

New Hampshire Medicaid Annual Report



State Fiscal Year 2011

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

February 15, 2013

*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 171,000 people at some point during State Fiscal Year 2011 (SFY 2011, July 1, 2010 – June 30, 2011). Those covered included low-income children, pregnant women, parents with children, elders, and people with disabilities. In an average month during the year 137,073 people were covered.*

The Medicaid Program has had a significant impact on the provision of health care coverage to vulnerable populations, particularly low-income children. Approximately 18% of all NH's children received their health care coverage through Medicaid while 70% of children received their coverage through Employer Sponsored Insurance. For all ages, the national average for the percentage of a State's population enrolled in Medicaid is 16%. At 7%, New Hampshire has the lowest average percentage of its population enrolled in Medicaid in the nation. For the 2010/2011 period, an estimated 11% of NH residents were uninsured; 7% of children were without health insurance (national averages were 16% for all residents and 10% for children).†

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, 2010 through June 30, 2011.

Medicaid beneficiaries tend to have a higher burden of illness than privately insured individuals.‡ They are twice as likely to have asthma and mental health disorders among children, and twice as likely to have asthma, coronary artery disease, hypertension, and

depression and three to four times more likely to suffer from a stroke or chronic obstructive pulmonary disease (COPD) among adults, and three to four times more likely among adults and children to use hospital emergency rooms; and five times as likely to have lung cancer or heart failure among adults. 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 (during the period of this report, NH Medicaid was not operating under a managed care model).

New Hampshire state government spent a total of \$5.32 Billion in SFY 2011 (state, federal, and other funds combined). Of this amount, \$1.43 Billion, or 26.8% of all state expenditures, was accounted for by Medicaid (second only to Education at 27.9% of state spending). Half (50.3%) 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 and its extension (which ended June 2011). 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 \$617 per month for each member, with average monthly costs ranging from \$231 for each low-income child (age less than 19) covered, up to \$2,825 for beneficiaries covered under Medicaid waiver programs and \$3,277 for recipients of long-term care nursing home services.

The Medicaid program deploys a robust constellation of utilization management and quality improvement strategies to contain costs and improve member 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 managed care strategies to its fee-for-service world. To further these efforts, the Senate Bill 147 was passed by the New Hampshire General Court and signed into law by Governor John Lynch on June 2, 2011. Senate Bill 147 required the Department to transition the NH

* Coverage includes those with full Medicaid benefits and those where NH Medicaid only paid for Medicare premiums and co-payments.

† Kaiser State Health Facts, Health Insurance Coverage of the Total Population 2010-2011.

‡ While this is generally true, Medicaid enrolled children from households with higher incomes have a significantly lower burden of illness than those with lower incomes. See *Children's Health Insurance Programs in New Hampshire* <http://www.dhhs.nh.gov/ombp/documents/chip09.pdf>

Medicaid program to a managed care model for all its services except dental care.

Delivery of Medicaid services during SFY 2011 resulted in 5,828,699 claims through 20,907 health care providers, including 4,000 community organizations.

Services provided to beneficiaries included the following:

- 23,681 inpatient hospital admissions
- 471,908 outpatient hospital visits
- 455,529 primary care visits*
- 4,880 births
- 298,884 home health and private duty nursing visits
- 137,472 dental visits by children
- 67,638 complex radiology tests*
- 1,488,636 prescriptions

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 when New Hampshire's unemployment rate rose from 3.4% in December of 2007 to a peak of 7.1% in February of 2010, declining to 4.9% by June 2011. NH Medicaid enrollment tracked unemployment, increasing by 3.9% in SFY 2008 then rising an additional 10.1% in SFY 2009. However, even with the significant drop in the unemployment rate in SFY 2010 and SFY 2011, Medicaid enrollment continued to increase at the rate of 4.6% in SFY 2010 and another 2.6% during SFY 2011.

Increased Medicaid enrollment was the driving factor for increased total spending in the past several years. Due to rate reductions and reductions in use of services per member in SFY 2011 total patient specific costs were essentially unchanged, even though enrollment increased. Total spending increased by 6.0% in SFY 2008, 4.8% in SFY 2009, then 3.8% in SFY 2010. In SFY 2011, total spending on patients decreased slightly by 0.4%. After per patient costs increased by 4.4% from SFY 2006 to SFY 2008, they dropped an additional 2.0% in SFY 2009, 2.5% in SFY 2010 and another 3.0% in SFY 2011, rolling back per patient costs for the NH Medicaid program to lower than SFY 2006 levels.

While the reasons behind this decline are multifaceted, there was a 5.0% reduction in costs per claim from SFY 2008 to SFY 2011 (a period that has seen

provider rate reductions), and there was a reduction in claims per patient of 2.8% over the same period (due in part to enrollment of a marginally healthier population during the recession and the introduction of additional utilization controls). Thus, while Medicaid enrollments have continued to increase, the growth in total expenditures has slowed.

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.

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-

* Note: number is not comparable to prior reports due to definitional change.

income populations, including working families, elderly people, children receiving foster care services, 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.)

In March 2010, federal health care reform legislation, referred to as the Affordable Care Act (ACA) was enacted. The ACA will impact private and public health insurance programs (including Medicaid and CHIP) through changes in eligibility, health care delivery, quality initiatives, consumer protections, program integrity, and revenues/financing. Implementation dates vary—with some provisions, such as allowing dependents under age 26 to remain on their parents' policies and waste/fraud prevention initiatives, scheduled for the fall of 2010—and others anticipated over the next several years, including in 2014 the possible expansion of Medicaid eligibility to effectively 138% of the Federal Poverty Level for all adults that were previously not eligible (such as parents and childless, non-disabled adults).

Given the proportion of states' budgets dedicated to Medicaid, the continued increase in federal spending, and the ACA's expected impacts on the health care system, much attention has been focused on Medicaid reform. 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.

The Office of Medicaid Business and Policy (OMBP) has focused these past several years on managed care strategies to control costs and ensure that beneficiaries receive efficient and high quality care. These managed care activities – also employed in private sector managed care – include a robust Pharmacy Benefit Management Program (PBM), utilization management (e.g., prior authorization, service limits, concurrent inpatient review, discharge planning and care management), statewide distribution of incontinence supplies, and volume-based purchasing for vision care and eyeglass frames/lenses. Providers, DHHS staff, and eventually beneficiaries will have access to real-time information appropriate to their needs through the web-based capabilities available in the new Medicaid Management Information System (MMIS) beginning in calendar year 2013.

Despite the fact that New Hampshire Medicaid did not contract with a managed care organization in the period covered by this report, beneficiaries continued to consistently match or outperform beneficiaries

whose care is delivered by Medicaid managed care organizations when measured against many nationally recognized metrics and benchmarks. Selected results are presented in this annual report; more detailed information is available in the annual report on children's health insurance (plus other studies on primary care access/cost/utilization and other program issues undertaken as part of quality assurance and improvement activities).*

As SFY 2011 was coming to a close, it was clear that change was coming to the New Hampshire Medicaid program and that SFY 2012 would begin a year of transition. In SFY 2011, the legislature enacted a law requiring the New Hampshire Department of Health and Human Services to employ a managed care model for administering the Medicaid program. RSA 126-A:5, XIX (a) laid out several options for the DHHS Commissioner, which included a traditional capitated Managed Care Organization (MCO), an Accountable Care Organization (ACO), a Primary Care Case Management model (PCCM) or a combination of these models. (Subsequently, after research and careful deliberation, the DHHS Commissioner chose to proceed with a traditional capitated MCO contract model.) Once the Commissioner had made a recommendation to the Health and Human Services Oversight Committee for the best managed care model for NH, the statute also required the Department to issue a five-year Request for Proposals in October 2011.† Another change that would impact the Medicaid program in SFY 2012 (and beyond) was initiated in the SFY 2011 session, when the legislature directed the DHHS to transition its combination Children's Health Insurance Program (CHIP) to a Medicaid Expansion.‡

* See www.dhhs.nh.gov/ombp/publications.htm

† Managed care in NH is governed by RSA chapter 420-B, which relates to HMOs and RSA 420-J, which relates to managed care in general. However, not all of the statutory requirements, particularly those that require coverage of certain services or categories of people are applicable to the Medicaid program that is governed by separate federal requirements.

‡ A Medicaid Expansion is one of three models federal law allows states to use to administer their CHIP; the other two are a stand-alone program or a combination. NH operated as a combination with 0-1 year olds in Medicaid and the up to 19 year olds in a stand-alone program administered by the NH Healthy Kids Corporation with medical and dental insurance delivered by Harvard Pilgrim and Delta Dental.

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, long-term care, and psycho-social support services for the frail elderly, people with physical and developmental disabilities, and those with mental illness; and
- “wraparound” coverage that supplements 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.

A new hospice benefit was offered beginning in SFY 2011.

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 on the following page.

Table 1: NH Medicaid Covered Services (as of 6/30/2011)

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)
 Inpatient Hospital Swing Beds, SNF
 Inpatient Hospital Swing Beds, ICF
 Advanced Registered Nurse Practitioner
 X-Ray Services
 Family Planning Services
 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
 Services for Persons < Age 21

State Mandates

Home & Community Based Services Waivers:

- Acquired Brain Disorder
- Developmentally Disabled
- Choices for Independence
- In Home Supports

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
 Personal Care Services
 Wheelchair Van
 Podiatrist Services
 Placement Services
 Occupational Therapy
 Nursing Facility Services for Children with Severe Disabilities
 Inpatient Psychiatric Facility Services Under Age 22
 Speech Therapy
 Home Based Therapy
 Audiology Services
 Child Health Support Service
 Outpatient Hospital, Mental
 Hospice

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 limits*)
- Psychotherapy (*12 visits per year*)
- Podiatrist Services (*4 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*)

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.
- *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

* 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 Bureau of Behavioral Health eligibility requirements and to \$4,000 per fiscal year for individuals who meet BBH low utilizer eligibility criteria. Also, numerous changes to the limits were made in SFY2012 including removal of the physician and outpatient hospital caps, imposition of an ED visit cap, and an increase in the psychotherapy cap.

Medicaid, income levels vary from 300% of FPL for infants to 40% FPL for parents, and 450% of FPL for employed disabled adults (MEAD), as shown in Figure 1 on the following page.

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 FPL
- 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)

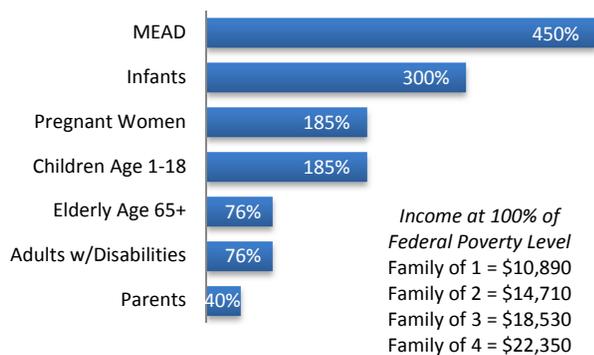
[†] In 1974, New Hampshire, like over thirty other states at the time, elected for the “209(b)” status provided in the federal law that created the Supplemental Security Income (SSI) program (the federal income assistance program for disabled, blind, or aged individuals). When creating the SSI program, 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.

[§] The ACA extended ARRA eligibility maintenance of effort (MOE) requirements for adults until 2014 and for children until 2019.

^{**} 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). Home and Community Based Services (HCBS) waivers allow states to offer special services to Medicaid beneficiaries who would otherwise need institutional care.

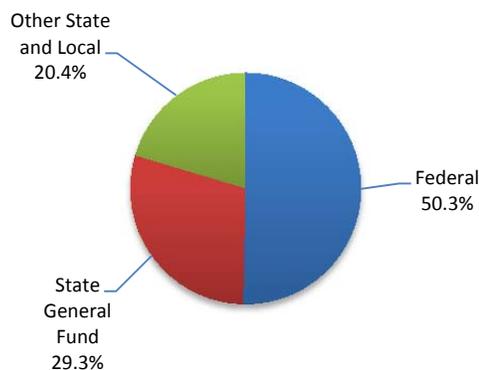
New Hampshire has several waiver programs in operation (note: all participants in waiver programs utilize regular state plan services in addition to the waiver services):

- Home and Community Based Care for Acquired Brain Disorders (HCBC-ABD) services are available to individuals with traumatic brain injuries or neurological disorders who choose 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.
- The Choices For Independence program (formerly known as the Home and Community-Based Care program for the Elderly and Chronically Ill) provides an option 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 Funding Sources

The NH Medicaid budget is comprised of federal, state general, and other state and local funds. The federal government covered 50% of New Hampshire’s \$1.43 billion spent by the Medicaid program in State Fiscal Year (SFY) 2011.

Figure 2: NH Medicaid Funding Sources, SFY 2011
 Total New Hampshire Medicaid Spending \$1.4 Billion



Total Medicaid funding increased by less than 1% (from \$1.42 to \$1.43 billion) from SFY 2010 to SFY 2011. While the amount of federal funds increased slightly in 2011, the proportion decreased very slightly. The amount and proportion of state general funds both decreased slightly. The amount and proportion of other state and local funds increased. Temporary FMAP increases under ARRA resulted in the receipt of an additional \$115.1 Million in federal funds during SFY 2011 that are not included in the NH Medicaid funding figures above. Although these funds were accepted and expended by NH Medicaid they replaced previously appropriated State general and other funds.

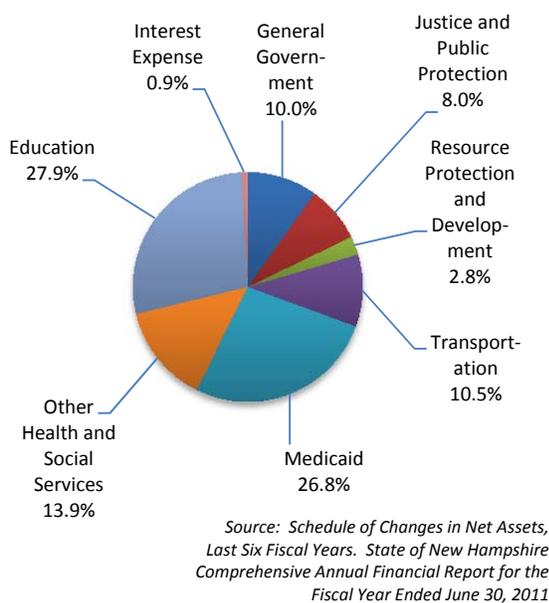
Medicaid and the New Hampshire State Budget

In SFY 2011, Medicaid accounted for 26.8% of NH state budget expenses, second only to education at 27.9%. Note that for illustration purposes, the chart below separates Medicaid from the remainder of spending under the Health and Social Services budget category.

