55
Grantham	1,019	85	\$646,645	\$634.59
Greenfield	1,597	133	\$2,395,241	\$1,499.84
Greenland	1,540	128	\$820,500	\$532.79
Greenville	2,948	246	\$992,338	\$336.61
Groton	267	22	\$186,915	\$700.05
Hampstead	3,698	308	\$2,820,926	\$762.82
Hampton	9,813	818	\$6,566,984	\$669.21
Hampton Falls	823	69	\$518,461	\$629.96
Hancock	956	80	\$609,946	\$638.02
Hanover	1,311	109	\$1,513,522	\$1,154.48
Harrisville	500	42	\$261,443	\$522.89
Haverhill	7,973	664	\$6,440,257	\$807.76
Hebron	831	69	\$284,223	\$342.03

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Henniker	3,309	276	\$1,464,487	\$442.58
Hill	1,693	141	\$696,025	\$411.12
Hillsborough	8,934	745	\$4,545,718	\$508.81
Hinsdale	6,094	508	\$1,984,548	\$325.66
Holderness	1,454	121	\$773,109	\$531.71
Hollis	1,959	163	\$1,396,735	\$712.98
Hooksett	8,156	680	\$4,712,249	\$577.76
Hopkinton	3,001	250	\$2,692,170	\$897.09
Hudson	14,767	1,231	\$7,997,570	\$541.58
Jackson	394	33	\$213,996	\$543.14
Jaffrey	6,510	543	\$3,916,474	\$601.61
Jefferson	1,141	95	\$630,248	\$552.37
Keene	27,517	2,293	\$29,285,107	\$1,064.26
Kensington	769	64	\$376,219	\$489.23
Kingston	3,669	306	\$2,209,952	\$602.33
Laconia	37,401	3,117	\$26,365,959	\$704.95
Lancaster	7,872	656	\$5,245,066	\$666.29
Landaff	399	33	\$201,818	\$505.81
Langdon	480	40	\$189,423	\$394.63
Lebanon	13,659	1,138	\$10,613,213	\$777.01
Lee	2,177	181	\$1,093,919	\$502.49
Lempster	1,614	135	\$870,353	\$539.25
Lincoln	2,157	180	\$923,855	\$428.31
Lisbon	3,387	282	\$1,482,955	\$437.84
Litchfield	4,463	372	\$3,327,177	\$745.50
Littleton	12,776	1,065	\$8,651,359	\$677.16
Londonderry	12,679	1,057	\$7,012,252	\$553.06
Loudon	4,456	371	\$2,983,661	\$669.58
Lyman	481	40	\$161,976	\$336.75
Lyme	441	37	\$533,444	\$1,209.62
Lyndeborough	907	76	\$564,169	\$622.02
Madbury	898	75	\$423,344	\$471.43
Madison	2,229	186	\$901,470	\$404.43
Manchester	215,607	17,967	\$117,403,353	\$544.52
Marlborough	2,824	235	\$1,369,711	\$485.03
Marlow	682	57	\$507,306	\$743.85
Mason	329	27	\$67,890	\$206.35
Meredith	7,043	587	\$3,707,519	\$526.41
Merrimack	12,599	1,050	\$7,925,853	\$629.09
Middleton	1,711	143	\$492,185	\$287.66
Milan	1,360	113	\$905,371	\$665.71
Milford	13,323	1,110	\$7,446,457	\$558.92
Milton	7,026	586	\$2,682,023	\$381.73
Monroe	826	69	\$506,692	\$613.43
Mont Vernon	1,125	94	\$842,799	\$749.15
Moultonborough	3,137	261	\$984,687	\$313.89
Nashua	117,106	9,759	\$71,692,323	\$612.20
Nelson	1,082	90	\$393,817	\$363.97
New Boston	3,405	284	\$2,573,912	\$755.92
New Castle	112	9	*	*
New Durham	2,831	236	\$1,393,615	\$492.27
New Hampton	2,409	201	\$1,210,817	\$502.62

