



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

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

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

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# 1. Executive Summary

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Ensuring access to care for all New Hampshire Medicaid beneficiaries is a priority of the NH Department of Health and Human Services. The Department has created a comprehensive system of monitoring access for approximately 5% of Medicaid beneficiaries who continue to receive their benefits from the Fee for Service (FFS) delivery system. NH's system is a multi-stage process of routinely monitoring a variety of data (e.g. utilization, other payer rates) for potential access issues. Issues that are confirmed receive rigorous analysis for root causes and corrective action if warranted. While the system includes quarterly monitoring, this document is the second annual report which includes newly added results for 2016, as well as quarterly results from the first annual report covering January 2014 – December 2015, consistent with the Center for Medicare and Medicaid new rules governing FFS access monitoring.

At this time, the data do not indicate existing access problems. Provider to member ratios are favorable, consistent with the Medicaid managed care standards, and network analysis shows the majority of NH licensed practicing physicians are enrolled as NH FFS Medicaid providers.

The Department has undertaken a staged implementation of Medicaid managed care, from December 2013 through February 2016, resulting in significant changes and reductions in the FFS population. The majority of the current FFS population are beneficiaries who are briefly in the FFS program while awaiting transition into managed care. This “plan selection period” is less than 60 days. Only a small number of beneficiaries are not eligible to enroll in managed care and remain in FFS. Given these recent changes and a FFS population in transition, the Department is unable to provide an accurate baseline or develop reliable controls at this time. While monitoring will continue, the Department anticipates that several years will be needed to establish baseline data from a stable FFS population and to identify appropriate access standards.

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

## 2. Introduction

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The New Hampshire Department of Health and Human Service (the Department, DHHS) Medicaid-Fee for-Service Access Monitoring Plan is a matrixed collaboration between the Office of Medicaid Services (OMS), the Office of Quality Assurance and Improvement (OQAI), the Division of Client Services (DCS), and the Office of Finance (OOF). This report describes New Hampshire Medicaid’s healthcare access activities for beneficiaries receiving medical services from its fee-for-service (FFS) program. The report analyzes service data from January 2014 through December 2016 to report on the level of FFS provider availability and utilization of healthcare by Medicaid FFS beneficiaries over the three-year period. When available, more recent data is also used to describe the current Medicaid population and anticipated program changes impacting subsequent access monitoring.

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### Background

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

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

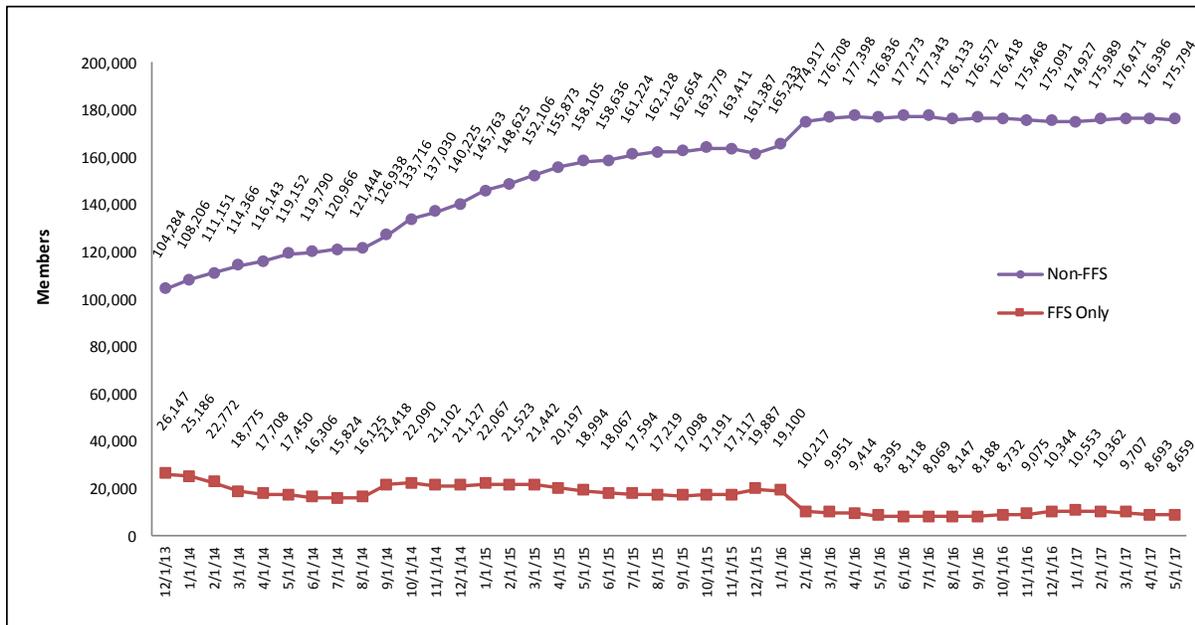
Medicaid services provided through Medicaid managed care plans include medical, pharmacy, and behavioral health services (i.e., mental health and substance misuse). As of May 2016, excluded services include dental care and long-term care services provided as part of the state’s 1915(b) waivers, specifically nursing facility services, services provided under the Choice for Independence (CFI) waiver, and services provided under the developmental disability (DD), acquired brain disorder (ABD), and in-home support (IHS) support waivers. Planning is underway to include these long-term care services in managed care in the near future. Currently, 4.7% of the Medicaid beneficiaries are covered by the FFS-only program (Figure 1), with the majority of beneficiaries in the “Plan Selection Period” prior to mandatory managed care enrollment (Figure 2).<sup>2</sup>

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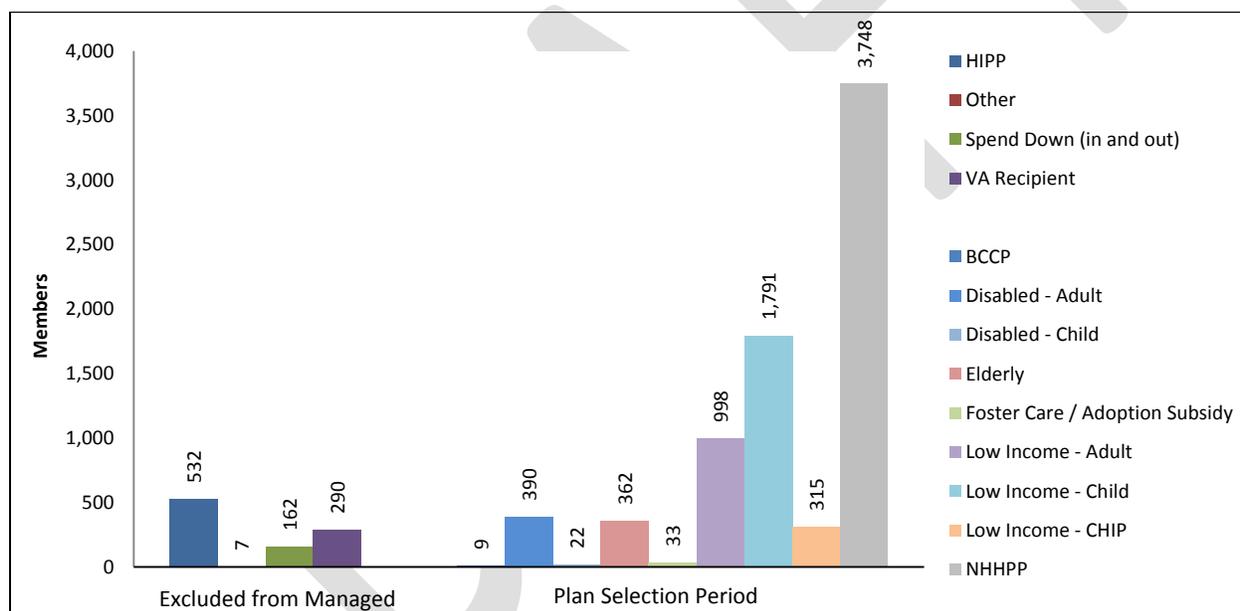
<sup>1</sup> New Hampshire Administrative rules He-W 506.05(c)

<sup>2</sup> Background data for all figures may be found in the Appendix.