Total spending for the NH state budget decreased 2.8% from SFY 2010 to SFY 2011 (\$5.47 to \$5.32 billion). Total Medicaid spending increased, but only by 0.7% (\$1.42 to \$1.43 billion). Medicaid spending as a proportion of the entire NH budget also increased slightly from 2010 (25.9%) to 2011 (26.8%).

Figure 3: NH State Budget by Category, SFY 2011

Total New Hampshire State Budget \$5.3 Billion



Medicaid Organization and Spending Within NH DHHS

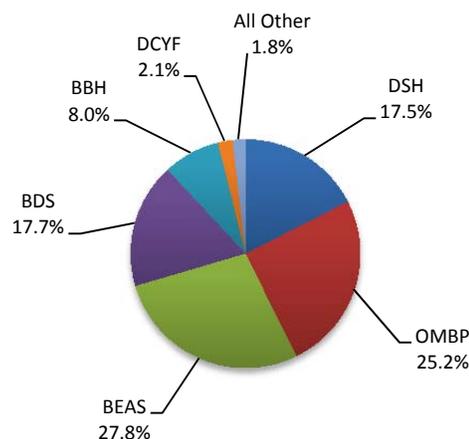
In New Hampshire, the Medicaid Program is administered within the Department of Health and Human Services (DHHS). Functional responsibility for the many components of the program is coordinated among several organizational units within DHHS. These include the Office of Medicaid Business and Policy (OMBP: medical and pharmacy, Medicaid Director, planning and policy, data and research, federal reporting, financial management, disproportionate share hospital), the Division of Family Assistance (DFA: eligibility determination), the Bureau of Behavioral Health (BBH: community mental health system), the Bureau of Developmental Services (BDS: developmental disabilities and acquired brain disorders), the Bureau of Elderly and Adult Services (BEAS: aged and long-term care), and the Division of Children, Youth, and Families (DCYF: foster care services). 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 \$1.43 billion can be broken down into activities or Department organizational units. BEAS accounted for the highest proportion of Medicaid spending at 27.8%. OMBP was second highest, at 25.2%. BDS accounted for 17.7%, while disproportionate share

hospital (DSH) payments accounted for 17.5%.* Eight percent of Medicaid spending was through BBH, 2.1% by DCYF, and 1.8% for “All Other”† activities.

Figure 4: NH Medicaid Expenditures, SFY 2011

Total NH Medicaid Spending \$1.4 Billion‡



Source: NH DHHS, Office of Business Operations

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 (19%) consists of Disproportionate Share payments to hospitals (certain general hospitals and NH Hospital) and ProShare payments 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%). While the actual amount and proportion of Medicaid spending on provider payments decreased slightly from SFY 2010 to SFY 2011, the amounts

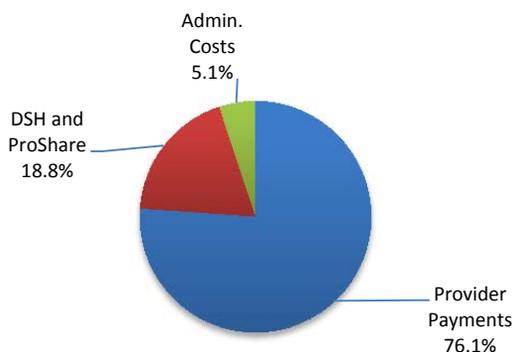
* Certain hospitals are recognized by the State as serving a disproportionate share of Medicaid and uninsured patients. These hospitals receive additional Medicaid payments for providing inpatient and outpatient care to Medicaid enrollees.

† “All Other” units expending Medicaid funds include the Division of Family Assistance, Office of Improvement, Integrity and Information, 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. Outside of DHHS, funds were expended by the Department of Information Technology.

‡ During SFY 2011 DHHS updated the distribution methodology for Upper Payment Limit calculations in accordance with NH and federal requirements regarding Uncompensated Care payments in lieu of Disproportionate Share Hospital funds. These changes were part of a complex series of adjustments approved by the Joint Legislative Fiscal Committee (Item 10-345, approved November 17, 2010).

and proportions for NHH, DSH & ProShare increased slightly and administrative costs were stable.

Figure 5: NH Medicaid Spending by Type, SFY 2011
Total NH Medicaid Spending \$1.4 Billion*



Source: NH DHHS, Office of Business Operations

Medicaid Payment Rates

New Hampshire Medicaid pays for medical services in a variety of ways, depending on the provider and services rendered. Payment methods fall into two general types: payment for a specific services on a per unit basis and payment for a group of services bundled together into a single comprehensive payment (e.g., inpatient hospital stays).

Appendix 3 summarizes changes to payment methodologies and rates in State Fiscal Year 2011.

Medicaid Enrollment and Expenditures

In State Fiscal Year 2011, NH Medicaid provided health care and psycho-social support coverage to an average of 137,073 persons each month, serving 171,210 unique persons over the year.[†] As noted above, the Medicaid program expended a total of \$1.43 billion in SFY 2011 of which \$1.08 billion (76%) was attributable to Medicaid provider payments for services. In order to accurately examine the relationship between those enrolled on Medicaid

* See footnote at bottom of previous page.

[†] Note average enrollment represents the average number of persons enrolled in the NH Medicaid program throughout SFY 2010 and not point in time statistics.

and the services they have used it is necessary to analyze the data not by what was paid for by NH Medicaid in SFY 2011, but the services that occurred during that year, totaling \$1.01 billion. Throughout the next sections the data presented is based on SFY 2011 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 2011. Low-income children represent 58% of NH Medicaid members yet only account for 22% of total program expenditures. Persons with disabilities (severely disabled children and adults with physical or mental illness disabilities) represent 16% of the population and account for 46% 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 23% of total expenditures. Low-income adults, while comprising 12% of the Medicaid population, only account for 8% of the expenditures.

Table 4: NH Medicaid Enrollment and Medical Provider Expenditures for SFY 2011

Eligibility Category	Average Monthly		Medicaid Expenditures	Percent of Cost
	Enrollment 2011	Percent Enrolled		
Low-income Child	80,380	58.6%	\$223,200,335	22.0%
Low-income Adult	16,500	12.0%	\$78,541,729	7.8%
Children with Severe Disabilities in Home Care	1,615	1.2%	\$36,457,896	3.6%
Adults with Physical Disabilities	8,592	6.3%	\$203,590,034	20.1%
Adults with Mental Illness Disabilities	11,854	8.6%	\$227,383,162	22.5%
Elderly	9,043	6.6%	\$236,564,096	23.4%
QMB/SLMB Only	9,090	6.6%	\$6,667,429	0.7%
Total	137,073		\$1,012,543,187	

\$Difference from \$1.43 Billion due to provider spending for services with dates of services (7/1/2010-6/30/2011); does not reflect administrative, cost settlements, rebates or other off-claim payments. Additionally, rows do not sum to the total amount due to \$138,506 with missing eligibility information.

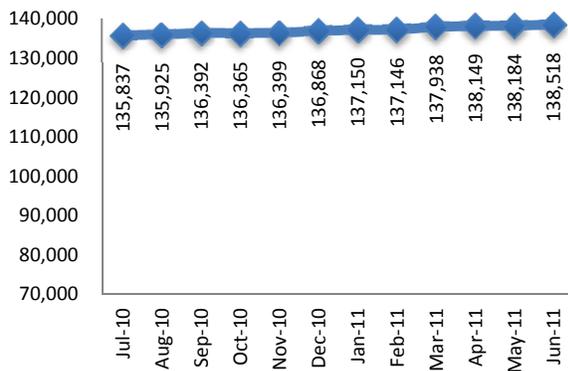
Medicaid Enrollment

Nationally, increases in Medicaid enrollment have tracked with the increase in unemployment due to the poor economy since late 2007. During SFY 2008, only one state saw a double-digit increase in Medicaid enrollment and seven states actually saw decreases. SFY 2009 was the first 12-month period since the early 1990's when every state experienced a growth in Medicaid enrollment (14 states had a double-digit

increase). Every state except one (where growth was flat) saw additional enrollment increases in SFY 2010 (13 in double-digits).^{*} New Hampshire mirrored this trend. After increasing by 3.9% in SFY 2008 and 10.1% during SFY 2009, the rate of growth in NH Medicaid enrollment slowed to 4.6% in 2010 and 2.6% in SFY2011. As Figure 6 shows, enrollment growth in NH during SFY 2011 increased very slowly.

Figure 6: NH Medicaid Enrollment by Month, SFY 2011

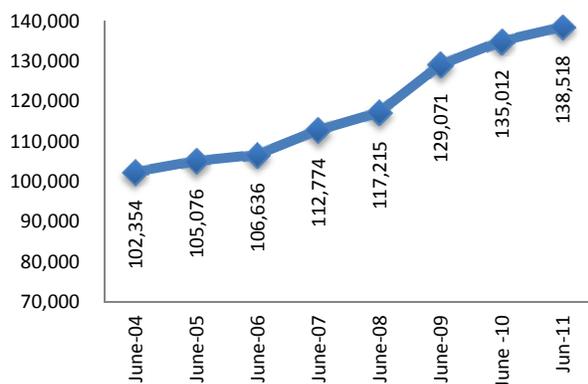
Note: Includes retroactive and partial month enrollment



From June 2004 through June 2008, growth in the number of NH Medicaid enrollees was less than 6% per year. Between June 2008 and June 2009, NH Medicaid enrollment increased 10%. The 5% growth in NH Medicaid from 2009 to 2010 was comparable to the growth observed prior to the 2009 increase. NH was not unique in this rapid growth period that was observed in all states during the last two years due to the poor economy. In SFY 2011, the growth rate decreased to 2.6%.

Figure 7: NH Medicaid Enrollment for Month of June Over Time, SFY 2004 - 2011

Note: Includes retroactive and partial month enrollment

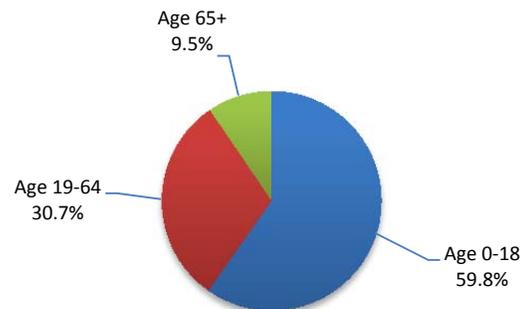


^{*} Medicaid enrollment: June 2010 Data Snapshot, Kaiser Family Foundation, February 2011, <http://www.kff.org/medicaid/upload/8050-03.pdf>

In SFY 2011, children (members 18 years or less) made up 60% 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 on the following page, members age 19 to 64 represented 31% 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 (low-income and severely disabled children groups combined, see Table 4).

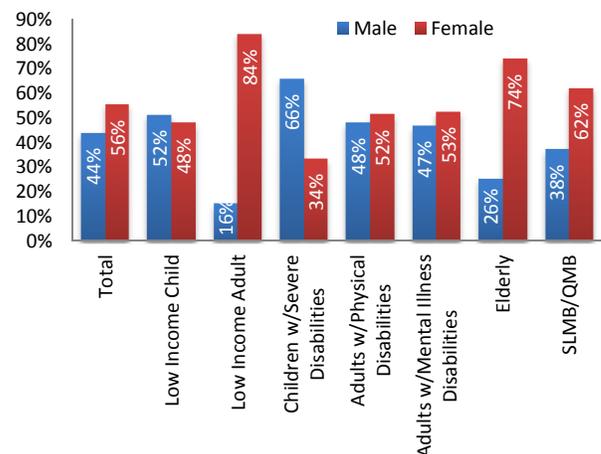
Figure 8: NH Medicaid Enrollment by Age Categories, June 2011

Total Enrollment in June of 2011 = 138,518



Females account for over half of Medicaid enrollees. Gender differences were observed in all eligibility categories with females predominating low-income adults (84%, due to pregnant women eligibility category and greater likelihood of heading single parent low-income households) and the elderly (74%, due to longer lifespan and likelihood of fewer resources than males). As shown in Figure 9, 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 2011

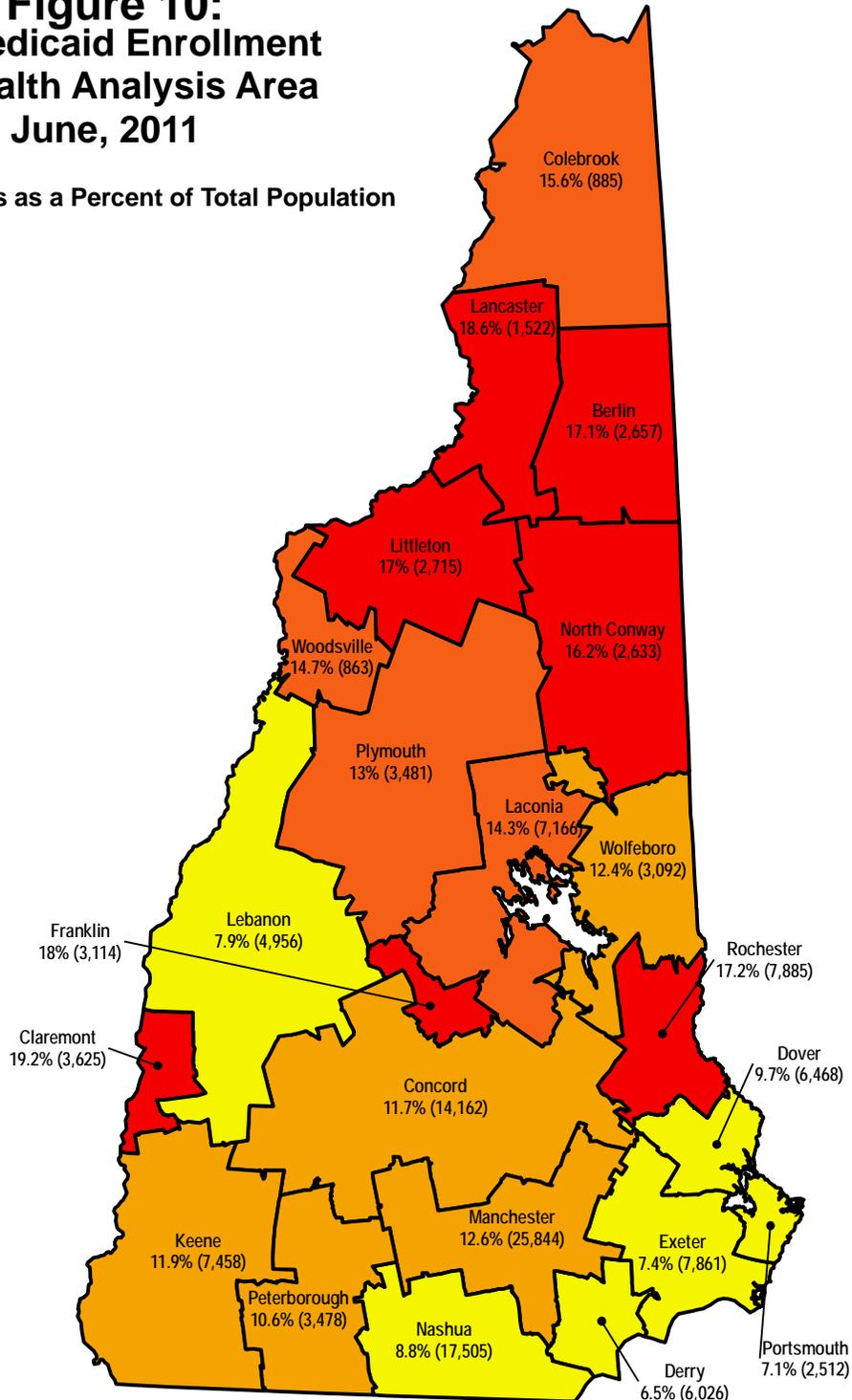


The percent of the population covered by NH Medicaid varies by Health Analysis Area (HAA) from a low of 7% in the Derry area to a high of 19% in Claremont. Figure 10 displays the percent of population enrolled in NH Medicaid for each of the HAAs.