<b>City/Town</b>	<b>Members Months</b>	<b>Average Enrollment</b>	<b>Expenditures</b>	<b>Per Member Per Month Payment</b>
New Ipswich	5,128	427	\$1,679,255	\$327.47
New London	1,719	143	\$1,728,053	\$1,005.27
Newbury	1,682	140	\$994,373	\$591.19
Newfields	547	46	\$578,637	\$1,057.84
Newington	388	32	\$280,580	\$723.14
Newmarket	8,197	683	\$3,805,352	\$464.24
Newport	14,185	1,182	\$9,990,174	\$704.28
Newton	2,696	225	\$1,039,938	\$385.73
North Hampton	2,385	199	\$1,538,379	\$645.02
Northfield	6,093	508	\$3,051,490	\$500.82
Northumberland	4,212	351	\$2,563,135	\$608.53
Northwood	3,929	327	\$2,792,513	\$710.74
Nottingham	2,660	222	\$1,402,134	\$527.12
Orange	150	13	\$69,444	\$462.96
Orford	2,095	175	\$3,283,687	\$1,567.39
Ossipee	9,496	791	\$4,903,705	\$516.40
Pelham	5,353	446	\$2,832,449	\$529.13
Pembroke	7,726	644	\$4,763,082	\$616.50
Peterborough	6,924	577	\$4,504,254	\$650.53
Piermont	808	67	\$468,157	\$579.40
Pittsburg	1,199	100	\$601,698	\$501.83
Pittsfield	8,868	739	\$3,980,536	\$448.87
Plainfield	978	82	\$722,578	\$738.83
Plaistow	4,422	369	\$3,047,543	\$689.18
Plymouth	7,787	649	\$4,420,116	\$567.63
Portsmouth	22,921	1,910	\$26,189,894	\$1,142.62
Randolph	202	17	\$291,745	\$1,444.28
Raymond	11,959	997	\$5,682,996	\$475.21
Richmond	1,665	139	\$1,362,040	\$818.04
Rindge	4,590	383	\$2,012,569	\$438.47
Rochester	59,486	4,957	\$30,059,767	\$505.33
Rollinsford	2,478	207	\$1,305,826	\$526.97
Roxbury	326	27	\$158,384	\$485.84
Rumney	3,747	312	\$2,551,076	\$680.83
Rye	2,138	178	\$1,816,045	\$849.41
Salem	18,305	1,525	\$10,954,766	\$598.46
Salisbury	1,528	127	\$529,070	\$346.25
Sanbornton	2,485	207	\$1,224,435	\$492.73
Sandown	3,701	308	\$2,138,134	\$577.72
Sandwich	950	79	\$959,822	\$1,010.34
Seabrook	14,228	1,186	\$5,796,361	\$407.39
Sharon	266	22	\$173,495	\$652.24
Shelburne	357	30	\$129,334	\$362.28
Somersworth	25,122	2,094	\$10,693,502	\$425.66
South Hampton	298	25	\$93,657	\$314.29
Springfield	1,525	127	\$877,863	\$575.65
Stark	968	81	\$453,852	\$468.86
Stewartstown	3,075	256	\$3,711,182	\$1,206.89
Stoddard	807	67	\$341,553	\$423.24
Strafford	3,096	258	\$1,477,508	\$477.23
Stratford	3,291	274	\$1,539,801	\$467.88
Stratham	2,802	234	\$1,677,667	\$598.74

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Sugar Hill	356	30	\$164,260	\$461.40
Sullivan	761	63	\$229,824	\$302.00
Sunapee	2,709	226	\$2,029,629	\$749.22
Surry	548	46	\$469,602	\$856.94
Sutton	716	60	\$218,062	\$304.56
Swanzey	10,673	889	\$4,856,539	\$455.03
Tamworth	3,648	304	\$1,489,108	\$408.20
Temple	1,089	91	\$946,786	\$869.41
Thornton	1,555	130	\$876,417	\$563.61
Tilton	8,252	688	\$5,462,624	\$661.98
Troy	4,717	393	\$2,175,386	\$461.18
Tuftonboro	1,905	159	\$907,443	\$476.35
Unity	1,399	117	\$2,590,163	\$1,851.44
Wakefield	7,651	638	\$3,091,591	\$404.08
Walpole	3,432	286	\$1,713,727	\$499.34
Warner	3,265	272	\$1,340,552	\$410.58
Warren	2,227	186	\$8,199,068	\$3,681.66
Washington	1,593	133	\$640,266	\$401.92
Waterville Valley	64	5	*	*
Weare	8,050	671	\$4,426,410	\$549.86
Webster	1,397	116	\$753,789	\$539.58
Wentworth	1,413	118	\$702,197	\$496.95
Wentworth's Location	12	1	*	*
Westmoreland	1,077	90	\$1,548,812	\$1,438.08
Whitefield	6,995	583	\$13,971,887	\$1,997.41
Wilmot	652	54	\$396,886	\$608.72
Wilton	4,154	346	\$1,613,303	\$388.37
Winchester	11,028	919	\$6,147,984	\$557.49
Windham	4,512	376	\$3,998,912	\$886.28
Windsor	400	33	\$347,519	\$868.80
Wolfboro	6,978	582	\$4,730,579	\$677.93
Woodstock	1,832	153	\$727,312	\$397.00
Out Of State Or No Zip	21,408	1,784	\$24,446,142	\$1,141.92

\* Expenditures and per member per month not shown when fewer than 10 average members for reasons of statistical reliability and confidentiality

# Glossary

**Beneficiary** – An individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. Many individuals are eligible for Medicaid but not enrolled and are therefore not program enrollees.