**Figure 1. New Hampshire FFS Only and Non-FFS Enrollment, 12/1/2013 - 5/1/2017**



**Figure 2. New Hampshire Medicaid Members Not in Medicaid Managed Care Program and the Medicaid Expansion Premium Assistance Program-Plan Section Period, 5/1/2017**



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

## Medicaid Transition to Managed Care

The proportion of the NH Medicaid population covered through FFS-only has declined steadily since managed care commenced December 2013. Figure 1 displays how enrollment for the FFS population changed over time. Before December 2013, there were over 130,000 beneficiaries covered by FFS. Beginning in December 2013, the majority of the FFS population transitioned to Medicaid managed care program.

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

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

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## Medicaid Fee-For-Service Population

Figure 2 illustrates the distribution of eligibility status among the FFS-only population. New Hampshire beneficiaries receiving medical services through the FFS-only program are primarily comprised of members in a managed care plan selection period. The "Plan Selection Period" includes beneficiaries who, after becoming Medicaid eligible, have up to 60 days to choose a health plan; plan enrollment then begins the first of the following calendar month. The "Excluded from Managed Care" category refers to those FFS beneficiaries who are not eligible for any Medicaid managed care program; this group is also known as the "FFS-only" group. On May 1, 2017, there were a total of 8,659 FFS beneficiaries with more than 89% (7,668) of those being Plan Selection Period beneficiaries who will stay in the FFS population for less than 90 days. The remaining 11% (991) Excluded from Managed Care beneficiaries are primarily beneficiaries in the HIPP and those with Veterans Affairs benefits receiving medical services in that.

In providing an analysis of claims data for this Access to Care Monitoring report, New Hampshire has subdivided the FFS population into a "Voluntary for Managed Care" population for the period of time prior to February 1, 2016, before the 1915(b) waiver further reduced the FFS population by eliminating opting out of managed care. These members are currently being served by the managed care health plans however, during their tenure in FFS, it is possible that the Voluntary for Managed Care population utilized services differently than the remaining FFS population. For this reason, data analysis has been stratified by Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care beneficiaries in this report, as appropriate. Reporting for the Voluntary for Managed Care population may not continue after this 2017 Access report.

# PART 1 – ACCESS MONITORING PLAN

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### 3. Approach to Access Monitoring

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

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

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

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

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

The data and analysis set forth in this report establish the current access levels for these providers and focal areas through analysis of trends from January 2014 through December 2016. Because of the significant decrease in the FFS population related to implementation of the Medicaid managed care program, control limits utilized in past access evaluations are no longer applicable to the current study period and are not included.

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<sup>3</sup> 42 U.S.C. 1396a(a)(30)(A)

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

ed in this report. New Hampshire intends to establish and use new control limits to monitor trends as the FFS population stabilizes.

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

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## **Step 1 - Monitoring For Potential Access Issues**

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

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

### **Characteristics of the FFS Beneficiary Population**

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

### **Identification of FFS Beneficiary Needs**

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

### **Availability and Changes in Utilization of Health Services**

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

- Primary Care Providers,
- Physician specialists (e.g. Cardiology, urology, radiology),

- Behavioral Health services,
- Pre/post natal obstetric services including labor and delivery,
- Home health services, and
- Other services with identified access issues.

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

Control limits will be used as the primary tool to monitor access trends by providing a consistent indication of a potential access problem as each new quarter of data are available. Control limits are set statistically above and below the trend data to represent the boundaries of the trend. Fluctuation outside of controls limits will signal DHHS to investigate further. Because the FFS population decreased considerably after the implementation of Medicaid managed care program in December 2013 and then again with the implementation of the 1915b waiver on February 1, 2016, historical control limits are not applicable for this year's study. Control limits will be included in subsequent access plan reports, after the FFS population has stabilized and sufficient data have been collected to produce statistically sound control limits; the Department anticipates setting control limits no later than 2019. When control limits have been calculated and can be used, Office of Quality Assurance and Improvement will work with the Office of Medicaid Services to frame any needed analysis such that the Office of Medicaid Services can initiate any needed corrective action.

### **Provider Rate Review Including Review of Rates from Other Payers**

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

There are four steps to each rate review. First, the DHHS system data is queried to provide an annual volume of the service, any previously requested rate changes, and the execution date of any changed rates. Second, rates are collected from other New England Medicaid programs<sup>5</sup>, Medicare and commercial payers via New Hampshire's legislatively mandated All Payer Claims Database - the NH Comprehensive Healthcare Information System. All collected rates are charted to include the average, minimum, maximum and median price. Next, the NH volume of services is used to calculate the fiscal impact using 60% of the Medicare rate. Finally, recommendations and analysis are provided to the Department's Chief Financial Officer and Medicaid Director for final decision making and include:

- A recommended rate;
- A comparison of the rate to other regional payers;
- Analysis of the volume of NH Medicaid practitioners providing the service; and
- The NH DHHS budget impact.

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<sup>5</sup> New England Medicaid rates gathered from individual state websites.

For access monitoring, the rate history and final rate determination will be considered in any needed corrective action.

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## **Step 2 - Analyze Any Potential Concerns**

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

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

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## **Step 3 - Respond to Confirmed Access Issues**

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

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

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

If the Access Response Team determines that an access issue does exist, the Medicaid Director will write a summary report of the issue and include the summary in an update to the Access to Care Plan report, along with any recommendations for improved monitoring.

## 4. Community Engagement

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

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### Medical Care Advisory Committee

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

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

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

The New Hampshire MCAC does not exceed 23 members and is comprised of Medicaid beneficiaries, beneficiary/consumer advocacy groups, members of the general public concerned about health service delivery to Medicaid beneficiaries, healthcare professionals who serve Medicaid beneficiaries, and other knowledgeable individuals with experience in healthcare, rural health, Medicaid law and policy, healthcare financing, quality assurance, patient's rights, health planning, and those familiar with the healthcare needs of low-income population groups and the Medicaid population. The MCAC serves as a resource to engage stakeholders in the process of resolving identified access issues.

MCAC meetings are open to the public, and routinely, at least three representatives of the general public are in attendance. DHHS program staff members from all aspects of the New Hampshire Medicaid program are in attendance.

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## Provider Relations

The NH Medicaid Provider Relations Manager is responsible for:

- Communicating program updates to all enrolled providers and their professional associations;
- Identifying and resolving claims issues with the MMIS;
- Developing/conducting provider trainings on NH Medicaid enrollment and new program and policy initiatives;
- Working with managed care organizations to resolve provider issues; and
- Managing special projects related to enrollment and revalidation.

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

The Provider Relations Manager is in charge of Revalidation's provider training and information sessions, which began in June, 2017. Trainings are conducted via the same methods mentioned above. Numerous written communications were delivered via e-mail blasts and were posted on the website to keep providers informed of the Revalidation process and its requirements. In addition, outreach to professional organizations began in the winter, 2017.

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

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## Other Stakeholder Involvement

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

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

On June 6, 2016, the Governor signed into law SB 553 instructing the Department of Health and Human Services to develop an implementation plan for the remaining unimplemented phases of the Medicaid managed care program primarily consisting of LTSS.

The Department as directed convened a stakeholder group consisting, at a minimum, of representatives of the following stakeholders: each managed care plan under contract with the state, the New Hampshire Association of Counties, the New Hampshire Health Care Association, Community Support Network, Inc., Granite State Independent Living, the Brain Injury Association of New Hampshire, Granite State Home Health Association, a member of the house of representatives appointed by the speaker of the house of representatives, a member of the senate appointed by the senate president, an independent case management organization industry representative, a member of the governor's commission on managed care designated by the commission, and a member of the medical care advisory committee designated by the committee.

The working group has been charged and is currently providing consultation to the Department in developing the plan for implementation of LTSS services. Following the creation of the group the Department's SFY 2018 and 2019 budget included legislation that the first of LTSS could not be implemented prior to July 1, 2019.

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## **Customer Services for Medicaid Beneficiaries**

The New Hampshire Office of Medicaid Services works collaboratively with the Division of Client Services to provide assistance to Medicaid beneficiaries. Client Services engages with beneficiaries on a daily basis to determine and assist with beneficiary needs whether in person, on-line or telephonically. The Division's Customer Service Center, a single point of entry for calls, is also used as a real-time surveillance tool to monitor potential trends and problems as phone calls from beneficiaries alert staff to access. The Division of Client Services manages beneficiaries' eligibility, grievances, requests for information, explanation of services available, and questions concerning provider access and availability. As a result, Customer Services is on the forefront of New Hampshire Medicaid's efforts to understand and respond to beneficiaries' needs.