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 42% of the total NH Medicaid population.

**Figure 10:
NH Medicaid Enrollment
by Health Analysis Area
June, 2011**

Medicaid Enrollees as a Percent of Total Population



Notes:
Data based on total enrollment of 138,518 enrolled at any time during the month of June, 2011. 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 1/31/2011.

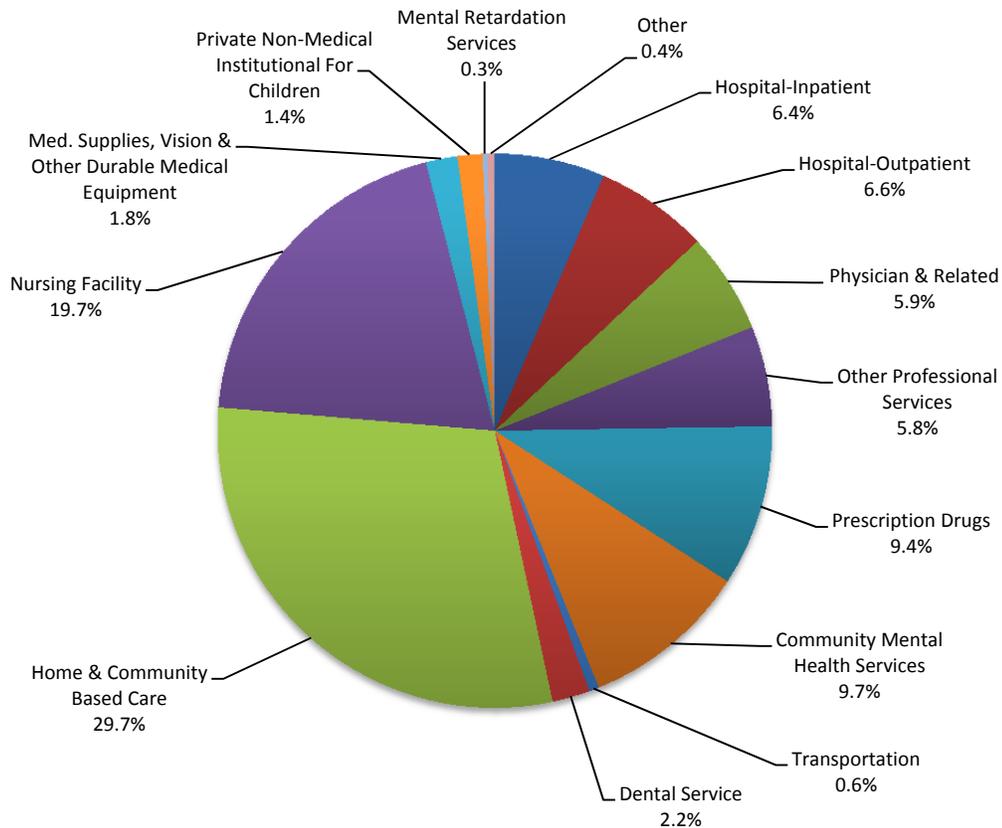
Payments by Service Types

In SFY 2011, 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, 51% of provider payments were associated with long-term care services (comprised of

services* accounted for 6% of spending, while dental, vision, transportation, 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-4c.)

Table 5 provides expenditures and number of members using each service category. The most frequently

Figure 11: Distribution of NH Medicaid Payments by Types of Service, SFY 2011



home and community-based care, nursing facility and private non-medical institutions for children). The total combined payments for the four home and community based care (HCBC) programs accounted for 30% (\$301 million) of total payments and nursing facilities another 20% (\$200 million). Additionally, 1% of long-term care 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 13% (6.6% for outpatient and 6.4% for inpatient services), and physician and other related services another 6%. Additionally, behavioral health services contributed another 10% of payments, other professional

used services were physician-related services and prescription drugs. Over 125,000 members (73%) utilized physician-related services during SFY 2011 at an average yearly cost of \$475 per user. Prescription drugs were the next most frequently used service with over 102,000 (60%) members at an annual cost of \$925 per user. Additionally, over half (54%) of members used outpatient services with an average payment of \$723. While long-term care services represent the

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

† Other services include nursing facility services for children with severe disabilities, 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.

highest cost areas, they served a small proportion of members—HCBC served 13,918 (8%) members and nursing homes provided services to 7,014 members (4%). At least one service was used by 88% of all Medicaid members, leaving 12% 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 2011

Service Category	Total Claim Payments	Service Users	Service Users as a Percent of Members	Average Paid Per User Per Year
Home & Community Based Care	\$300,675,125	13,918	8.1%	\$21,603
Nursing Facility	\$198,968,266	7,014	4.1%	\$28,367
Community Mental Health Services	\$98,488,152	28,108	16.4%	\$3,504
Prescription Drugs	\$95,187,910	102,875	60.1%	\$925
Hospital-Outpatient	\$66,960,441	92,609	54.1%	\$723
Hospital-Inpatient	\$65,016,175	18,127	10.6%	\$3,587
Physician & Related	\$59,461,681	125,054	73.0%	\$475
Other Professional Services	\$59,170,789	49,754	29.1%	\$1,189
Dental Service	\$22,297,523	59,133	34.5%	\$377
Vision & Other Durable Medical Equipment	\$18,626,195	35,028	20.5%	\$532
Private Non-Medical Institutional For Children	\$14,670,928	950	0.6%	\$15,443
Transportation	\$5,797,654	12,736	7.4%	\$455
Other	\$4,215,303	521	0.3%	\$8,091
Nursing facility services for children with severe disabilities	\$3,007,045	38	0.0%	\$79,133
Total**	\$1,012,543,187	149,884	87.5%	\$6,756

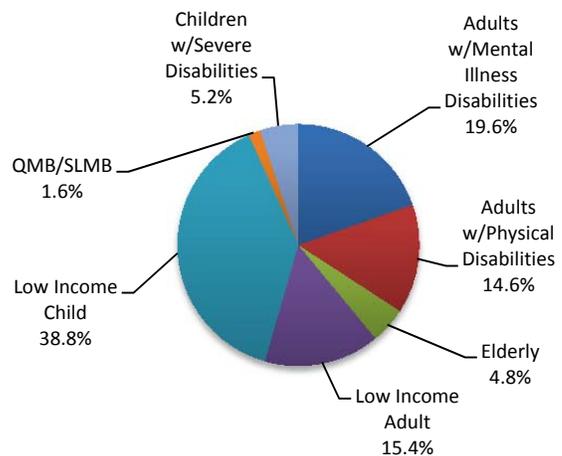
**NH Medicaid expenditures totaled \$1.43 billion in SFY 2011. The figures in this table cover payments to providers based on dates of service from July 1, 2010 through June 30, 2011. The figures in this table do not include expenditures for administration, cost settlements, rebates, and other types of non-claim payments.

Payments by Member Eligibility

Spending on acute care* services is driven by the health needs of children and members with disabilities. Children account for 44% of payments for acute care services, with low-income children accounting for 39% and severely disabled children an additional 5% (Figure 12). Adult members with disabilities account for another 34% of acute care services, 19% for members with mental illness disabilities, and 15% for those with physical disabilities. Low-income adults (15%), the elderly (5%) and QMB/SLMB† (2%) account for the remainder.

Figure 12: NH Medicaid Spending for Acute Care Services by Eligibility Category, SFY 2011

Total Acute Care Spending \$400,033,912



In contrast, spending on long-term care services‡ is driven by the elderly (41%) and adult members with disabilities (49%), 25% for those with mental illness disabilities, and 24% for those with physical disabilities. Children account for 10%, 7% for low-income children and 3% for severely disabled children. Low income adults without disabilities use very little long-term care services (Figure 13).

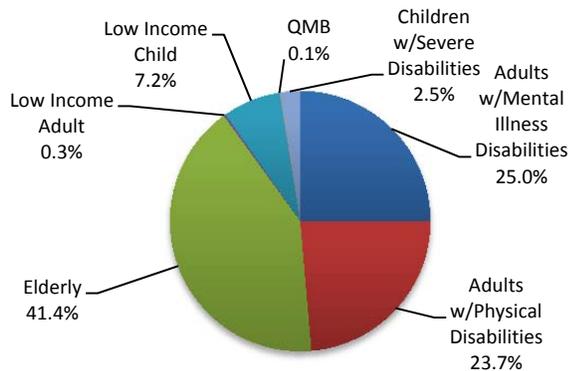
* Acute care includes behavioral health, inpatient and outpatient hospital, physician, other professional, dental, vision, DME, transportation and other services.

† “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, nursing facility services for children with severe disabilities, and PNMI for children.

Figure 13: NH Medicaid Spending for Long-Term Care Services by Eligibility Category, SFY 2011

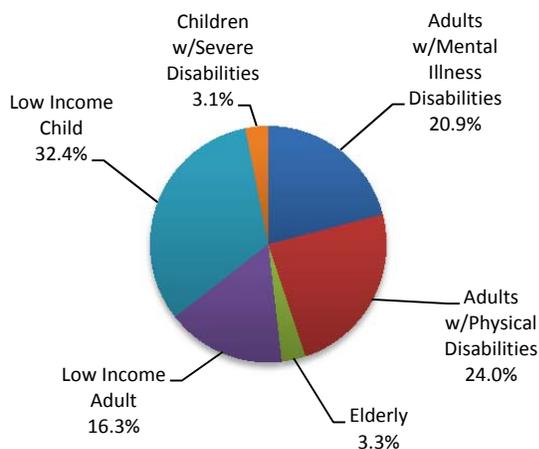
Total Long-term Care Spending \$517,321,365



Spending on prescription drugs is more broadly distributed; however, adult members with disabilities still constitute the largest proportion at 45%; 24% for those with physical disabilities and 21% for those with mental illness disabilities (Figure 14). The elderly account for 3% of prescription drug expenditures (see discussion of Medicare Part D below). Children accounted for another 35%; 32% for low-income children and 3% 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 2011

Total Prescription Drugs \$95,187,910



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 2011, New

Hampshire paid almost \$33 million* back to the federal government, up from \$30 million in SFY 2010. Additionally, NH Medicaid receives rebates for prescription drugs. In SFY 2011, NH Medicaid received \$54 million in rebates (up from \$45 million in SFY 2010). 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).

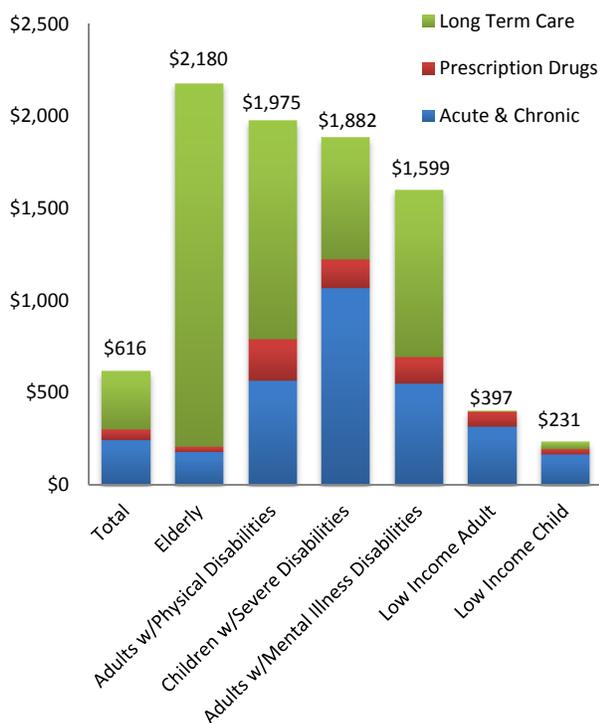
Per Member Per Month Payment Rates

NH Medicaid spending varies widely by eligibility category. On average, NH Medicaid spent \$616 per member per month for services in SFY 2011. Among the full benefit eligibility groups there is a ten-fold difference in spending per member per month (PMPM).† PMPM spending varies from \$231 for low-income children to \$2,180 for the elderly (whether in long-term care or not). 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 \$1,882, whose health needs are both acute and long-term. Long-term care services are the primary care need for adults with disabilities and the elderly. Adults with physical disabilities PMPM was \$1,975, while adults with mental illness disabilities PMPM was \$1,599. (For a complete listing of PMPM spending by service categories for each eligibility category see Appendix 5. A complete listing of Medicaid provider payments, enrollment, and PMPMs by town is listed in Appendix 7.)

* This figure does not include an adjustment credit of nearly \$7 million NH received back from the federal government for clawback payments the State made on the additional enhanced FMAP NH received during SFY 2011.

† 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).