**Categorically Needy** – A phrase describing certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. There are “categorically needy” groups that states are required to cover, such as pregnant women and infants with incomes at or below 122 percent of the Federal Poverty Level (FPL). There are also “categorically needy” groups that states may at their option cover, such as pregnant women and infants with incomes above 133 percent and up to 185 percent of the FPL. Unlike the “medically needy,” a “categorically needy” individual may not “spend down” in order to qualify for Medicaid. See Medically Needy, Spend-down.

**Centers for Medicare and Medicaid Services (CMS)** – The agency in the federal Department of Health and Human Services with responsibility for administering the Medicaid, Medicare and State Children’s Health Insurance programs at the federal level.

**Co-payment** – A fixed dollar amount paid by a Medicaid enrollee at the time of receiving a covered service from a participating provider. Co-payments, like other forms of enrollee cost-sharing (e.g.; deductibles, co-insurance), may be imposed by state Medicaid programs only upon certain groups of enrollees, only with respect to certain services, and only in nominal amounts as specified in federal regulation.

**Deficit Reduction Act of 2005 (DRA)** – Enacted in February 2006 to reduce the rate of federal and state Medicaid spending growth through new flexibility on Medicaid premiums, cost sharing and benefits, along with tighter controls on asset transfers in order to qualify for long-term care through Medicaid.

**Disproportionate Share Hospital Payments (DSH)** – Payments made by a state’s Medicaid program to hospitals that the state designates as serving a “disproportionate share” of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid enrollees. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

**Dual Eligibles** – A term used to describe an individual who is eligible for both Medicare and for Medicaid coverage. Some Medicare beneficiaries are eligible for Medicaid payments for some or all of their Medicare premiums, deductibles and co-insurance requirements, but not for Medicaid nursing home benefits. As of January 1, 2006 prescription drug coverage for all duals is provided through Medicare Part D instead of through Medicaid.

**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services** – One of the services that all states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. Services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. They also include diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services with respect to adult beneficiaries.

**Federal Financial Participation (FFP)** – The term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. See FMAP, below, for Medical services. For administration, states receive FFP depending upon the type of administrative costs. The cost of activities related to claims processing, fraud detection, family planning, compensation and training of skilled professional medical personnel, and certain other activities are reimbursed at a higher rate than the base rate.

**Federal Medical Assistance Percentage (FMAP)** – The term for the federal matching rate for payment of services, i.e. the share of the costs of Medicaid services that the federal government bears. FMAP varies depending upon a state’s per capita income. Enhanced FMAP is provided for services provided to optional low-income children groups and for family planning services.

**Federal Poverty Level (FPL)** – The federal government’s working definition of poverty, used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the federal Department of Health and Human Services.

**Federally Qualified Health Center (FQHC)** – States are required to include services provided by FQHCs in

their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers as well as by “look alike” clinics that meet requirements for federal funding but do not actually receive federal grant funds.

**Fee-For-Service** – A method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient who then submits them to the insurance company or are submitted by the provider to the patient’s insurance carrier for reimbursement.

**Financial Eligibility** – In order to qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources an individual is allowed to have in order to qualify for coverage.

**Home and Community-Based Services (HCBS) Waiver** – Also known as a “1915 (c) waiver” after the enabling section in the Social Security Act, this waiver authorizes the Secretary of HHS to allow a state Medicaid program to offer special services to beneficiaries who are at risk of institutionalization in a nursing facility or mental health facility.

**Katie Beckett Option** – The popular name for the option available to states of making eligible for Medicaid children with disabilities who require the level of care provided in the hospital, nursing facility or ICF/MR but can be cared for at home and would not otherwise qualify for Medicaid if not institutionalized.

**Mandatory** – State participation in the Medicaid program is voluntary. However, if a state elects to participate, the state must at a minimum offer coverage for certain services for certain populations. These eligibility groups and services are referred to as “mandatory” in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds. See Optional.

**Medical Assistance** – The term used in the federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a state’s Medicaid program on behalf of individuals eligible for benefits.