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

New Hampshire's managed care organizations and marketplace Qualified Health Plans work closely with New Hampshire Medicaid and the Division of Client Services to assure client and provider requirements and service expectations are met.

# PART 2 – 2016 ACCESS ASSESSMENT

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# 5. Data and Analysis

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

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

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

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

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## Methodology

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

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

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

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

Historically, New Hampshire Medicaid compiled eligibility and administrative claims data for four years (16 quarters) of FFS paid claims reflecting services used by Medicaid FFS beneficiaries to set monitoring standards. However, for this report, three years of results without historical monitoring standards were presented

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

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

## Data Sources

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

## Population Included in Trend Data

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

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

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

## Service Date Periods and Claims Run-out

All utilization reports are based on last date of service for calendar year quarters. In order to provide a consistent basis for comparing reports over time, it was necessary to also provide consistent claims run-out for each quarter. Quarterly measures are based on six months of claims run-out (e.g., where the service period being reported covers July - September 2015, the report will include all claims paid through March 31, 2016).

## Geographic Grouping

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

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

### **Age and Eligibility Grouping**

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

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

### **Medicaid Managed Care Enrollment Status Grouping**

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

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

### **Control Limits**

For study periods before December 2013, control limits were used in New Hampshire's previous six published access reports as the primary tool to monitor access. However, since the FFS population decreased considerably after the Medicaid managed care program transition in December 2013, control limits are not available for this year's study. Control limits based on historical trends will be included in subsequent access evaluations, after the FFS population stabilizes and sufficient data are collected to produce statistically sound control limits. When instated, control limits will be employed in quarterly trend charts to provide a consistent indication of a potential access problem as each new quarter of data are available. Control limits will be set as three standard deviations (following conventional practice<sup>6</sup>) from the mean based on historical data. The final control limits will be determined when there are three- four years (12-16 quarters) of results from a relatively stable FFS population.

### **Small Numbers**

Because New Hampshire is a small state, it is necessary to take into account the volume of data available for reporting. For some combinations of age and eligibility, the volume of data is too small to allow for meaningful reporting. Rates based on smaller numbers are more volatile due to random variation. Please refer to Appendix B of this report for quarters with numerators or denominators less than 30.

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

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## New Hampshire Medicaid FFS Beneficiaries

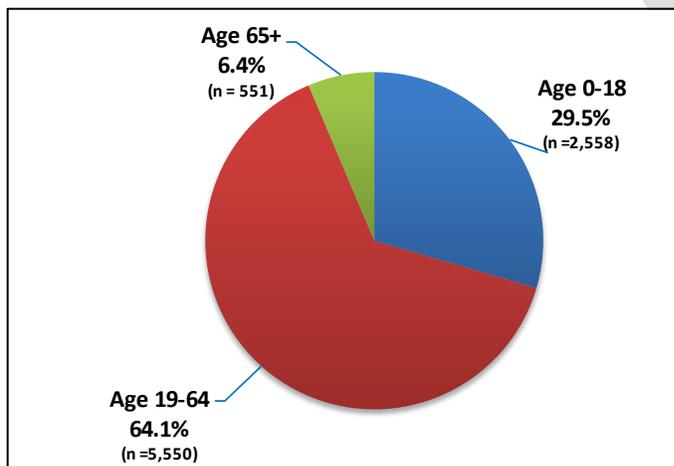
### Overview of New Hampshire Medicaid FFS Beneficiaries

Figures 3 and 4 are based on the entire Medicaid FFS beneficiary population and show the distribution of beneficiaries by age, eligibility group, and gender as of May 1, 2017.

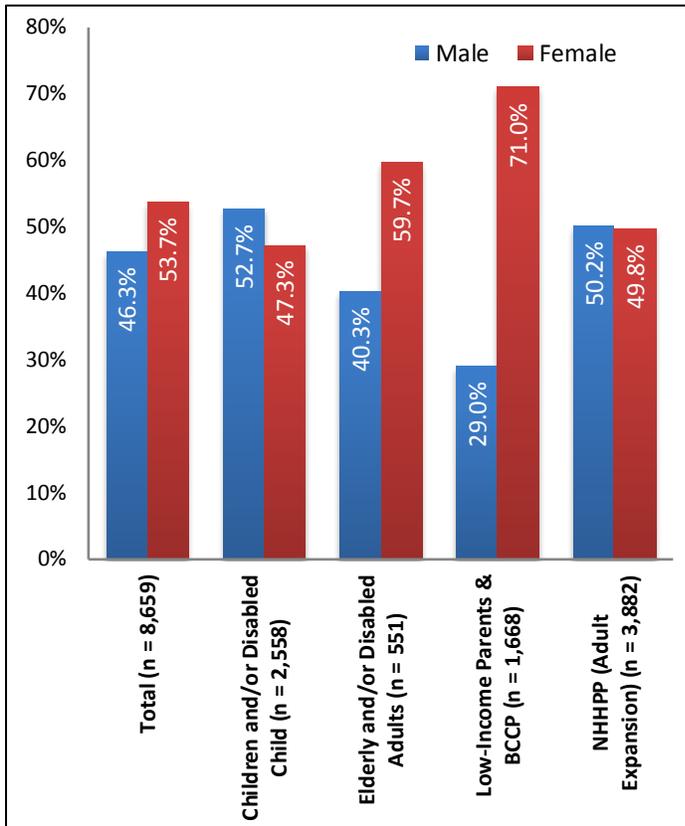
Children (members 18 years or less) make up 29.5% of the New Hampshire Medicaid FFS population. As shown below, beneficiaries age 19 to 64 represent 64.1% of beneficiaries and the remaining 6.4% are members aged 65 plus.

Females account for over half (53.7%) of FFS Medicaid beneficiaries. Gender differences are observed in three eligibility categories with females predominating the low-income parent & BCCP category (71.0%, due to pregnant women eligibility category and greater likelihood of heading single parent low-income households) and the elderly and/or disabled adults category (59.7%, due to longer lifespan and likelihood of having fewer resources than males). The only group in which males make up a notable larger proportion of beneficiaries is the children and/or disabled child category.

**Figure 3. NH Medicaid FFS Beneficiaries by Age Categories, May 1, 2017**



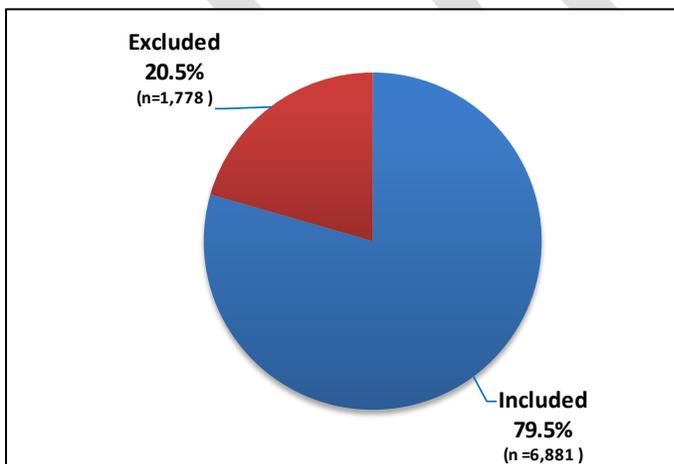
**Figure 4. NH Medicaid FFS Beneficiaries by Gender and Eligibility Category, May 1, 2017**



### Population Subject to Access Monitoring

Figure 5 demonstrates that 20.5% of the beneficiaries were excluded as of May 1, 2017 due to Medicare and/or other medical insurance. All subsequent figures on utilization trends, exclude Medicare dual eligibles, and those beneficiaries known to have other medical insurance. These beneficiaries are excluded because the focus of this report is access to medical and behavioral health care for beneficiaries with Medicaid as their primary source of health insurance, and not for services paid for by other payers.