Figure 15: NH Medicaid per Member per Month Spending by Eligibility Groups, SFY 2011



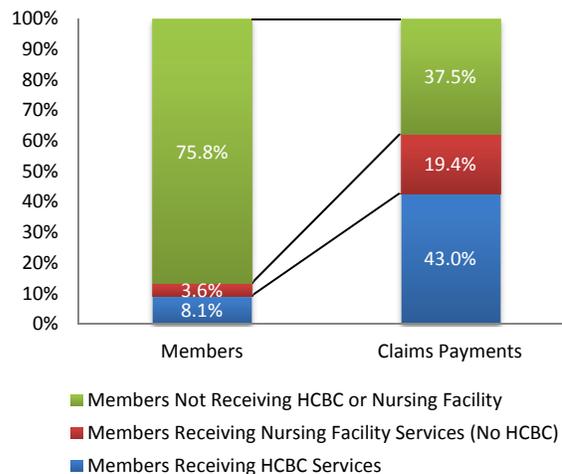
Overall average PMPMs decreased 3.8% between SFY 2010 (\$640) and 2011 (\$615). The savings in low income adult services was the largest with a 5.9% decrease in PMPM, followed by the severely disabled children with a 5.3% decrease. All other eligibility groups declined 3% or less.

Per Member Per Month Payment Rates for Members in Long-Term Care Programs

As described on page 6, 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. Eight percent of NH Medicaid members were on the HCBC waivers during SFY11, however these members accounted for 43% of the total claims payments during the year (Figure 16). Waiver program services (see page 6) accounted for 69% of all claims payments for HCBC participants. Members in nursing homes accounted for 4% of members and 19% of all claims payments. Given the significant level of care needs for HCBC participants and nursing home residents, the PMPM costs for HCBC waiver participants (\$2,825) and nursing home residents (\$3,277) are significantly higher than all other members (\$292). The HCBC participants had significantly higher non-long-term care costs per member per month (\$876) than the members in nursing

homes (\$163). A complete breakdown of costs for HCBC waiver and non-waiver participants is provided in Appendix Table 6a.

Figure 16: Distribution and Costs of NH Medicaid Members Using Home and Community Based Care Services (HCBC), in Nursing Facilities, and all Others, SFY 2011

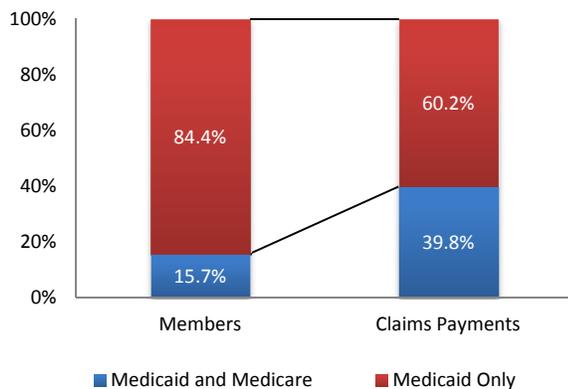


Per Member Per Month Payment Rates for Members Dually Eligible for Medicare

Medicaid members who are entitled to Medicare, often referred to as “dual eligibles” are another group that has extensive care needs. People with Medicare who also have limited income and resources may qualify for Medicaid. These members are older or have disabilities. Forty-five percent of dual eligibles are receiving HCBC or nursing facility services. Medicaid will pay for services covered under the program, but not covered by Medicare*. About 16% of NH Medicaid members are dually eligible for Medicare, however they account for 40% of NH Medicaid payments (Figure 17). Medicaid PMPM for dual eligibles is \$1,436 compared with Medicaid only (non-dual) members PMPM of \$447. Removing long-term care costs, the Medicaid only members PMPM of \$324 was higher than the dual eligibles PMPM of \$254. 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.

* 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 17: Distribution of NH Medicaid Members and Costs by Members Dually Eligible for Medicare, SFY 2011



Trends in Medicaid Service Spending

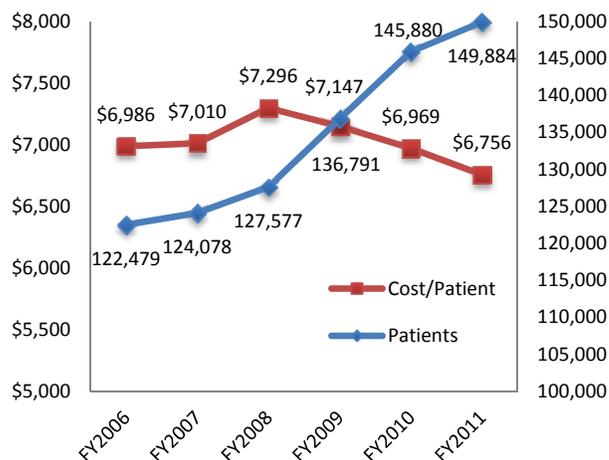
In order to examine trends in cost it is helpful to look at costs on a per patient (user of services) and per claim basis and service use on a claims per patient basis. Per patient costs presented below are simply the total costs for services divided by the number of patients who used that service. Per claim costs are the total costs for services divided by the number of claims paid for that service. Claims per patient are the number of claims for a service divided by the number of members using that service.

NH Medicaid services that drive most spending—long-term care, hospital inpatient, mental health, pharmacy and physician services—have increased in both utilization and total costs. However, most of these high cost services show a decrease in per patient costs. Pharmacy, physician and some long-term care services are exceptions where per patient costs have continued to increase. Total enrollment has increased (3%), slowing from the 10% increase observed in SFY 2009. Overall total spending for NH Medicaid services increased 18% from 2006 to 2011*. Per patient costs increased by 4.4% from SFY 2006 to SFY 2008 and then have dropped 2% to 3% per year, basically rolling back per patient costs for the NH Medicaid program to lower than the 2006 level. This drop was driven by a total cost per claim decrease of near 5% between SFY 2009 and 2011, a period of payment rate decreases as well as reduction in service use per member (a combination of marginally healthier new members enrolled during the recession and increased utilization control). Cost trends are highlighted below (Appendix 4a contains a detailed listing of costs for

* In 2006, Medicaid payments for services were \$855,698,545.

services from SFY 2009 thru 2011; Appendix 4b contains a high level trend summary of service use as measured by claims per patient and unit costs as measured by cost per claim).

Figure 18: NH Medicaid Costs per Patient and Number of Unique Patients, SFY 2006-2011



Long-Term Care Cost Trend: Home and community based care (HCBC) services for members with developmental disabilities and acquired brain disorders increased in 2011 compared to 2009, providing care to 16.5% more developmentally disabled members. The program costs increased 13.2% resulting in a net decrease in per patient spending for this waiver of 2.8%. Upon further investigation, fewer claims per patient (2.5% less) and a higher cost per claim (11.0% increase) were observed from 2009 to 2011. HCBC enrollment declined 4% for members in the waiver serving the elderly and adults with physical disabilities, while the total program costs showed little change and the per patient costs increased 22% suggesting a higher intensity of services provided to participants in this program. The use of private non-medical institution (PNMI) services for children decreased 13.9% and costs decreased 26.7%. Nursing home care in intermediate care facilities (ICF) services decreased by 1.5% in the number of members served and 5.4% in total payments for a net decrease of 4.0% in per person costs. Total claims per member served increased 15.6%, while the cost per claim declined 18.1% as a result of a change in payment rates.

Hospital Cost Trend: The number of members using general hospital inpatient and outpatient services increased 5.1% and 6.1% respectively from 2009 to 2011. Hospital inpatient total costs decreased (3.6%), resulting in a net decline of 8.3% per patient for inpatient services. Hospital inpatient claims per patient

increased slightly increased 0.7%, while cost per claim decreased 8.3% due to rate cuts from 2009 to 2011. Hospital outpatient costs declined 4.8% resulting in a 10.2% decrease in spending per patient. Reduced services measured by claims per patient (decreased 7.3%) and reduced costs of services measured by cost per claim (decreased 3.1%) were observed over the period in outpatient services.

Mental Health Center Cost Trend: Mental health centers served 7.4% more members in 2011 compared with 2009, while total costs declined slightly (0.9%) resulting in a 7.7% decrease in cost per patient.

Physician Services Cost Trend: Physicians served 13.3% more members in 2011 compared with 2009, while total costs rose 19.0%. Increased service use as measured by an increase in claims per member of 5.2% is the primary driver for increased physician service costs (costs per claim declined slightly, by 0.26%).

Pharmacy Cost Trend: Reimbursement for pharmacy is the third highest cost center for NH Medicaid in 2011, surpassing mental health centers, hospital inpatient and outpatient spending. Members using prescription drugs increased (8.9%) and the total dollars spent increased (11.9%), resulting in a 2.9% increase in spending per patient from 2009 to 2011. While the claims per patient remained fairly constant over the period (decreased only 1%), the cost per claim increased 4.1% suggesting prescription drug price was the primary driver of the increase in pharmacy costs.

Dental Cost Trend: From 2009 to 2011, members receiving dental services increased 13.9%, with a 9.9% increase in total spending, resulting in a decrease of 3.6% in per patient costs. Claims per patient and cost per claim decreased slightly over the period suggesting the increase number of members receiving services was the primary driver of increased dental costs. The trend is indicative of the success New Hampshire has had in improving access and use of dental services by children.

Tracking Access and Quality

Along with providing health care 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 health maintenance organization (HMO) averages for reporting year 2011, covering calendar year 2010 data are used.†

Note: all measures in this section are calculated for members who do not have Medicare coverage, because 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. Sixty-eight percent of children were continuously enrolled in SFY 2010 and included in these measures.

* NH CHIS quality metrics reported here are based on the NCQA HEDIS design specifications: HEDIS 2010, Technical Specifications, Volume 2. National Committee for Quality Assurance. 2010. www.ncqa.org. However, specifications for the NH CHIS quality metrics vary slightly 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.

† 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.

‡ 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.

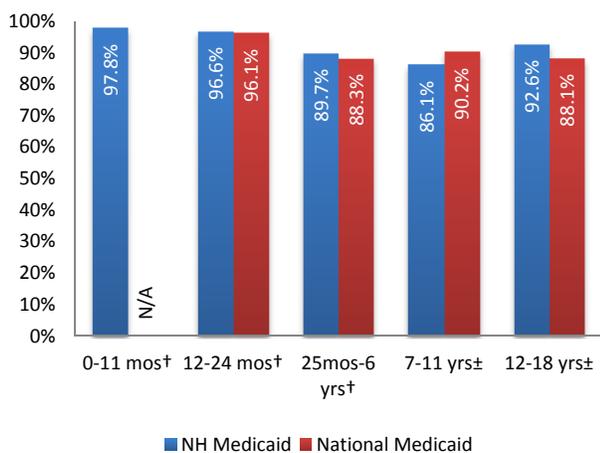
The HEDIS access to primary care practitioner measure is not a measure of just preventive services; the visits reported include both visits for preventive services and visits for medical illness and other problems.

In SFY 2011, 98% of children in their first eleven months and 97% 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-six percent of children age 7 to 11 had at least one primary care visit in the past two years, while 93% 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 similar to national HEDIS averages (slightly higher for three age groups, and lower for one).

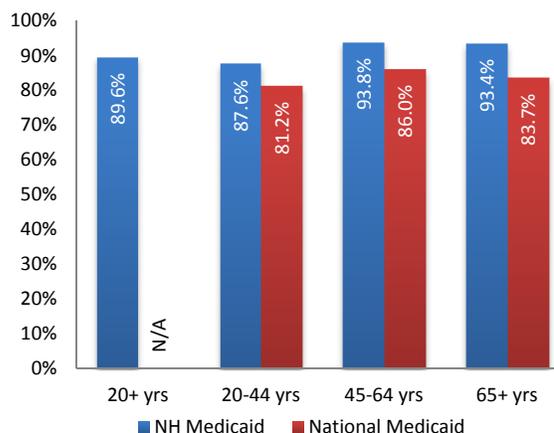
Figure 19: Percent of Children Receiving a Primary Care Visit during the Year by Age Group, SFY 2011



† 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 2011. Members age 45 and over had the highest access rate with over 93% accessing care. Adults age 20 to 44 had the lowest percentage of access at 88%—however, all age groups exceeded the national Medicaid audited NCQA HEDIS rates (Figure 20).

Figure 20: Adults' Access to Preventive/Ambulatory Health Services by Age Group, SFY 2011

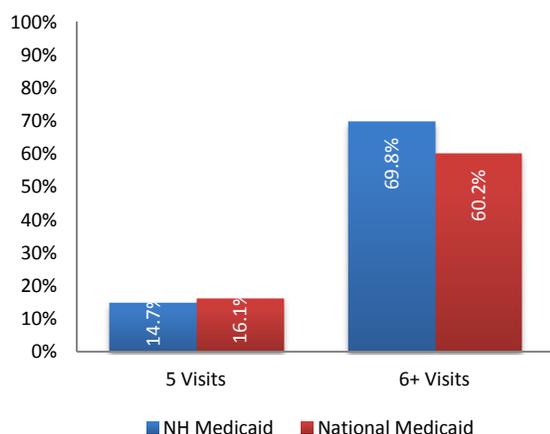


Use of Preventive Services

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.

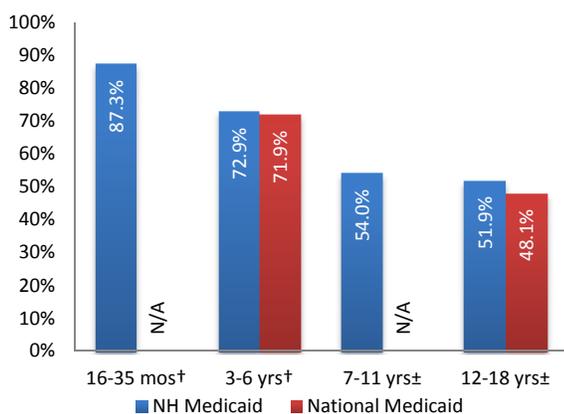
Nearly 70% of infants between 1 and 15 months of age had the expected 6 or more well-child visits, exceeding the national average (Figure 21). An additional 15% had 5 during the period, for a total of 85% with five or more visits, higher than the combined national average of 76%.

Figure 21: Percent of Infants 1 to 15 Months Old 5+ Well-Child Visits, SFY 2011



Eighty-eight percent of children under the age of 3 in NH Medicaid received their scheduled well-child visit in SFY 2011. Seventy-three percent of children age 3 to 6 years and 54% of children age 7 to 11 years received their scheduled visits in the past two years, as did 52% 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 national averages (Figure 22).

Figure 22: Percent of Children with Well-Child Visits by Age Group, SFY 2011



† Well-child visit in the past year.
‡ Well-child visit in the past two years.