**Medically Needy** – A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses. These individuals meet Medicaid’s categorical requirements- i.e., they are children or parents or aged

or individuals with disabilities- but their income is too high to enable them to qualify for “categorically needy” coverage. Instead, they qualify for coverage by “spending down” – i.e., reducing their income by their medical expenses. States that elect to cover the “medically needy” do not have to offer the same benefit package to them as they offer to the “categorically needy.” See Categorically Needy, Spend-down.

**Medicare Part D** – The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a new Medicare Part D prescription drug program. Medicaid drug coverage for dual eligibles, those who qualify for both Medicaid and Medicare, was transferred to Medicare as of January 1, 2006. States are required to make monthly “clawback” payments to Medicare, reflecting savings in Medicaid drug expenditures.

**Optional** – The term used to describe Medicaid eligibility groups or service categories that states may cover if they so choose and for which they may receive federal Medicaid matching payments at their regular matching rate or FMAP. See Mandatory.

**Prior Authorization** – A mechanism that state Medicaid agencies may employ at their option to control use of covered items or services. When an item or service is subject to prior authorization, the state Medicaid agency will not pay for it unless approval is obtained in advance.

**Qualified Medicare Beneficiary (QMB)** – A Medicare beneficiary with income or assets too high to qualify for coverage under Medicaid, but whose income is at or below 100% of the federal poverty line (FPL) and whose countable resources do not exceed \$4,000. QMBs are eligible to have Medicaid pay all of their Medicare cost-sharing requirements, including monthly premiums for Part B coverage, help with Part D cost sharing requirements, and all required deductibles and coinsurance (up to Medicaid payment amounts). QMBs may qualify for Medicaid coverage if they meet certain spend-down requirements.

**Rural Health Clinic (RHC)** – States are required to include services provided by RHCs in their basic Medicaid benefits package. RHC services are ambulatory care services (including physician’s services and physician assistant and nurse practitioner services) furnished by an entity that is certified as a rural health clinic for Medicare purposes. An RHC must either be located in a rural area that is a federally designated shortage area or be determined to be essential to the delivery of primary care services in the geographic area it serves.

**Specified Low-income Medicare Beneficiary (SLMB)** – A Medicare beneficiary with income or assets too high to qualify for coverage under Medicaid, but whose income is between 100% and 135% of the federal poverty line (FPL) and whose countable resources do not exceed \$4,000. SLMBs are only eligible to have Medicaid pay their Medicare Part B monthly premiums. SLMB 120s (100-120% FPL) may qualify for Medicaid coverage if they meet certain spend-down requirements. SLMB 135s (120-135% FPL) cannot also receive Medicaid coverage.

**Spend-Down** – For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. However, in some eligibility categories—most notably the “medically needy,” individuals may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by “spending down”. Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual’s income during that period. Once the individual’s income has been reduced to a state-specified level, the individual qualifies for Medicaid benefits for the remainder of the period. See Medically Needy.

**State Children's Health Insurance Program (SCHIP)** – Provides health insurance coverage for uninsured low-income children. Authorized under Title XXI of the Social Security Act and jointly financed by the Federal and State governments and administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. In contrast to Medicaid, SCHIP is a block grant to the states; eligible children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for SCHIP. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or combination).

**State Medicaid Plan** – Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments). The state Medicaid plan must meet federal statutory requirements.

**State Plan Amendment (SPA)** – A state that wishes to change its Medicaid eligibility criteria, covered benefits, or provider reimbursement rates must amend its state Medicaid plan. Similarly, states must conform their Medicaid plans to changes in federal Medicaid

law. In either case, the state must submit a state plan amendment to CMS for approval.

**Temporary Assistance for Needy Families (TANF)** – A block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children. States may, but are not required, to extend Medicaid coverage to all families receiving TANF benefits; states must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.

**Total Cost of Coverage** – This is the sum of all expenditures for health care benefits, including the net amount paid for facility services, professional services, and prescriptions filled. It represents the amount after all pricing guidelines have been applied and all third party, co-payment, coinsurance, and deductible amounts have been subtracted.

**Waivers** – When requested by a state, the Secretary of HHS may waive certain requirements or limitations of the federal Medicaid statute, allowing the state to receive federal Medicaid matching funds, which would not otherwise be available. One example is Section 1915(c) waivers for home- and community-based services, which allow states to offer special services to beneficiaries at risk of institutionalization in a nursing facility or mental health facility. Another example is Section 1115 demonstration waivers, which allow states to cover certain categories of individuals or services (or both), which would not be covered otherwise.

# Contributors

This study was in part conducted by the Onpoint Health Data (Onpoint) and the Muskie School of Public Service, University of Southern Maine under a contract with the State of New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy. Contributors to the report are listed below.

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