**Figure 5. NH Medicaid FFS Beneficiaries Subject to Access Monitoring Plan, May 1, 2017**



## New Hampshire Medicaid FFS Beneficiary Enrollment Trends

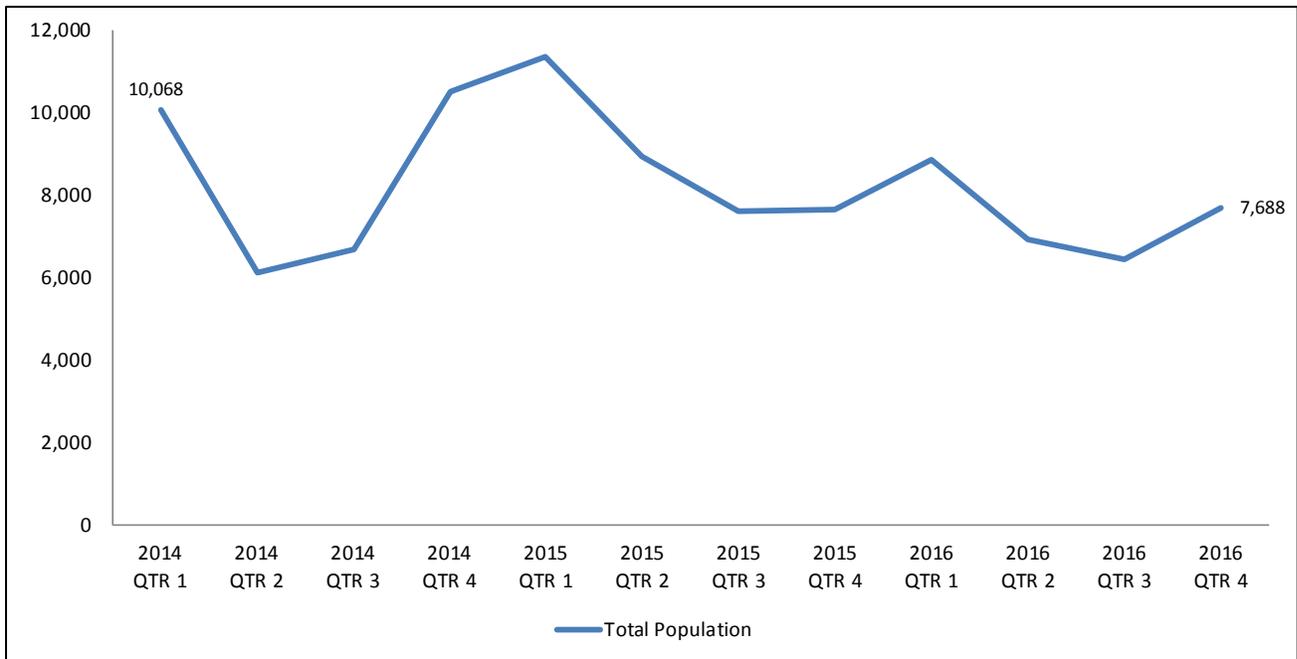
This section reviews trends in average monthly enrollment by quarter of New Hampshire FFS Medicaid beneficiaries. The data in the figures are presented by quarter. Utilization trends are tracked for these beneficiaries.

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

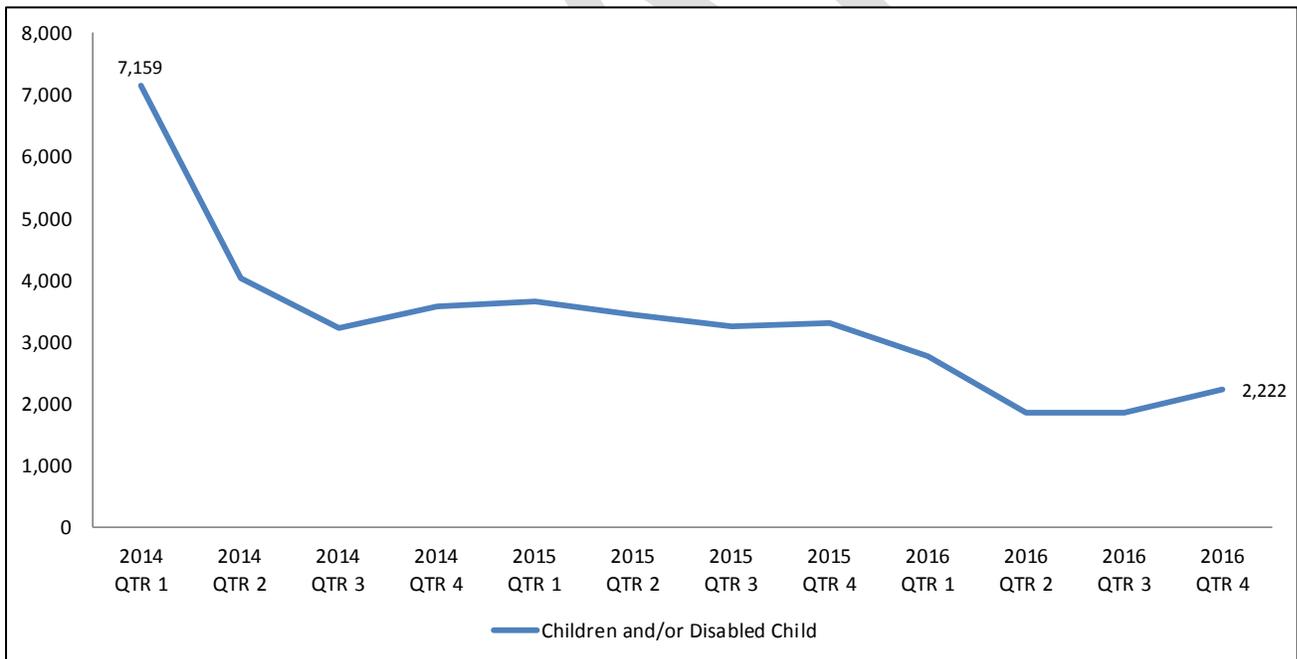
Figures for enrollment trends indicate that the FFS population continued to change between 2014 and 2016 due to the following:

- Decreases from the children and/or disabled child and low-income parents & breast and cervical cancer program (BCCP) eligibility groups between Quarter 1 of 2014 and Quarter 3 of 2014 contributed to the decrease for the overall FFS population from Quarter 1 of 2014 to Quarter 2 of 2014.
- NHHPP beginning in Quarter 3 of 2014 which impacts the trend in Plan Selection Period population as enrollment increased, leading to an increase in FFS population transitioning to Medicaid managed care program and an increase in Excluded from Managed Care population due to efforts to increase use of the Health Insurance Premium Payment (HIPP) program as required by the state statute that implemented the NHHPP. In addition, the up (Quarter 3 to Quarter 4) and down trend (Quarter 4 to Quarter 1) for NHHPP is because there is an end of year period where members in plan selection are held in FFS until the first of the next year.
- Increases in Medicaid managed care program population in Quarter 4 of 2015 due to the previously Voluntary for Managed Care children and/or disabled children moving to the Medicaid managed care program in advance of the group being mandatorily enrolled for managed care, February 1, 2016.
- There were no beneficiaries in the Voluntary for Managed Care category in 2016. Beneficiaries leaving the Voluntary for Managed Care category in Quarter 4 of 2015 contributed to the increase from Quarter 4 of 2015 to Quarter 1 of 2016 for the Plan Selection Period category.