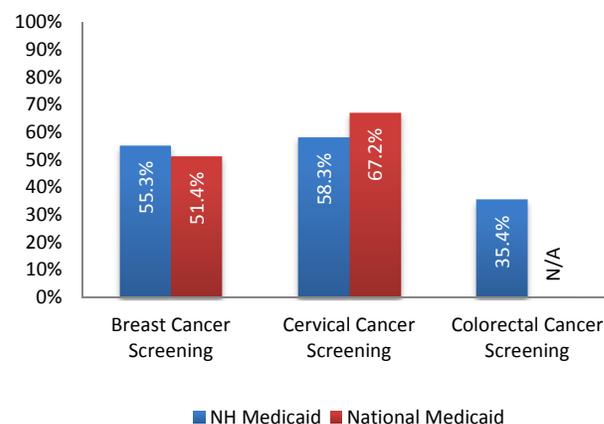
The adult screening rate for breast cancer was slightly higher than with national NCQA rates. Over half (55%) of female members received a breast cancer screening. Screening provides women with earlier detection of breast cancer, allowing for more treatment options and better chance of survival. Women

age 42 to 69* (N=3,100) are considered for this measure.

Cervical cancer screening was lower than the National NCQA rate with 58% of women having received a cervical cancer screening. 2011 National NCQA average screening rates were 51% for breast cancer and 67% 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=10,090).

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 35% of members. This measure assesses whether adults 50-75† years of age (N=2,703) with continuous enrollment had the appropriate screening for CRC.

Figure 23: Adult Preventive Screenings, SFY 2011



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 slightly lower than that observed in national Medicaid NCQA reporting§

* 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.

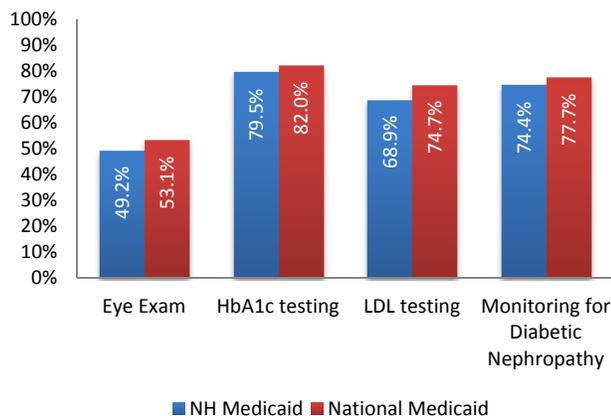
† See previous note; same is true for this measure for 65-75 year olds. Age range changed on this measure for the 2010 HEDIS specifications.

‡ 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.

(Figure 24): Glycosylated hemoglobin (HbA1c) testing at 80%; 74% of members with diabetes received monitoring for diabetic nephropathy as indicated; 49% of members with diabetes received an eye examination; while 69% received low-density lipoprotein (LDL) cholesterol testing.

Figure 24: Comprehensive Diabetes Care, SFY 2011* Diabetic Members (N=1,851)



Effectiveness of Care

Antibiotic Use in Upper Respiratory Infections

There are growing concerns with the over prescribing of antibiotics. Upper respiratory infections (URI), particularly colds, sore throats, and acute bronchitis have clear clinical guidelines about when antibiotic therapy is appropriate. In particular, over use of antibiotic treatment in pharyngitis has been shown to be an important indicator of appropriate antibiotic use among all respiratory tract infections.[†] Overuse of antibiotics is harmful as it exposes people to the drug's side effects and may increase resistance to the effects of antibiotic treatment resulting in the need for stronger antibiotics overtime. Evidence suggests that over prescribing of antibiotics is linked to the growing prevalence of antibiotic resistance bacteria.[‡]

HEDIS effectiveness of care measures identifies three measure of the overuse of antibiotics included in Figure 25: appropriate treatment for children with upper respiratory infection (URI), appropriate testing for children with pharyngitis and avoidance of antibiotic treatment in adults with acute bronchitis. All of these measures incorporate the NH CHIS pharmacy claims

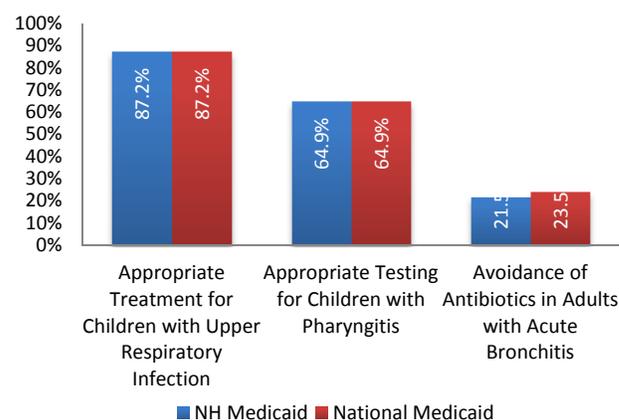
* The Nephropathy measure had a coding change from previous years.
[†] Agency for Health Care Quality and Research, National Quality Measures Clearinghouse Website <http://www.qualitymeasures.ahrq.gov/>
[‡] Ibid.

data. All measures are based on continuous enrollment during the state fiscal year (zero or one month gap in coverage during fiscal year).

Pharyngitis and Upper Respiratory Infection in Children

Sore throat is a common cause for parents to seek medical services for their children. In the United States, over 7 million outpatient visits are linked to sore throat annually. Less than a third of these will be associated with group A streptococcus (GAS). Pediatric guidelines recommend a strep test (rapid assay or throat culture) with a positive GAS be administered prior to prescribing antibiotics for children. Two measures are provided in Figure 25 as evidence of use of appropriate antibiotic prescribing for children with upper respiratory infections.

Figure 25: Effectiveness of Care, SFY 2011



The HEDIS appropriate treatment for children with URI measures the percentage of continuously enrolled children 3 months to 18 years of age who were diagnosed with URI and were not dispensed an antibiotic prescription[§]. In State Fiscal Year 2011, 88.1% of children diagnosed with URI were not dispensed an antibiotic, similar to the national HEDIS average.

The appropriate testing for children with pharyngitis HEDIS measure determines the percentage of continuously enrolled children 2–18 years of age diagnosed with pharyngitis and dispensed an antibiotic who also received a streptococcus (strep) test. In State Fiscal Year 2011, 80.4% of children diagnosed with pharyngitis and prescribed antibiotics received a strep test. While significantly better than the National Medicaid average of 64.9%, nearly 20 percent of chil-

[§] This measure is reported as inverted rates [1 - (numerator/eligible population)] thus a higher rate indicates appropriate treatment (i.e., proportion for whom the medication was *not* prescribed). (AHRQ)

dren received an antibiotic without evidence of a test for GAS.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

In the absence of a comorbid condition or other antibiotic appropriate infection, clinical guidelines do not indicate treating healthy adults with acute bronchitis with an antibiotic. Acute bronchitis is one of the primary drivers of office or clinic visits in the US. Most of the acute bronchitis diagnosed is not bacteria related, yet antibiotic prescribing occurs in up to 80% of these visits.*

Avoidance of antibiotic treatment in adults with acute bronchitis is used to assess the percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription within three days of the visit[†]. Consistent with the national trend in over prescribing, 78.5% of adults were prescribed an antibiotic, while only 21.5% were not prescribed an antibiotic.

* Ibid.

[†] This measure is reported as inverted rates [1 - (numerator/eligible population)] thus a higher rate indicates appropriate treatment (i.e., proportion for whom the medication was *not* prescribed). (AHRQ)

Discussion

The New Hampshire Medicaid program served more than 171,000 beneficiaries at some point during the 12-month period covered in this Annual Report. This State Fiscal Year 2011 (SFY 2011) 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 NH expenditures. In SFY 2011, while Medicaid accounted for the second highest percentage of NH state budget expenses at 26.8%, exceeded only by education at 27.9%. Medicaid spending as a percentage of total State spending increased slightly in SFY 2011, after declines from SFY 2007 (28.4%) through SFY 2010 (25.9%).

From SFY 2009 to SFY 2011, total Medicaid enrollment increased 12%, however total spending increased by only 3.6%. Total spending was constrained by a decline in cost per patient of 5.5%. From SFY 2006 to SFY 2008, per patient costs increased 4.4%. Beginning in SFY 2009 per patient cost have decreased by 2 to 3 percent per year, dropping per patient costs to rates lower than their SFY 2006 level. This change was due to many factors, principally reduced rates, a marginally healthier membership enrolled during the recession, and increased utilization controls.

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. Roughly nine percent of Medicaid beneficiaries participated in the HCBC waivers that accounted for 43% of total claims payments. Members in nursing homes accounted for 4% of members and 19% of claims payments. Per member per month (PMPM) costs for members using long-term care services were \$2,825 PMPM for waiver participants and \$3,277 PMPM for nursing home residents. In contrast, members not using long-term-care had a PMPM of \$292.

While NH unemployment rate has declined to 4.9% by June 2011, NH Medicaid continues to experience

an increase in enrollment. While not as dramatic as the 10% SFY 2009 increase, enrollment rose another 3.3% between SFY 2010 and 2011.

The SFY 2012 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 and the slow pace of jobs development in this beginning of the economic recovery.

The end of SFY 2011 saw legislation enacted that would require the Department of Health and Human Services to administer the Medicaid program as a managed care model (Senate Bill 147). This continued the process that began with the release of a Request for Information (RFI) in the beginning of the fiscal year (July 2011), the purpose of which was to gather input and suggestions in order to assess the feasibility of transitioning from the Fee for Service (FFS) model, assess stakeholder interest in participating in more efficient and effective approaches to the financing and delivery of Medicaid services and to use the collected information from the RFI to develop a subsequent RFP. Information gathered from this RFI informed the Department and legislative deliberations in the second half of SFY 2011.

Senate Bill 147 was passed by the New Hampshire General Court and signed into law by Governor John Lynch on June 2, 2011. The new law required the Department to transition the NH Medicaid program to a managed care model for all its services except dental care and to do so within a risk-based capitated financing structure. As will be described in detail in the SFY 2012 New Hampshire Medicaid Annual Report, the Department has subsequently issued Requests for Proposals and contracted with three managed care companies to administer New Hampshire's new Care Management program.

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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 members 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
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)

Implementation Date	Program Expansion	Reason
10/21/1991	Exclude SSA income and resource accounts set up under Plan for Achieving Self Support	State initiative - out of court settlement with NH Legal Assistance
5/11/1992	Resource offset for life insurance. Adult categories of financial and medical assistance	State initiative - Favreau v. Department of Human Services Consent Decree
7/1/1992	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)
8/10/1993	Certain trusts established for the benefit of disabled individuals are exempt resources for Medicaid eligibility determinations.	Federal Mandate (OBRA 93)
12/1/1993	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)
1/1/1994	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)
7/1/1994	Use of shortened application form, presumptive eligibility for poverty level pregnant women who apply through prenatal clinics	State Initiative
7/1/1994	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)
1/1/1995	Increase income limits for specified low-income Medicare beneficiaries to 120% federal poverty level	Federal Mandate (OBRA 90)
5/1/1996	Conversion from "full-month" Medicaid coverage (if the individual is eligible at any time during the month, the individual is eligible for the whole month) to date specific eligibility.	State Initiative
2/1/1997	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
1/1/1998	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)
1/1/1998	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.
5/1/1998	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
7/1/1999	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))
8/1/1999	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)

Implementation Date	Program Expansion	Reason
8/1/1999	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
4/1/2000	Increase in the NHEP/FAP maximum shelter allowance subsequently changed the NHEP/FAP SON by \$25.	State Initiative
8/1/2000	Allow 50% earned income disregard for TANF cat needy; increase cat needy resource limit to \$2000	State Initiative
8/1/2000	Extend 12 month EMA to TANF cat needy cases closed due to increased income or hours of employment	State Initiative
10/1/2000	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
1/1/2001	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))
1/1/2001	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)
3/1/2001	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 (authorized under Public Law 106-354)
2/1/2002	New Coverage group - Medicaid for Employed Adults with Disabilities – MEAD	State Mandate (RSA 167:6; TWWIIA)
4/2003 - 6/2003	State Medicaid matching rates raised by 2.95 % from 4/03 thru 6/04 as temporary federal fiscal relief for the states due to a 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)
2003	Implemented In Home Supports Waiver for children with severe developmental disabilities, birth to age 21, living at home with their families.	State mandate – RSA 161-I:7; 171-A:3; 18, IV
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
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 member having a medical home.	State Initiative (Chp. 177:123, NH Laws of 2005)

Implementation Date	Program Expansion	Reason
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)
3/2010	The "Affordable Care Act" (ACA) is comprehensive federal health care reform legislation, impacting private insurance and public health programs through changes in structure, costs, delivery, quality, program integrity, and revenues/financing. Implementation dates vary and stretch over a number of years. Medicaid impacts include a major expansion up to 133% FPL, delivery system and payment reform initiatives, and improvements in the areas fraud and waste prevention. The ACA is a combination of two pieces of federal legislation.	Federal Initiative & Mandate – Patient Protection and Affordable Care Act (PPACA) Federal Initiative & Mandate – Health Care and Education Reconciliation Act of 2010 (HCERA)
6/2011	Senate Bill 147 was passed by the New Hampshire General Court and signed into law by Governor John Lynch on June 2, 2011. The new law required the Department to transition the NH Medicaid program to a managed care model for all its services except dental care and to do so within a risk-based capitated financing structure.	State Initiative

Appendix 2: Recent New Hampshire Laws Relative to Medicaid

The following recently enacted laws impacted NH Medicaid during SFY 2011.

- Enacted package including the following provisions (Chp. 144, NH Laws of 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, 2011;
 - Extended the cap on the total amount counties were required to pay for persons eligible to receive nursing home services at \$105 million for each of fiscal years 2011 and 2012;
 - Required DHHS to submit a Medicaid state plan amendment to suspend direct graduate medical education payments to hospitals until June 30, 2011;
 - Suspended certain laws relative to the funeral expenses to recipients of public assistance and other reimbursement for care of an assisted person until June 30, 2011;
 - Limited the ability of DHHS to change program eligibility standards and rates in the biennium ending June 30, 2011;
 - Required DHHS to establish an uncompensated care payment system, submit an amendment to the state Medicaid plan regarding the system, and report to the Oversight Committee on Health and Human Services by January 1, 2011; and
 - Required DHHS to remit reimbursement to Children's Hospital Boston at a maximum rate of 80% of costs for the biennium ending June 30, 2011.