**Figure 6. NH Medicaid FFS Enrollment, CY 2014-2016, Average Members in Quarter: Total Population**  
*Note: excludes Medicare dual eligibles and members with other medical insurance*

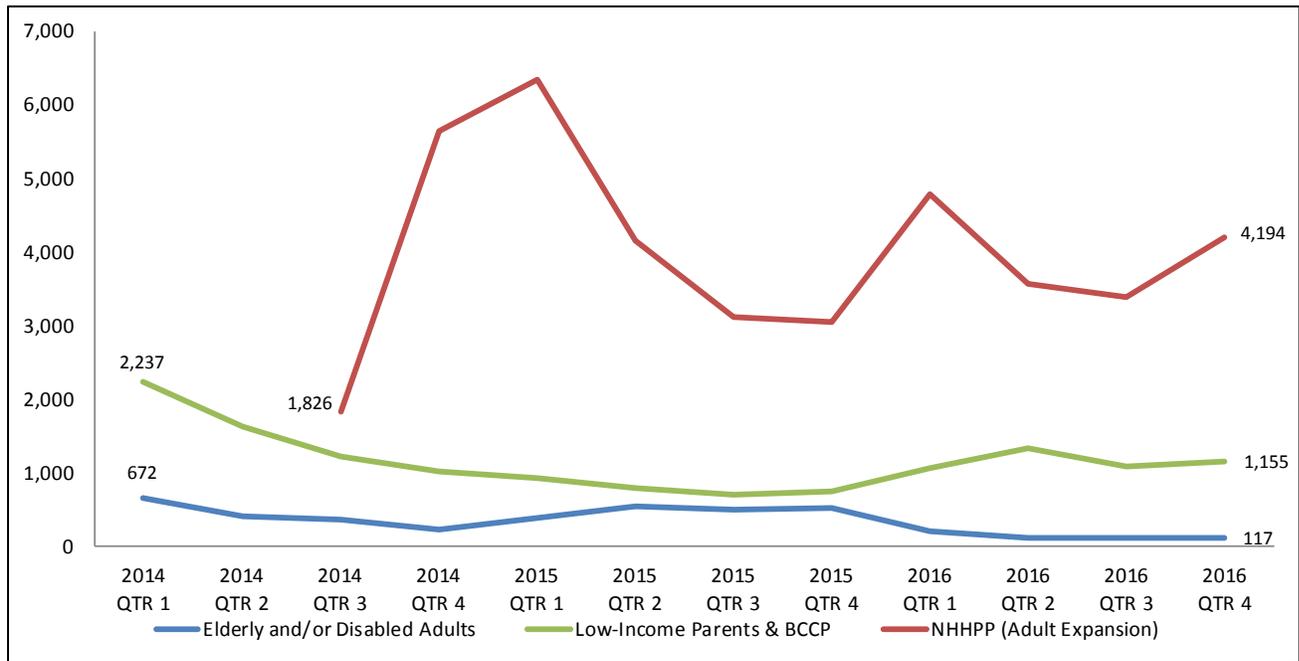


**Figure 7. NH Medicaid FFS Enrollment, CY 2014-2016, Average Members in Quarter: Children and/or Disabled Child**  
*Note: excludes Medicare dual eligibles and members with other medical insurance*



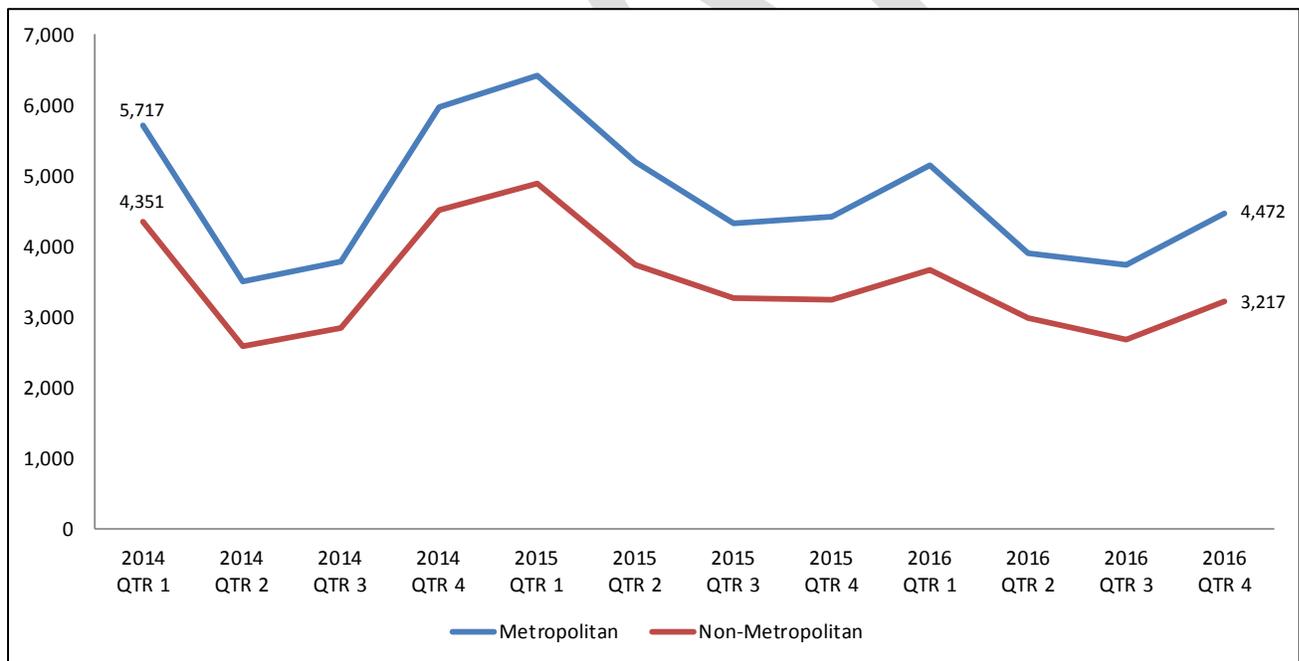
**Figure 8. NH Medicaid FFS Enrollment, CY 2014-2016, Average Members in Quarter: Adults by Eligibility Group**

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

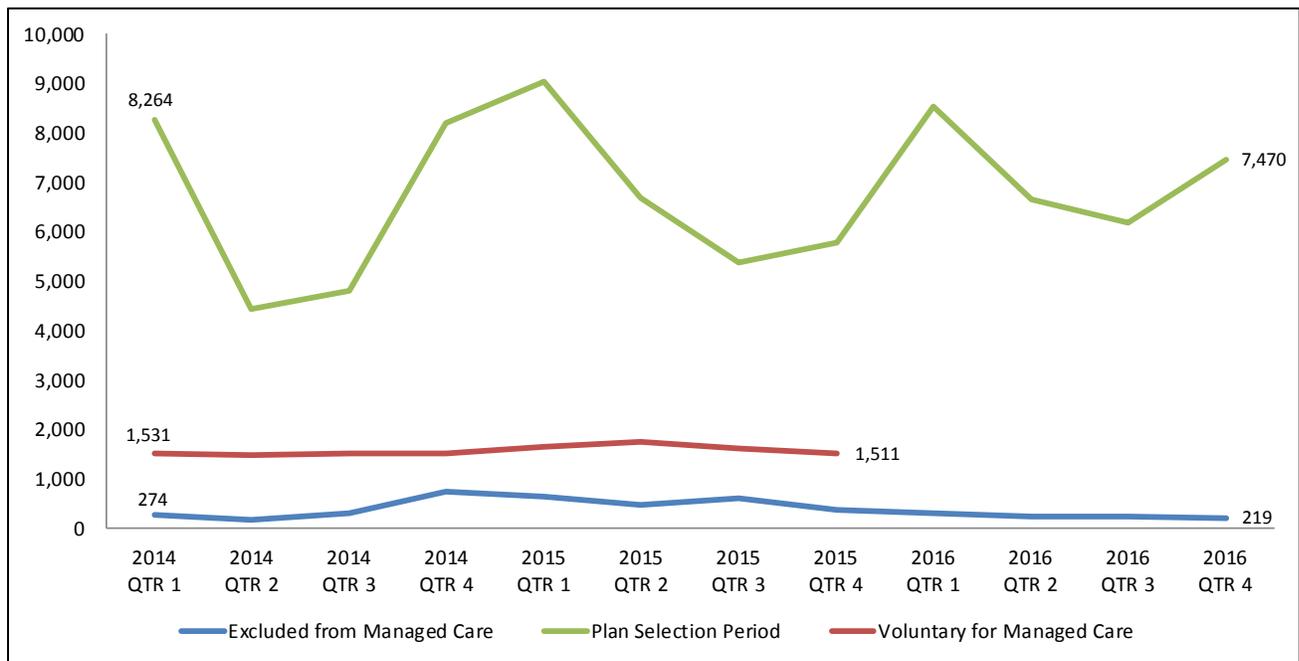


**Figure 9. NH Medicaid FFS Enrollment, CY 2014-2016, Average Members in Quarter: Metropolitan and Non-Metropolitan Counties**

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



**Figure 10. NH Medicaid FFS Enrollment, CY 2014-2016, Average Members in Quarter:**  
**Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**  
*Note: excludes Medicare dual eligibles and members with other medical insurance*



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016. The increase from Quarter 4 of 2015 to Quarter 1 of 2016 for the Plan Selection Period category was partially due to the added beneficiaries from the Voluntary for Managed Care category.

## FFS Provider Availability

The provider availability analysis focuses on whether healthcare services are accessible to Medicaid beneficiaries. Measures are included on provider participation in the New Hampshire Medicaid FFS Program, percent of active providers from all enrolled FFS providers for Quarter 4 of 2016, time/distance analysis for primary care providers, and ratios of beneficiaries to active providers.

### Physician and Hospital Participation

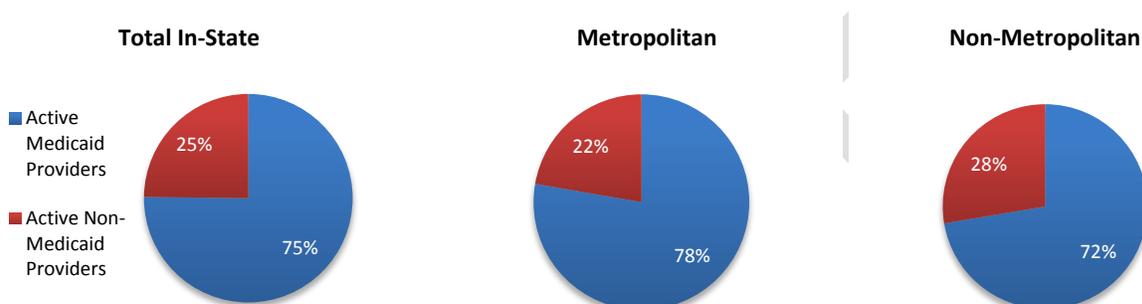
All of New Hampshire’s 26 acute care hospitals as well as two of three specialty hospitals actively provide services to FFS beneficiaries. In contrast to many states, New Hampshire’s Medicaid beneficiaries share the same delivery system as the general population, and the distribution of Medicaid patient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

Figure 11 provides information on the most recently available data on enrollment by active licensed providers. As can be seen in Figure 11, the majority (75%) of licensed practicing physicians are also active (at least one claim in 2016) New Hampshire Medicaid FFS providers.<sup>7</sup> The same is true for both the metropolitan (78%) and non-metropolitan counties (72%). The decrease in the percentage of active Medicaid providers

<sup>7</sup> NH Board of Medicine

from 90% in 2013 to 75% in 2016 is attributed to the decrease in the FFS population after the transition to the Medicaid managed care program in December 2013. Since there are far fewer FFS enrollees in 2016, there is much lower utilization of services, and thus fewer active providers servicing FFS population. In order to ensure providers stayed enrolled with FFS after the transition to managed care New Hampshire included provisions in its contracts that required all providers enrolled with MCOs to also be enrolled in FFS. When comparing results between 2015 and 2016, the percentage of active Medicaid providers remains the same at the statewide level and differs by 2 percentage points for both metropolitan and non-metropolitan counties.

**Figure 11. Active NH Medicaid In-State FFS Physician Providers Compared to Licensed Providers With NH Billing Address, 2016**



Ratios of New Hampshire Medicaid FFS beneficiaries to active providers are very high, which also explains why most individual practitioners have small numbers of Medicaid FFS patients in their panel (as compared to more populous or urban states). For example, New Hampshire has a population of 1.3 million<sup>8</sup> people, and a total of 4,192 licensed practicing physicians for a ratio of 318 people per licensed physician, while there are 7,688 Medicaid FFS beneficiaries (average FFS beneficiaries as of Quarter 4 of 2016 from Figure 6) and a total of 3,152 active (billing within 2016) physicians for a ratio of 2.4 people per physician for the New Hampshire Medicaid FFS population.

### Percent of Active FFS Providers

For the FFS providers enrolled in the New Hampshire Medicaid FFS program, the following table displays the percentage of active providers for Quarter 4 of 2016. Since the current FFS provider network remains similar to the network before the Medicaid managed care program implementation, and the FFS population had a large decrease related to managed care implementation, the percentages of active providers vary from 32.1 percent (Home Health) to 59.1 percent (Cardiology). This indicates that one-third to one-half of the FFS providers provided services to the FFS population (i.e., submit at least one claim in Quarter 4 of 2016) for the provider types listed in the table below.

Provider Type	Total FFS Providers	Active FFS Providers	Percent
Cardiology	154	91	59.1%
Home Health	84	27	32.1%
Obstetricians/Gynecologists <sup>9</sup>	3,405	1,451	42.6%

<sup>8</sup> Data Source: <https://www.census.gov/quickfacts/fact/table/NH,US/PST045216>, accessed on July 19, 2017.

<sup>9</sup> Includes some primary care providers since they may provide some services offered by obstetricians/gynecologists.

Provider Type	Total FFS Providers	Active FFS Providers	Percent
Pediatricians	428	227	53.0%
Primary Care Providers	3,675	1,579	43.0%
Radiology	257	135	52.5%
Surgery	752	258	34.3%

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

The contract with New Hampshire managed care organizations (MCOs) specifies time and distance standards for Medicaid beneficiaries to have access to specific provider types. These standards were applied to FFS beneficiaries as of May 1, 2017 to monitor time and distance to Primary Care Providers, Pediatricians, and Maternity providers. The table below shows that all corresponding FFS beneficiaries met these standards as of May 1, 2017.

Provider Time and Distance Standard	Criteria for Beneficiaries	Standard Met / Not Met
Primary Care Providers – <i>Two (2) within forty (40) minutes or fifteen (15) miles</i>	All FFS beneficiaries as of May 1, 2017	Met
Pediatricians <i>Two (2) within forty (40) minutes or fifteen (15) miles</i>	FFS beneficiaries 18 years of age or younger as of May 1, 2017	Met
Obstetricians/Gynecologists <i>One (1) within sixty (60) minutes or forty-five (45) miles</i>	Female beneficiaries 13 years of age or older as of May 1, 2017	Met

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

Figures 12 through 14 demonstrate the trends in FFS beneficiaries to active providers (those with one claim in the quarter) or FFS health service deliveries to delivery providers. One figure each is presented for Primary Care Providers, Pediatricians, and Maternity. For each figure, there are three trend lines: one representing the statewide data, one for metropolitan area data, and another for non-metropolitan area data. Appropriate control limits will be developed as the FFS population stabilizes and more data points become available in future reports.

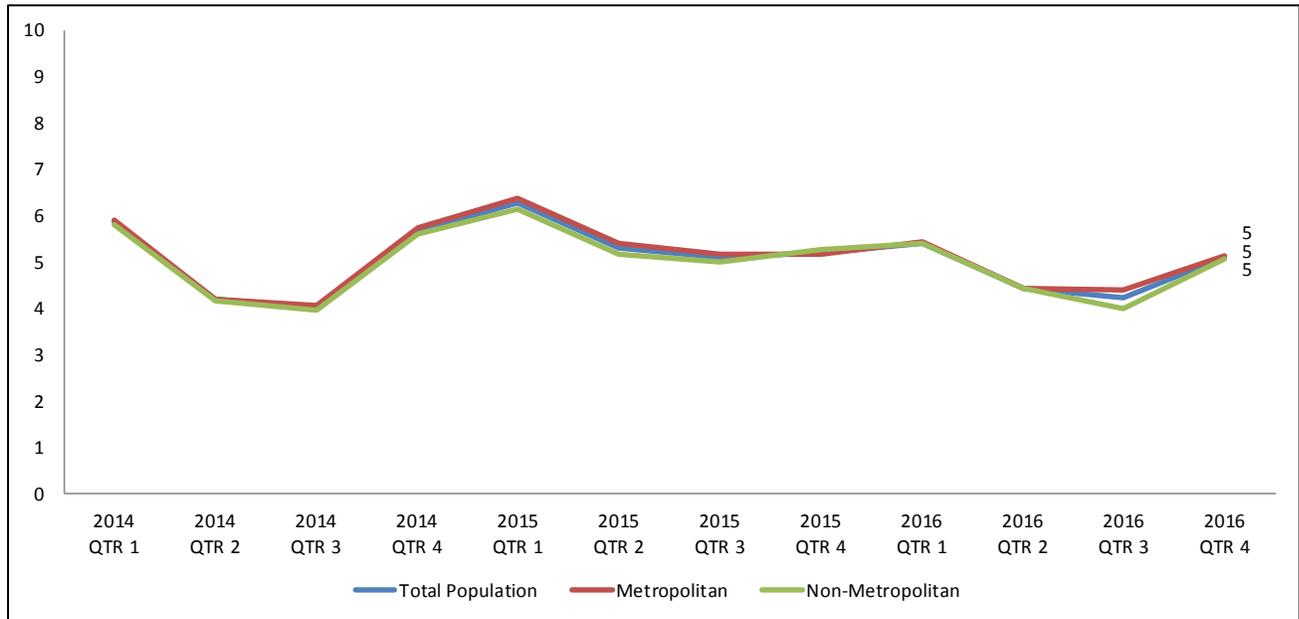
The deliveries-to-delivery provider ratio chart (Figure 14) compares active providers to deliveries, as opposed to the general female population-to-providers, which accounts for changes in fertility rates in the population.