- Enacted package including the following provisions (Chp. 1, NH Laws of 2010 Special Session):
 - Made further reductions to DHHS appropriations for the biennium ending June 30, 2011;
 - Required DHHS to consolidate social services and medical contracts, without reducing program services, in order to reduce General Fund spending for the fiscal year ending June 30, 2011;
 - Suspended direct and indirect graduate medical education payments to hospitals until July 1, 2011;
 - Suspended catastrophic aid payments to hospitals until June 30, 2011;
 - Suspended the home health rate setting rule through June 30, 2011;
 - Changes the due date of the Medicaid enhancement tax, effective July 1, 2010; and
 - Reduced rates for residential providers by 2% for fiscal year 2011.

- Consolidated the budget amount DHHS was required to reduce (under Chp. 144, NH Laws of 2009) over biennium ending June 30, 2011. (Chp. 4:3, NH Laws of 2010).

- Permits DHHS to recover medical assistance costs from the portion of settlements or judgments reasonably attributed to medical expenses. (Chp. 15, NH Laws of 2010).

- Directed DHHS to seek funding for a children's oral health initiative that would enable primary care providers to deliver preventive oral health services to children between 0 and 3 years of age under Medicaid, contingent upon future funding and approval of a state Medicaid plan amendment. (Chp. 76, NH Laws of 2010).

- Modified the methodology used by DHHS for determining appropriate long-term care settings by comparing facility costs to home and community-based costs for certain high cost cases. (Chp. 112, NH Laws of 2010).

- Established a commission on health care cost containment, including review of Medicaid reimbursements rates, options for a common payment system, and incentives to increase the efficiency of care. (Chp. 224, NH Laws of 2010).
- Authorized DHHS to establish an electronic asset verification system to obtain financial records in order to verify eligibility for medical assistance for the aged, blind, and disabled. (Chp. 308, NH Laws of 2010).

Appendix 3: Summary of Provider Payment Rate Changes in SFY 2011

Rate changes and/or payment methodology changes occurred in the following areas across the NH Medicaid program in SFY 2011:

- Inpatient and outpatient hospitals: routine updates to MS-DRG weights and outpatient interim rates;
- Reinstatement of durable medical equipment rates in effect prior to the SFY 2010 rate decrease effective 4/1/10;
- Routine encounter rate changes for FQHC/RHC;
- Routine rate changes for Private Non-Medical Institutions (residential care for children); foster care services; and home-based therapeutic services for children;
- Rollback of various mental health center services rate increases in SFY 2010;
- Increased rate for levonorgestrel-releasing IUD;
- Increased rate for intrauterine copper contraceptive;
- Increased rates for specific cardiac, neurologic, orthopedic and ophthalmologic procedure codes reflecting new technologies and/or procedures;
- Termination of specific procedure codes for services not covered under the NH Medicaid State Plan;
- Added Immunization codes 90460 and 90461;
- Added capacity to rent a TENS unit for two months; and
- Reducing the rate for anesthesia/deep sedation administered by dentists to be consistent with the same service provided by anesthesiologists.

Appendix 4a: NH Medicaid Expenditures by Service Categories, SFY 2011 Service Dates

Note: Sorted by SFY 2011 Total Cost

Category of Service	FY 2009			FY 2010			FY 2011			Percent Change 2009 to 2011		
	Patients	Payments	Cost Per Patient	Patients	Payments	Cost Per Patient	Patients	Payments	Cost Per Patient	Patients	Payments	Cost Per Patient
Home and Community Based Care: Developmentally Disabled /	3,968	\$179,699,021	\$45,287	4,230	\$189,835,877	\$44,878	4624	\$203,550,156	\$44,020	16.53%	13.27%	-2.80%
Intermediate Care Facility Nursing Home	6,199	\$189,523,897	\$30,573	6,180	\$188,658,009	\$30,527	6109	\$179,262,385	\$29,344	-1.45%	-5.41%	-4.02%
Prescription Drugs	94,575	\$85,048,590	\$899	101,322	\$92,036,010	\$908	102875	\$95,187,910	\$925	8.78%	11.92%	2.92%
Mental Health Center	20,449	\$94,605,787	\$4,626	21,714	\$95,818,429	\$4,413	21958	\$93,745,069	\$4,269	7.38%	-0.91%	-7.71%
Outpatient Hospital, General	87,310	\$70,297,301	\$805	89,492	\$74,487,604	\$832	92606	\$66,957,267	\$723	6.07%	-4.75%	-10.18%
Inpatient Hospital, General	16,968	\$63,180,266	\$3,723	17,739	\$60,476,194	\$3,409	17834	\$60,894,324	\$3,415	5.10%	-3.62%	-8.29%
Physicians Services	110,249	\$49,591,372	\$450	121,745	\$57,808,297	\$475	124898	\$59,056,650	\$473	13.29%	19.09%	5.08%
Home and Community Based Care: Choices for Independence	3,740	\$52,285,151	\$13,980	3,637	\$55,513,706	\$15,264	3595	\$52,169,876	\$14,512	-3.88%	-0.22%	3.80%
Clinic Services	8,526	\$37,758,961	\$4,429	9,865	\$37,982,723	\$3,850	10357	\$37,475,643	\$3,618	21.48%	-0.75%	-18.30%
Dental Service	51,931	\$20,296,633	\$391	58,080	\$22,282,794	\$384	59133	\$22,297,523	\$377	13.87%	9.86%	-3.56%
Furnished Medical Supplies or Durable Medical Equipment	15,281	\$13,970,228	\$914	16,409	\$15,565,670	\$949	16677	\$16,617,006	\$996	9.14%	18.95%	9.02%
Private Non-Medical Institutional For Children	1,103	\$20,005,787	\$18,138	1,019	\$16,747,544	\$16,435	950	\$14,670,928	\$15,443	-13.87%	-26.67%	-14.86%
Rural Health Clinic	24,509	\$12,742,094	\$520	25,418	\$13,770,634	\$542	25724	\$13,923,261	\$541	4.96%	9.27%	4.09%
Day Habilitation Center	2,956	\$9,097,498	\$3,078	3,118	\$9,951,040	\$3,191	3177	\$10,261,950	\$3,230	7.48%	12.80%	4.94%
Home Health Services	3,154	\$7,564,443	\$2,398	3,578	\$8,854,822	\$2,475	3176	\$9,805,572	\$3,087	0.70%	29.63%	28.75%
Private Duty Nursing	151	\$8,128,111	\$53,829	175	\$9,386,376	\$53,636	168	\$9,440,617	\$56,194	11.26%	16.15%	4.39%
Skilled Nursing Facility Nursing Home	3,362	\$10,490,604	\$3,120	3,278	\$9,760,388	\$2,978	3313	\$8,930,047	\$2,695	-1.46%	-14.88%	-13.61%
Personal Care	183	\$6,026,997	\$32,934	209	\$7,213,728	\$34,515	222	\$7,800,171	\$35,136	21.31%	29.42%	6.69%
SNF Nursing Home Atypical Care	51	\$4,832,384	\$94,753	69	\$6,363,777	\$92,229	68	\$7,009,650	\$103,083	33.33%	45.06%	8.79%
Intensive Home And Community Services	421	\$3,580,431	\$8,505	550	\$4,247,703	\$7,723	622	\$4,849,011	\$7,796	47.74%	35.43%	-8.34%
Psychology	6,376	\$3,667,994	\$575	7,346	\$4,302,928	\$586	7843	\$4,654,923	\$594	23.01%	26.91%	3.22%
Inpatient Psychiatric Facility Services Under Age 22	327	\$3,895,915	\$11,914	357	\$4,094,196	\$11,468	353	\$4,116,276	\$11,661	7.95%	5.66%	-2.12%
ICF Nursing Home Atypical Care	70	\$2,964,634	\$42,352	72	\$3,362,064	\$46,695	73	\$3,387,208	\$46,400	4.29%	14.25%	9.56%

Category of Service	FY 2009			FY 2010			FY 2011			Percent Change 2009 to 2011		
	Patients	Payments	Cost Per Patient	Patients	Payments	Cost Per Patient	Patients	Payments	Cost Per Patient	Patients	Payments	Cost Per Patient
Wheelchair Van	2,826	\$3,170,243	\$1,122	3,084	\$3,426,616	\$1,111	3213	\$3,150,405	\$981	13.69%	-0.63%	-12.61%
Medical Services Clinic	1,843	\$3,325,670	\$1,804	2,012	\$3,711,675	\$1,845	2079	\$3,090,480	\$1,487	12.81%	-7.07%	-17.60%
Placement Services	223	\$5,121,297	\$22,965	199	\$3,630,279	\$18,243	173	\$3,020,247	\$17,458	-22.42%	-41.03%	-23.98%
ICF Services For The Developmentally Disabled	42	\$3,028,496	\$72,107	49	\$3,119,373	\$63,661	38	\$3,007,045	\$79,133	-9.52%	-0.71%	9.74%
Ambulance Service	9,570	\$2,062,668	\$216	10,804	\$2,538,123	\$235	11157	\$2,647,249	\$237	16.58%	28.34%	9.85%
Optometric Services Eyeglasses	19,386	\$1,679,708	\$87	21,033	\$1,970,970	\$94	21429	\$2,009,189	\$94	10.54%	19.62%	7.77%
Home Based Therapy	501	\$1,719,866	\$3,433	465	\$1,673,470	\$3,599	455	\$1,741,762	\$3,828	-9.18%	1.27%	11.51%
Physical Therapy	1,944	\$1,216,670	\$626	2,230	\$1,493,245	\$670	2386	\$1,361,898	\$571	22.74%	11.94%	-8.82%
Child Health Support Service	400	\$1,417,132	\$3,543	347	\$1,336,716	\$3,852	347	\$1,194,693	\$3,443	-13.25%	-15.70%	-2.82%
Adult Medical Day Care	207	\$960,198	\$4,639	245	\$867,494	\$3,541	261	\$1,056,011	\$4,046	26.09%	9.98%	-12.78%
Laboratory (Pathology)	17,646	\$1,596,345	\$90	16,317	\$1,334,761	\$82	10265	\$1,019,139	\$99	-41.83%	-36.16%	10.31%
X-Ray Services	4,896	\$493,628	\$101	5,150	\$555,631	\$108	5614	\$671,803	\$120	14.67%	36.10%	18.48%
Family Planning Services	1,762	\$557,982	\$317	2,264	\$350,575	\$155	2028	\$500,322	\$247	15.10%	-10.33%	-22.17%
Occupational Therapy	452	\$419,940	\$929	543	\$548,857	\$1,011	648	\$493,761	\$762	43.36%	17.58%	-17.98%
Speech Therapy	308	\$157,697	\$512	431	\$265,803	\$617	502	\$376,774	\$751	62.99%	138.92%	46.59%
Advanced Registered Nurse Practitioner	2,012	\$385,769	\$192	2,018	\$332,992	\$165	1808	\$310,661	\$172	-10.14%	-19.47%	-10.51%
I/P Hospital Swing Beds, SNF	85	\$234,414	\$2,758	108	\$284,273	\$2,632	113	\$276,417	\$2,446	32.94%	17.92%	-11.31%
Podiatrist Services	3,393	\$205,199	\$60	3,402	\$242,910	\$71	3212	\$224,204	\$70	-5.33%	9.26%	16.34%
I/P Hospital Swing Beds, ICF	16	\$104,984	\$6,561	14	\$49,790	\$3,556	25	\$102,559	\$4,102	56.25%	-2.31%	-37.47%
Certified Midwife (Non-Nurse)	107	\$96,957	\$906	124	\$102,408	\$826	124	\$94,371	\$761	15.89%	-2.67%	-16.00%
Crisis Intervention	12	\$323,082	\$26,924	10	\$272,625	\$27,263	11	\$88,161	\$8,015	-8.33%	-72.71%	-70.23%
Audiology Services	618	\$29,593	\$48	707	\$33,196	\$47	766	\$33,502	\$44	23.95%	13.21%	-8.88%
Inpatient Hospital, Mental	1	\$1,068	\$1,068	1	\$5,100	\$5,100	1	\$5,574	Insf.	Insf.	Insf.	Insf.
Outpatient Hospital, Mental	27	\$1,516	\$56	31	\$1,859	\$60	41	\$3,174	\$77	51.85%	109.35%	38.23%
Disability Determination Service	0	\$0	\$0	11	\$417	\$38	10	\$363	Insf.	Insf.	Insf.	Insf.
Chiropractic	1,103	\$69,716	\$63	749	\$39,258	\$52	0	\$0	Insf.	Insf.	Insf.	Insf.
Other	2	\$247	\$124	1	\$0	\$0	0	\$0	Insf.	Insf.	Insf.	Insf.
Total*	136,791	\$977,634,356	\$7,147	145,880	\$1,016,708,930	\$6,969	149884	\$1,012,543,187	\$6,756	9.57%	3.57%	-5.48%

*Difference from \$1.43 Billion for SFY 2011 due to provider spending for services with dates of services (7/1/2010-6/30/2011); does not reflect administrative, cost settlements, rebates or other off-claim payments

Insf.=insufficient data

Appendix 4b: NH Medicaid Trends in per Member Service Use and Unit Costs, SFY 2011 Service Dates