#### Results

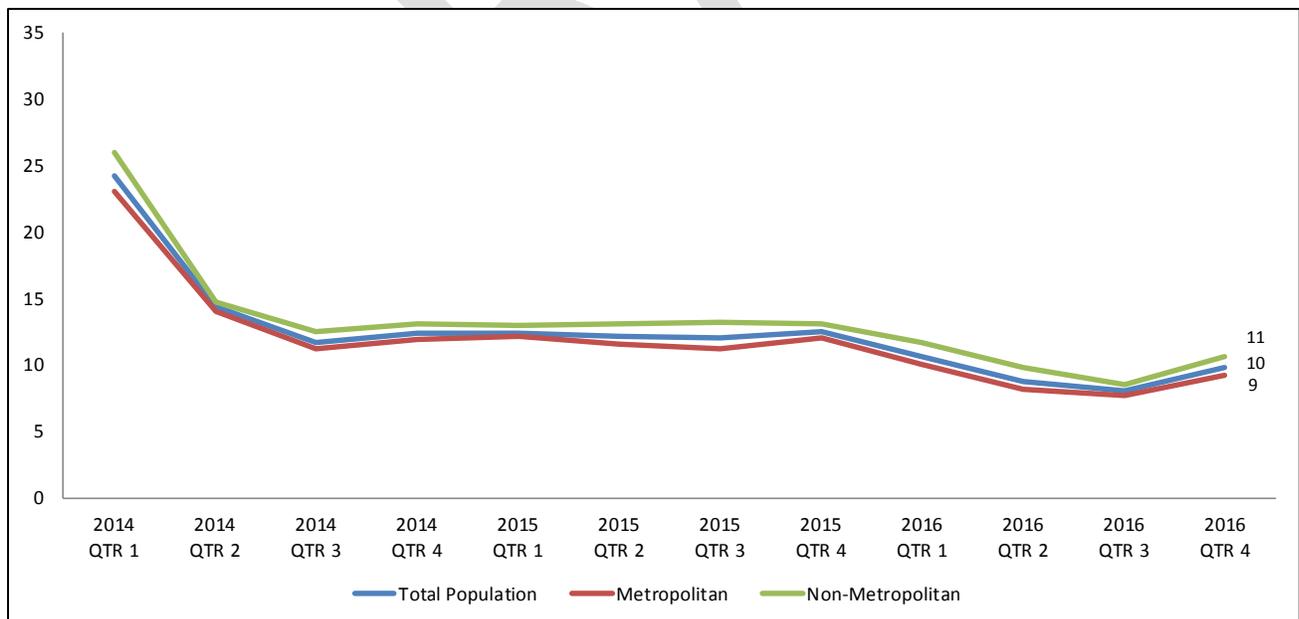
- The beneficiaries to active primary care providers and pediatricians ratios, as well as, deliveries-to-delivery provider ratios from CY 2014 to 2016 were much lower than the historical trends found in prior reports. This is due to the FFS population reduction of less than 10% (i.e., as of December 2016) of its size before the Medicaid managed care program transition while the number of active providers did not have a large change over the same time period (e.g., the percentage of active providers in the previous section shows that one-third to one-half of the FFS providers were still active in Quarter 4 of 2016).

- The trends for the beneficiaries to active primary care providers and pediatricians ratios were similar to the corresponding beneficiary enrollment trends (e.g., the drop, an improvement, in the first two quarters of Figure 13 was due to a drop in the number of FFS children and not due to a change in active provider numbers). Additionally, while there are sudden changes in 2014 for Figure 12 and Figure 13, the fluctuations in 2016 appear to be smaller.

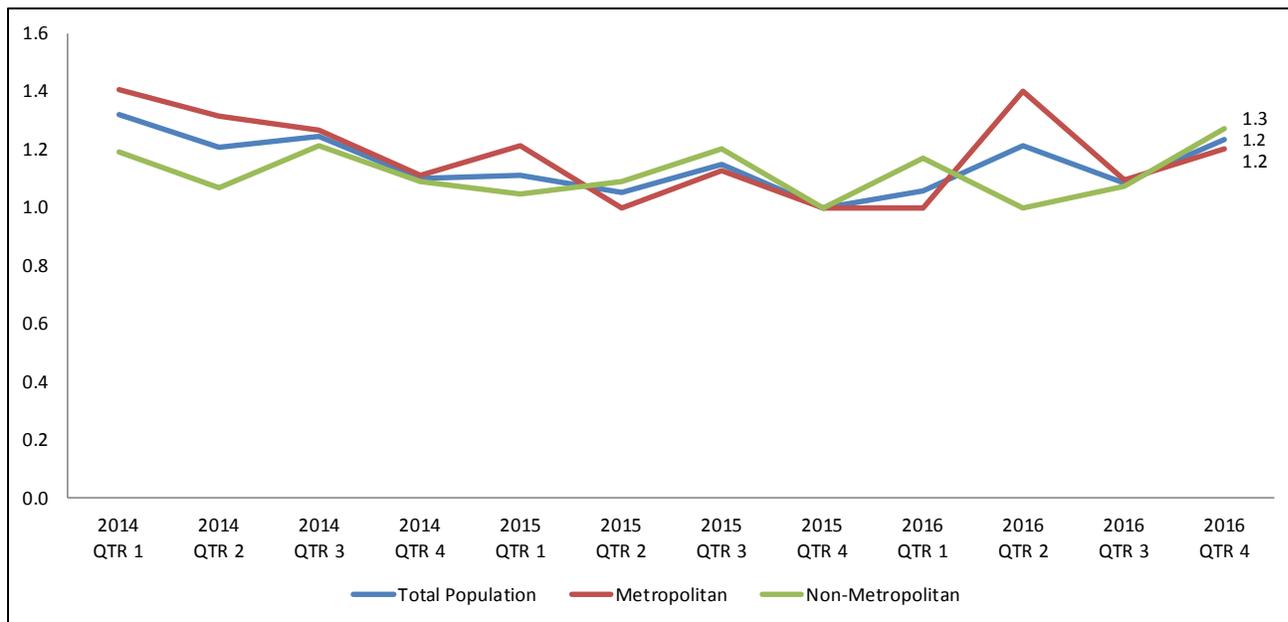
**Figure 12. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians), CY 2014-2016**



**Figure 13. Ratio of NH Medicaid FFS Child Beneficiaries to Active In-State Pediatricians, CY 2014-2016**



**Figure 14. Ratio of FFS Deliveries to Active Delivery FFS Providers, CY 2014-2016**



Note: The number of active delivery providers was less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 active delivery providers). Please use caution when interpreting results.