Category of Service Groups	2009					2011					Percent Change 2009-2011	
	Number of Members Using Service	Number of Services	Payments	Claims Per Patient	Cost Per Claim	Number of Members Using Service	Number of Services	Payments	Claims Per Patient	Cost Per Claim	Claims Per Patient	Cost Per Claim
Total	136,791	7,179,151	\$977,634,356	52.48	\$136.18	149,884	7,505,440	\$1,012,543,187	50.07	\$134.91	-4.59%	-0.93%
Hospital-Inpatient	17,259	22,393	\$67,077,249	1.30	\$2,995.46	18,127	23,676	\$65,016,175	1.31	\$2,746.08	0.67%	-8.33%
Hospital-Outpatient	87,312	472,699	\$70,298,817	5.41	\$148.72	92,609	464,839	\$66,960,441	5.02	\$144.05	-7.29%	-3.14%
Physician & Related	110,472	959,026	\$50,074,097	8.68	\$52.21	125,054	1,141,791	\$59,461,681	9.13	\$52.08	5.17%	-0.26%
Other Professional Services	52,456	1,195,241	\$58,573,497	22.79	\$49.01	49,754	1,117,537	\$59,170,789	22.46	\$52.95	-1.42%	8.04%
Prescription Drugs	94,575	1,383,496	\$85,048,590	14.63	\$61.47	102,875	1,486,887	\$95,187,910	14.45	\$64.02	-1.20%	4.14%
Behavioral Health Services	25,443	710,860	\$98,596,863	27.94	\$138.70	28,108	779,723	\$98,488,152	27.74	\$126.31	-0.71%	-8.93%
Transportation	10,976	65,471	\$5,232,911	5.96	\$79.93	12,736	68,595	\$5,797,654	5.39	\$84.52	-9.71%	5.75%
Dental Service	51,931	136,900	\$20,296,633	2.64	\$148.26	59,133	153,982	\$22,297,523	2.60	\$144.81	-1.22%	-2.33%
Home & Community Based Care	13,475	1,952,721	\$269,061,717	144.91	\$137.79	13,918	1,965,877	\$300,675,125	141.25	\$152.95	-2.53%	11.00%
Nursing Facility	6,948	93,705	\$208,150,917	13.49	\$2,221.34	7,014	109,359	\$198,968,266	15.59	\$1,819.40	15.61%	-18.09%
Vision & Other Durable Medical Equipment	31,707	144,268	\$15,649,936	4.55	\$108.48	35,028	157,040	\$18,626,195	4.48	\$118.61	-1.47%	9.34%
Private Non-Medical Institutional For Children	1,103	23,354	\$20,005,787	21.17	\$856.63	950	19,505	\$14,670,928	20.53	\$752.16	-3.03%	-12.20%
Nursing Facility Services for Children with Severe Disabilities	42	315	\$3,028,496	7.50	\$9,614.27	38	298	\$3,007,045	7.84	\$10,090.76	4.56%	4.96%
Other	605	19,377	\$6,538,846	32.03	\$337.45	521	19,300	\$4,215,303	37.04	\$218.41	15.66%	-35.28%

Appendix 4c: NH Medicaid Expenditures by Service Categories, SFY 2011 Paid Dates

Category of Service	Total Cost of Coverage
Home and Community Based Care: Developmentally Disabled / Acquired Brain Disorder / In Home Support Waiver	\$205,007,414
Intermediate Care Facility Nursing Home	\$180,044,171
Prescription Drugs	\$93,963,953
Mental Health Center	\$93,746,339
Outpatient Hospital, General	\$69,177,680
Inpatient Hospital, General	\$62,814,021
Physicians Services	\$59,947,709
Home and Community Based Care: Choices for Independence Waiver	\$52,640,993
Clinic Services	\$38,546,864
Dental Service	\$22,251,215
Furnished Medical Supplies or Durable Medical Equipment	\$16,975,519
Private Non-Medical Institutional for Children	\$14,822,269
Rural Health Clinic	\$13,982,990
Day Habilitation Center	\$10,417,338
Home Health Services	\$9,573,812
Private Duty Nursing	\$9,535,150
Skilled Nursing Facility Nursing Home	\$9,400,239
Personal Care	\$7,713,033
SNF Nursing Home Atypical Care	\$7,398,857
Intensive Home and Community Services	\$4,908,163
Psychology	\$4,740,218
Inpatient Psychiatric Facility Services Under Age 22	\$4,026,369
Wheelchair Van	\$3,170,776
Placement Services	\$3,115,022
Medical Services Clinic	\$3,047,092
ICF Services for the developmentally disabled	\$3,042,440
ICF Nursing Home Atypical Care	\$3,026,641
Ambulance Service	\$2,737,406
Optometric Services Eyeglasses	\$2,006,842
Home Based Therapy	\$1,667,046
Physical Therapy	\$1,410,670
Child Health Support Service	\$1,172,051
Adult Medical Day Care	\$1,091,535
Laboratory (Pathology)	\$1,021,285
X-Ray Services	\$681,731
Occupational Therapy	\$499,929
Family Planning Services	\$496,366
Speech Therapy	\$370,333
I/P Hospital Swing Beds, SNF	\$369,117
Advanced Registered Nurse Practitioners	\$316,382
Podiatrist Services	\$226,776
Crisis Intervention	\$98,140
I/P Hospital Swing Beds, ICF	\$96,661
Certified Midwife (Non-Nurse)	\$84,965
Audiology Services	\$34,616
Outpatient Hospital, Mental	\$2,880
Disability Determination Service	\$339

Category of Service	Total Cost of Coverage
Other	\$254
Subtotal - Provider Payments Tied to Specific Members	\$1,021,421,612

Category of Service	Total Cost of Coverage
Nursing Facility Supplemental Payments	\$72,688,121
Provider System Payout Non-Claim Specific	\$1,329,527
Insurance Premium Carrier System Payout	\$653,375
Provider Refund Claim Specific	(\$158,008)
Provider Recoupment Non-Claim Specific	(\$351,730)
Third Party Liability Carrier Refund Non-Claim Specific	(\$1,069,329)
Recipient Refund Non-Claim Specific	(\$1,884,761)
Provider Refund Non-Claim Specific	(\$8,348,560)
Subtotal - Non Claim Payments, Recoupments, Refunds	\$62,858,636
Grand Total*	\$1,084,280,248

* Total NH Medicaid expenditures totaled \$1.43 billion in SFY 2011. 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, 2010 through June 30, 2011. 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 2011

Category of Service Groups	Total Medicaid Enrollment	Low-income Adult	Low-income Child	Severely Disabled Child	Adults w/Mental Illness Disabilities	Adults w/Physical Disabilities	Elderly
HBCB	\$182.80	\$21.10	\$5.49	\$643.71	\$1,003.58	\$831.71	\$414.53
Behavioral Health Services	\$59.88	\$33.48	\$23.08	\$156.52	\$64.47	\$334.28	\$39.30
Dental Service	\$13.56	\$20.53	\$5.57	\$8.79	\$3.54	\$4.74	\$0.49
Hospital-Inpatient	\$39.53	\$24.53	\$67.62	\$50.58	\$137.21	\$49.23	\$43.22
Hospital-Outpatient	\$40.71	\$19.04	\$85.75	\$38.95	\$138.25	\$68.21	\$37.87
Nursing Facility	\$120.96	\$0.56	\$1.11	\$2.85	\$179.29	\$71.92	\$1,558.38
Nursing Facility Services for Children with Severe Disabilities	\$1.83	\$2.34	\$0.00	\$13.28	\$4.52	\$0.17	\$0.00
Other	\$2.56	\$3.93	\$0.00	\$0.00	\$0.34	\$2.71	\$0.00
Other Professional	\$35.97	\$27.96	\$40.48	\$673.16	\$54.54	\$32.74	\$6.13
Physician & Related	\$36.15	\$24.54	\$81.88	\$17.47	\$92.34	\$41.01	\$21.24
PNMI For Children	\$8.92	\$14.59	\$0.00	\$2.39	\$0.00	\$3.90	\$0.00
Prescription Drugs	\$57.87	\$31.98	\$78.28	\$154.24	\$221.18	\$140.09	\$28.75
Transportation	\$3.52	\$0.75	\$2.12	\$1.48	\$19.05	\$5.35	\$16.09
Vision & DME	\$11.32	\$6.08	\$5.30	\$118.36	\$56.42	\$12.44	\$14.05
Total	\$615.58	\$231.40	\$396.69	\$1,881.79	\$1,974.72	\$1,598.50	\$2,180.05

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 2011

Service Categories	Members Receiving Home & Community Based Care Services				Members Using Nursing Facilities and No Home & Community Based Care Services				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	\$22,262,016	3,424	24.60%	\$144.31	\$2,758,286	1,060	17.33%	\$45.96	\$39,995,872	13,643	10.51%	\$30.75
Hospital-Outpatient	\$12,066,505	10,240	73.57%	\$78.22	\$1,654,219	2,386	39.01%	\$27.56	\$53,239,716	79,983	61.60%	\$40.93
Physician & Related	\$10,207,689	12,105	86.97%	\$66.17	\$1,119,539	3,855	63.02%	\$18.65	\$48,134,453	109,094	84.02%	\$37.01
Other Professional Services	\$23,151,991	6,798	48.84%	\$150.07	\$240,261	2,475	40.46%	\$4.00	\$35,778,536	40,481	31.18%	\$27.51
Prescription Drugs	\$19,507,742	10,253	73.67%	\$126.45	\$1,725,846	4,757	77.77%	\$28.76	\$73,954,323	87,865	67.67%	\$56.86
Behavioral Health Services	\$13,929,716	3,296	23.68%	\$90.29	\$601,170	417	6.82%	\$10.02	\$83,957,266	24,395	18.79%	\$64.55
Transportation	\$2,865,833	3,247	23.33%	\$18.58	\$1,189,344	2,612	42.70%	\$19.82	\$1,742,477	6,877	5.30%	\$1.34
Dental Service	\$1,077,688	3,335	23.96%	\$6.99	\$9,340	36	0.59%	\$0.16	\$21,210,495	55,762	42.94%	\$16.31
Home & Community Based Care	\$300,675,125	13,918	100.00%	\$1,949.02	\$0	0	0.00%	\$0.00	\$0	0	0.00%	\$0.00
Nursing Facility	\$12,025,650	897	6.44%	\$77.95	\$186,942,616	6,117	100.00%	\$3,114.83	\$0	0	0.00%	\$0.00
Vision & Other Durable Medical Equipment	\$10,222,302	6,819	48.99%	\$66.26	\$464,599	1,387	22.67%	\$7.74	\$7,939,295	26,822	20.66%	\$6.10
Private Non-Medical Institutions For Children	\$5,388,262	392	2.82%	\$34.93	\$0	0	0.00%	\$0.00	\$9,282,666	558	0.43%	\$7.14
Nursing Facility Services for Children with Severe Disabilities	\$943,823	23	0.17%	\$6.12	\$0	0	0.00%	\$0.00	\$2,063,222	15	0.01%	\$1.59
Other	\$1,513,821	206	1.48%	\$9.81	\$0	0	0.00%	\$0.00	\$2,701,483	315	0.24%	\$2.08
Total	\$435,838,164	13,918		\$2,825	\$196,705,220	6,117		\$3,277	\$379,999,804	129,849		\$292

Appendix 6b: Comparison of NH Medicaid Members Cost and Service Use by Dual Eligible Status, SFY 2011

Service Categories	Dual Eligible			Medicaid Only		
	Total Claims Payment	Service Users	PMPM	Total Claims Payment	Service Users	PMPM
Home & Community Based Care	\$165,968,204	5,681	\$591.51	\$134,706,920	13,152	\$98.74
Nursing Facility	\$165,561,833	6,488	\$590.07	\$33,406,434	5,304	\$24.49
Behavioral Health Services	\$36,456,334	7,493	\$129.93	\$62,031,818	26,317	\$45.47
Prescription Drugs	\$3,317,288	12,889	\$11.82	\$91,870,622	95,227	\$67.34
Hospital-Outpatient	\$11,026,198	18,104	\$39.30	\$55,934,243	82,179	\$41.00
Hospital-Inpatient	\$6,538,261	4,213	\$23.30	\$58,477,914	14,255	\$42.86
Physician & Related	\$4,911,108	21,523	\$17.50	\$54,550,573	115,936	\$39.98
Other Professional Services	\$1,873,192	9,052	\$6.68	\$57,297,597	43,937	\$42.00
Dental Service	\$486,360	1,503	\$1.73	\$21,811,163	57,762	\$15.99
Vision & Other Durable Medical Equipment	\$3,634,172	9,655	\$12.95	\$14,992,023	29068	\$10.99
Private Non-Medical Institutional For Children	\$109,572	8	\$0.39	\$14,561,356	945	\$10.67
Transportation	\$2,910,435	6363	\$10.37	\$2,887,219	7,841	\$2.12
Other	\$44,535	7	\$0.16	\$4,170,768	519	\$3.06
Nursing Facility Services for Children with Severe Disabilities	\$0	0	\$0.00	\$3,007,045	38	\$2.20
Total	\$402,837,492	26,886	\$1,435.72	\$609,705,696	144,469	\$446.90

Appendix 7: New Hampshire Medicaid Enrollment and Total Expenditures by New Hampshire Cities and Towns – SFY 2011 Service Dates

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
ACWORTH	686	57	\$384,397	\$560
ALBANY	664	55	\$243,913	\$367
ALEXANDRIA	1,739	145	\$597,364	\$344
ALLENSTOWN	7,628	636	\$3,625,085	\$475
ALSTEAD	1,890	158	\$678,687	\$359
ALTON	5,578	465	\$2,406,976	\$432
AMHERST	4,194	350	\$2,522,717	\$602
ANDOVER	2,135	178	\$1,385,385	\$649
ANTRIM	3,649	304	\$1,558,907	\$427
ASHLAND	3,653	304	\$1,503,054	\$411
ATKINSON	2,923	244	\$9,276,837	\$3,174
AUBURN	3,130	261	\$1,616,157	\$516
BARNSTEAD	5,684	474	\$1,826,040	\$321
BARRINGTON	7,872	656	\$2,835,735	\$360
BARTLETT	2,625	219	\$846,982	\$323
BATH	1,472	123	\$472,944	\$321
BEDFORD	7,857	655	\$9,048,787	\$1,152
BELMONT	11,783	982	\$4,961,135	\$421
BENNINGTON	2,045	170	\$967,569	\$473
BENTON	251	21	\$41,274	\$164
BERLIN	24,866	2,072	\$18,532,254	\$745
BETHLEHEM	3,802	317	\$1,886,871	\$496
BOSCAWEN	6,979	582	\$9,615,109	\$1,378
BOW	3,456	288	\$2,663,648	\$771
BRADFORD	1,692	141	\$892,494	\$527
BRENTWOOD	2,728	227	\$4,151,412	\$1,522
BRIDGEWATER	323	27	\$79,957	\$248
BRISTOL	6,225	519	\$2,127,292	\$342
BROOKFIELD	536	45	\$238,129	\$444
BROOKLINE	2,029	169	\$1,159,660	\$572
CAMBRIDGE	24	2	*	*
CAMPTON	5,851	488	\$2,439,891	\$417
CANAAN	3,975	331	\$1,418,266	\$357
CANDIA	2,443	204	\$1,214,355	\$497
CANTERBURY	1,730	144	\$692,504	\$400
CARROLL	1,187	99	\$1,272,813	\$1,072
CENTER HARBOR	1,606	134	\$694,760	\$433
CHARLESTOWN	8,915	743	\$4,035,252	\$453

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
CHATHAM	355	30	\$62,667	\$177
CHESTER	2,690	224	\$1,504,433	\$559
CHESTERFIELD	2,130	178	\$1,278,256	\$600
CHICHESTER	1,776	148	\$1,177,263	\$663
CLAREMONT	31,662	2,639	\$22,195,957	\$701
CLARKSVILLE	427	36	\$114,535	\$268
COLEBROOK	5,644	470	\$3,551,214	\$629
COLUMBIA	499	42	\$192,476	\$386
CONCORD	72,572	6,048	\$80,819,397	\$1,114
CONWAY	22,485	1,874	\$14,210,023	\$632
CORNISH	1,174	98	\$327,533	\$279
CROYDON	543	45	\$476,005	\$877
DALTON	1,636	136	\$818,889	\$501
DANBURY	1,944	162	\$481,325	\$248
DANVILLE	3,201	267	\$1,572,312	\$491
DEERFIELD	3,225	269	\$1,605,807	\$498
DEERING	1,502	125	\$417,686	\$278
DERRY	35,525	2,960	\$18,588,015	\$523
DIXVILLE	10	1	*	*
DORCHESTER	416	35	\$89,678	\$216
DOVER	35,477	2,956	\$21,425,943	\$604
DUBLIN	1,354	113	\$406,251	\$300
DUMMER	334	28	\$140,864	\$422
DUNBARTON	1,630	136	\$990,233	\$608
DURHAM	1,780	148	\$1,141,578	\$641
EAST KINGSTON	1,222	102	\$307,964	\$252
EASTON	90	8	*	*
EATON	231	19	\$99,806	\$432
EFFINGHAM	2,380	198	\$1,342,699	\$564
ELLSWORTH	60	5	*	*
ENFIELD	4,275	356	\$2,353,932	\$551
EPPING	7,196	600	\$3,261,044	\$453
EPSOM	6,309	526	\$3,207,984	\$508
ERROL	459	38	\$188,919	\$412
EXETER	12,377	1,031	\$7,126,089	\$576
FARMINGTON	13,425	1,119	\$5,398,084	\$402
FITZWILLIAM	2,750	229	\$831,065	\$302
FRANCESTOWN	1,064	89	\$376,783	\$354
FRANCONIA	1,020	85	\$877,212	\$860
FRANKLIN	21,395	1,783	\$9,551,777	\$446
FREEDOM	1,580	132	\$581,111	\$368

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
FREMONT	3,232	269	\$1,684,677	\$521
GILFORD	6,929	577	\$3,532,558	\$510
GILMANTON	3,742	312	\$1,611,727	\$431
GILSUM	1,018	85	\$276,135	\$271
GOFFSTOWN	10,218	852	\$9,020,748	\$883
GORHAM	4,265	355	\$2,301,754	\$540
GOSHEN	1,281	107	\$774,189	\$604
GRAFTON	2,006	167	\$801,797	\$400
GRANTHAM	1,105	92	\$673,510	\$610
GREENFIELD	1,878	157	\$2,061,484	\$1,098
GREENLAND	1,874	156	\$1,039,643	\$555
GREENVILLE	3,215	268	\$1,145,940	\$356
GROTON	353	29	\$181,115	\$513
HALES LOCATION	12	1	*	*
HAMPSTEAD	4,628	386	\$2,970,092	\$642
HAMPTON	11,515	960	\$5,832,915	\$507
HAMPTON FALLS	1,182	99	\$537,156	\$454
HANCOCK	1,145	95	\$612,934	\$535
HANOVER	1,776	148	\$1,746,385	\$983
HARRISVILLE	587	49	\$303,821	\$518
HAVERHILL	8,821	735	\$6,176,229	\$700
HEBRON	1,022	85	\$211,389	\$207
HENNIKER	4,191	349	\$1,776,862	\$424
HILL	1,908	159	\$594,504	\$312
HILLSBOROUGH	10,823	902	\$4,685,910	\$433
HINSDALE	7,187	599	\$2,152,600	\$300
HOLDERNESS	1,987	166	\$912,980	\$459
HOLLIS	2,553	213	\$1,334,405	\$523
HOOKSETT	10,874	906	\$5,119,336	\$471
HOPKINTON	3,801	317	\$2,309,870	\$608
HUDSON	18,124	1,510	\$8,241,892	\$455
JACKSON	391	33	\$112,057	\$287
JAFFREY	8,687	724	\$4,196,158	\$483
JEFFERSON	1,300	108	\$460,227	\$354
KEENE	30,620	2,552	\$32,815,373	\$1,072
KENSINGTON	1,027	86	\$955,352	\$930
KINGSTON	4,828	402	\$2,606,417	\$540
LACONIA	43,021	3,585	\$27,824,733	\$647
LANCASTER	8,899	742	\$4,625,001	\$520
LANDAFF	545	45	\$251,156	\$461
LANGDON	794	66	\$312,387	\$393

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
LEBANON	14,499	1,208	\$8,325,533	\$574
LEE	2,836	236	\$1,640,249	\$578
LEMPSTER	2,063	172	\$948,140	\$460
LINCOLN	2,678	223	\$805,868	\$301
LISBON	3,656	305	\$1,661,589	\$454
LITCHFIELD	5,394	450	\$2,999,529	\$556
LITTLETON	15,075	1,256	\$8,947,641	\$594
LONDONDERRY	15,525	1,294	\$7,105,688	\$458
LOUDON	5,787	482	\$2,979,279	\$515
LYMAN	767	64	\$220,922	\$288
LYME	490	41	\$525,976	\$1,073
LYNDEBOROUGH	1,158	97	\$482,373	\$417
MADBURY	1,024	85	\$452,614	\$442
MADISON	3,023	252	\$977,830	\$323
MANCHESTER	253,232	21,103	\$130,556,368	\$516
MARLBOROUGH	2,796	233	\$958,893	\$343
MARLOW	1,020	85	\$492,152	\$483
MASON	514	43	\$60,807	\$118
MEREDITH	9,641	803	\$4,373,468	\$454
MERRIMACK	16,040	1,337	\$9,641,304	\$601
MIDDLETON	2,773	231	\$651,785	\$235
MILAN	1,845	154	\$896,346	\$486
MILFORD	17,287	1,441	\$7,784,221	\$450
MILTON	7,234	603	\$2,767,547	\$383
MONROE	852	71	\$309,885	\$364
MONT VERNON	1,183	99	\$815,591	\$689
MOULTONBOROUGH	3,986	332	\$1,428,158	\$358
NASHUA	139,558	11,630	\$75,137,712	\$538
NELSON	1,095	91	\$292,215	\$267
NEW BOSTON	3,703	309	\$2,858,997	\$772
NEW CASTLE	146	12	\$39,434	\$270
NEW DURHAM	3,053	254	\$1,039,086	\$340
NEW HAMPTON	3,106	259	\$1,393,283	\$449
NEW IPSWICH	7,876	656	\$2,084,916	\$265
NEW LONDON	1,962	164	\$1,242,548	\$633
NEWBURY	2,084	174	\$969,909	\$465
NEWFIELDS	652	54	\$494,369	\$758
NEWINGTON	422	35	\$308,035	\$730
NEWMARKET	9,316	776	\$3,612,195	\$388
NEWPORT	16,948	1,412	\$9,020,279	\$532
NEWTON	3,361	280	\$1,490,701	\$444

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
NORTH HAMPTON	3,022	252	\$1,963,628	\$650
NORTHFIELD	7,882	657	\$2,933,351	\$372
NORTHUMBERLAND	4,830	403	\$2,088,101	\$432
NORTHWOOD	4,968	414	\$2,306,209	\$464
NOTTINGHAM	3,750	313	\$1,830,295	\$488
ORANGE	167	14	\$34,157	\$205
ORFORD	2,440	203	\$3,731,657	\$1,529
OSSIPEE	11,380	948	\$4,878,166	\$429
PELHAM	6,799	567	\$2,948,360	\$434
PEMBROKE	9,237	770	\$4,547,332	\$492
PETERBOROUGH	8,398	700	\$4,996,156	\$595
PIERMONT	864	72	\$571,889	\$662
PITTSBURG	1,206	101	\$617,322	\$512
PITTSFIELD	9,899	825	\$3,969,183	\$401
PLAINFIELD	1,234	103	\$559,818	\$454
PLAISTOW	5,668	472	\$2,714,946	\$479
PLYMOUTH	8,807	734	\$4,667,781	\$530
PORTSMOUTH	24,517	2,043	\$24,133,286	\$984
RANDOLPH	257	21	\$165,622	\$644
RAYMOND	13,951	1,163	\$5,970,424	\$428
RICHMOND	1,933	161	\$1,117,737	\$578
RINDGE	7,032	586	\$1,858,200	\$264
ROCHESTER	69,077	5,756	\$31,722,519	\$459
ROLLINSFORD	2,977	248	\$1,326,020	\$445
ROXBURY	279	23	\$195,371	\$700
RUMNEY	3,845	320	\$1,671,791	\$435
RYE	2,551	213	\$1,665,692	\$653
SALEM	23,171	1,931	\$11,726,987	\$506
SALISBURY	1,864	155	\$529,691	\$284
SANBORNTON	3,595	300	\$1,373,983	\$382
SANDOWN	5,011	418	\$2,708,333	\$540
SANDWICH	1,141	95	\$211,972	\$186
SEABROOK	15,875	1,323	\$6,182,215	\$389
SHARON	341	28	\$213,561	\$626
SHELBURNE	337	28	\$166,963	\$495
SOMERSWORTH	29,996	2,500	\$12,249,528	\$408
SOUTH HAMPTON	258	22	\$227,995	\$884
SPRINGFIELD	1,263	105	\$492,817	\$390
STARK	1,065	89	\$453,262	\$426
STEWARTSTOWN	3,301	275	\$3,041,210	\$921
STODDARD	1,195	100	\$485,451	\$406

City/Town	Members Months	Average Enrollment	Expenditures	Per Member Per Month Payment
STRAFFORD	3,784	315	\$1,882,083	\$497
STRATFORD	3,668	306	\$1,523,049	\$415
STRATHAM	3,767	314	\$1,983,834	\$527
SUGAR HILL	319	27	\$128,338	\$402
SULLIVAN	916	76	\$218,944	\$239
SUNAPEE	3,232	269	\$1,681,512	\$520
SURRY	641	53	\$385,680	\$602
SUTTON	897	75	\$230,741	\$257
SWANZEY	12,196	1,016	\$5,342,835	\$438
TAMWORTH	4,246	354	\$1,631,769	\$384
TEMPLE	1,502	125	\$660,909	\$440
THORNTON	2,314	193	\$926,321	\$400
TILTON	9,838	820	\$5,309,673	\$540
TROY	5,247	437	\$1,699,251	\$324
TUFTONBORO	2,258	188	\$887,094	\$393
UNITY	1,298	108	\$2,246,658	\$1,731
WAKEFIELD	9,525	794	\$3,055,845	\$321
WALPOLE	4,295	358	\$1,684,973	\$392
WARNER	4,098	342	\$1,810,944	\$442
WARREN	2,716	226	\$8,437,450	\$3,107
WASHINGTON	1,789	149	\$473,939	\$265
WATERVILLE VALLEY	73	6	*	*
WEARE	10,189	849	\$4,094,028	\$402
WEBSTER	2,046	171	\$827,191	\$404
WENTWORTH	1,515	126	\$430,532	\$284
WENTWORTH'S LOCATION	8	1	*	*
WESTMORELAND	1,484	124	\$1,262,893	\$851
WHITEFIELD	7,573	631	\$14,358,303	\$1,896
WILMOT	899	75	\$406,194	\$452
WILTON	4,777	398	\$1,810,824	\$379
WINCHESTER	13,076	1,090	\$5,804,631	\$444
WINDHAM	5,532	461	\$4,376,941	\$791
WINDSOR	513	43	\$392,223	\$765
WOLFEBORO	8,628	719	\$4,310,290	\$500
WOODSTOCK	2,557	213	\$983,304	\$385
Out of State or Unknown	23,527	1,961	\$23,414,598	\$1,482
Total	1,746,999	145,583	\$1,012,543,187	\$580

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

Glossary

Beneficiary – See member.

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, coinsurance), 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.

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.

In and Out Medical Assistance – See Spend-Down.

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 or nursing facility but can be cared for at home and would not otherwise qualify for Medicaid if not institutionalized. Also known as Home Care for Children with Severe Disabilities.

Managed Care – A system of health care that manages and coordinates the delivery of services to promote cost-effective health care to enrollees through a contracted network of providers.

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 – The federal government health insurance program, created in 1965, that provides health care coverage for those 65 or older, and to those under 65 who receive Social Security Disability Insurance (SSDI) for 24 months, regardless of income. There are a range of cost sharing amounts for monthly premiums, deductibles, co-payments and coinsurance. Beneficiaries with limited income and resources can qualify for full or partial government subsidies to help cover these costs. See Dual Eligibles, Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary.

Medicare Part A (Hospital Insurance) – The part of Medicare that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care. Most people qualify to receive Part A by either paying Medicare taxes while they work or because they are disabled. Most beneficiaries don't have to pay a monthly premium, but there are a range of deductibles, co-payments and coinsurance, depending on the service received. Beneficiaries with limited income and resources qualify for government subsidies to help cover these costs.

Medicare Part B (Medical Insurance) – The part of Medicare that helps cover doctors' services and outpatient care, including preventive care, durable medical equipment (DME), laboratory tests, x-rays, mental health, some home health care, ambulance services, and medical supplies. Enrollment in Part B is voluntary. In addition to a monthly premium there are a range of deductibles, co-payments and coinsurance, depending on the service received. Beneficiaries with limited income and resources qualify for government subsidies to help cover these costs.

Medicare Part D (Prescription Drugs) – The part of Medicare (started in 2006) that helps cover prescription medications. Enrollment in Part D is voluntary for most people, but is mandatory for “dual eligible” recipients (qualify for both Medicare and Medicaid). There are a range of monthly premiums, deductibles, co-payments and coinsurance. Beneficiaries with limited income and resources (including all dual eligibles) qualify for government subsidies to help cover these costs.

Medicaid drug coverage for all dual eligibles was transferred to Medicare Part D in 2006. States are required

to make monthly “clawback” payments to Medicare, reflecting savings in Medicaid drug expenditures.

Member – 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.

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 by subtracting incurred medical expenses, the individual qualifies for Medicaid benefits for the remainder of the period. In NH, this is also referred to as “In and Out Medical Assistance.” See Medically Needy.

Children's Health Insurance Program (CHIP) – 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, CHIP 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 CHIP. States have the option of administering CHIP 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 methodologies 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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