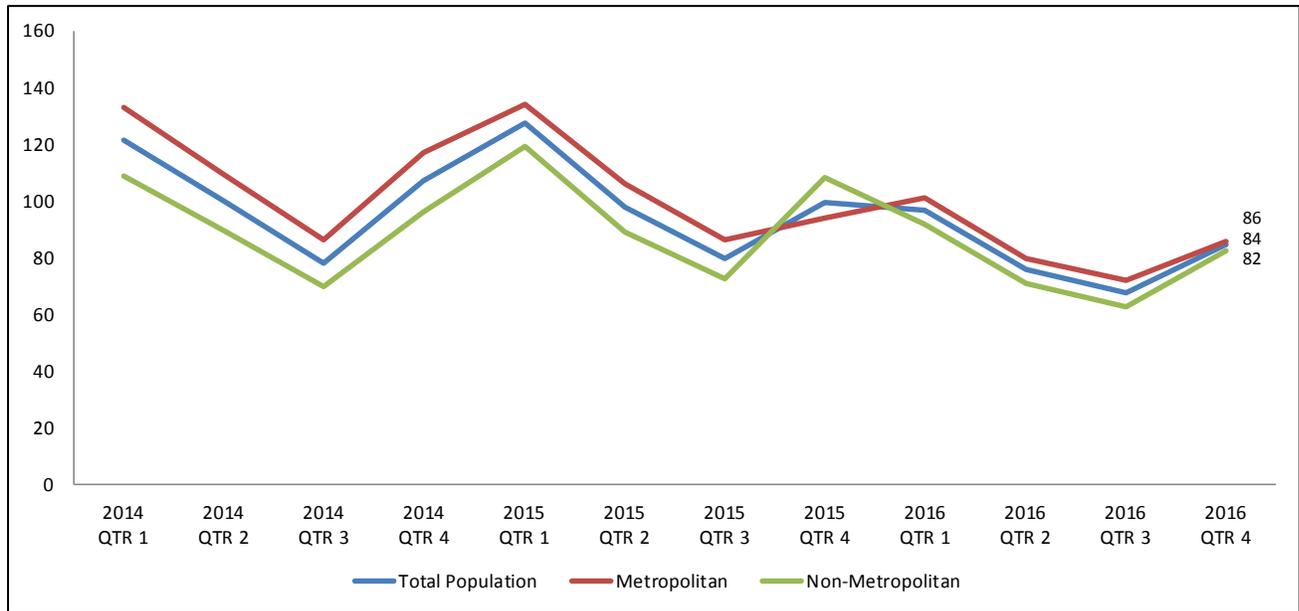
### Active FFS Cardiology, Radiology, Surgery, and Home Health Providers Ratios

Figures 15 through 18 demonstrate the trends in the ratio of FFS beneficiaries to active cardiology, radiology, surgery, and home health providers (those with one claim in the quarter). For each figure, the statewide trend is presented together with the trends by metropolitan and non-metropolitan areas. Appropriate control limits will be developed as the FFS population stabilizes and more data points become available in future reports.

#### Results

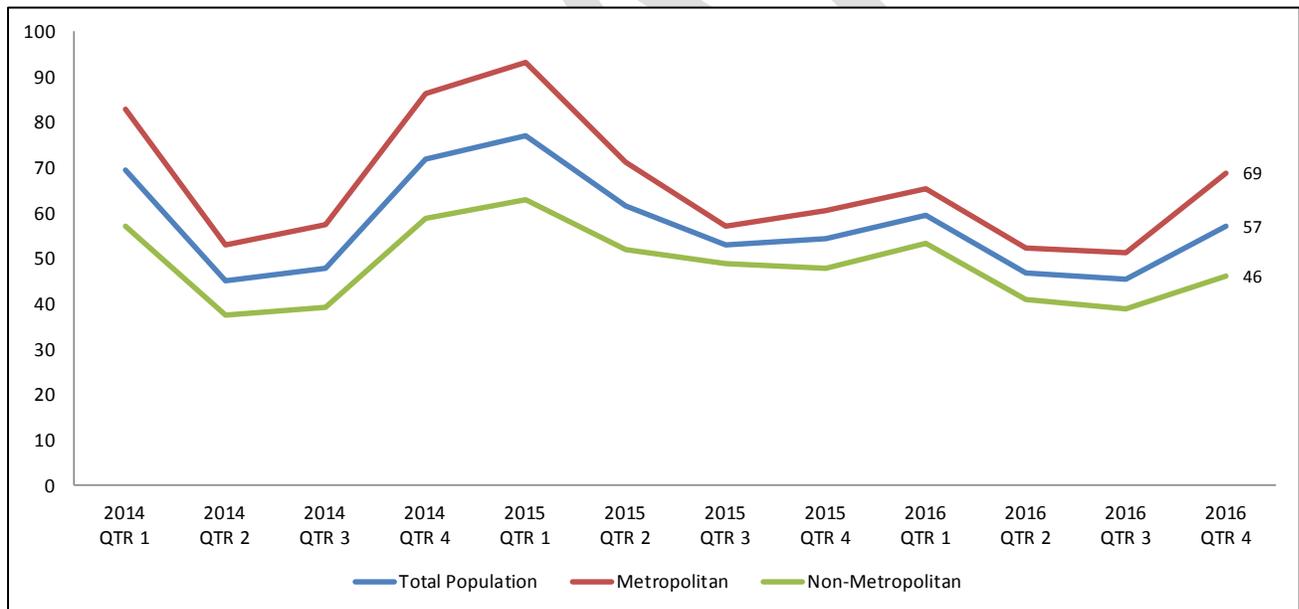
- The statewide ratios for the four different provider types varied from approximately 30 FFS beneficiaries per one active surgery provider to approximately 300 FFS beneficiaries per one home health provider.
- For all provider types, the upward and then downward trend over time for the statewide, metropolitan, and non-metropolitan areas were all similar to the enrollment trend, i.e., the ratios are being driven by changes in enrollment, not changes in active providers.
- Different sets of control limits may be set up for the statewide, metropolitan, and non-metropolitan areas for each of the three provider types.
- For home health providers, the total number of active providers was less than 30 for some quarters. Therefore, exercise caution when reviewing results for Figure 18.
- While the ratios in the metropolitan area were generally higher than those in the non-metropolitan area for cardiology, radiology and surgery providers, the ratios in the metropolitan area were generally lower than those in the non-metropolitan area for home health providers.

**Figure 15. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Cardiology Providers, CY 2014-2016**

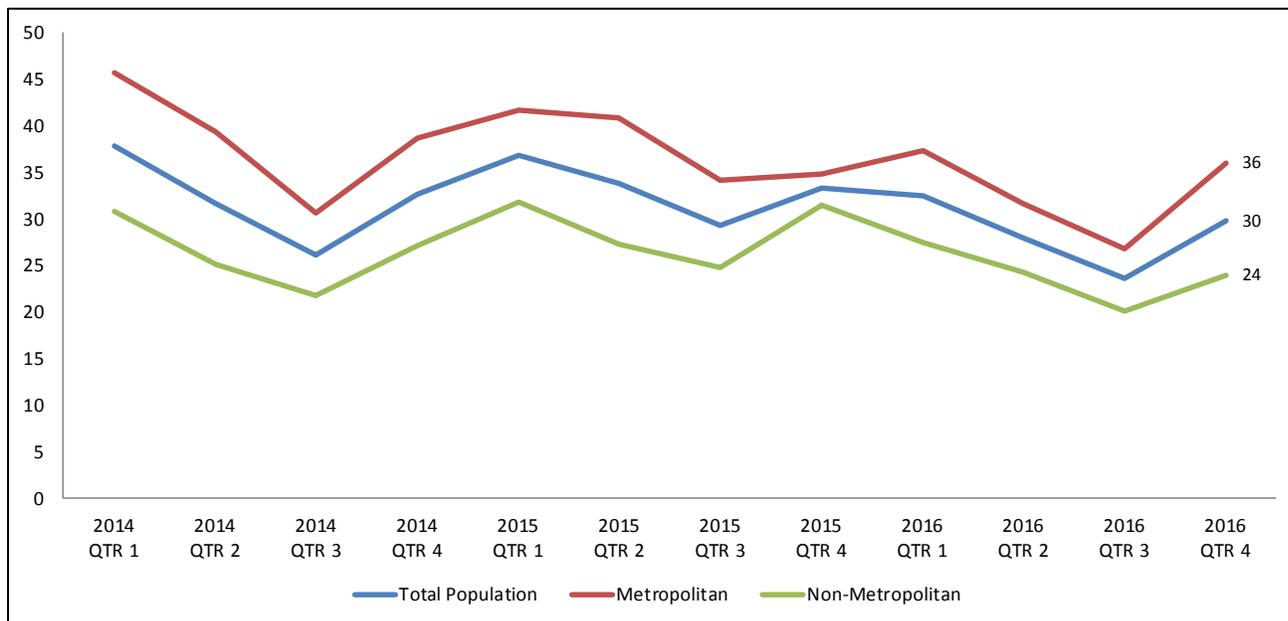


Note: The number of active cardiology providers in non-metropolitan area was less than 30 for Quarter 2 of 2014. Please use caution when interpreting results.

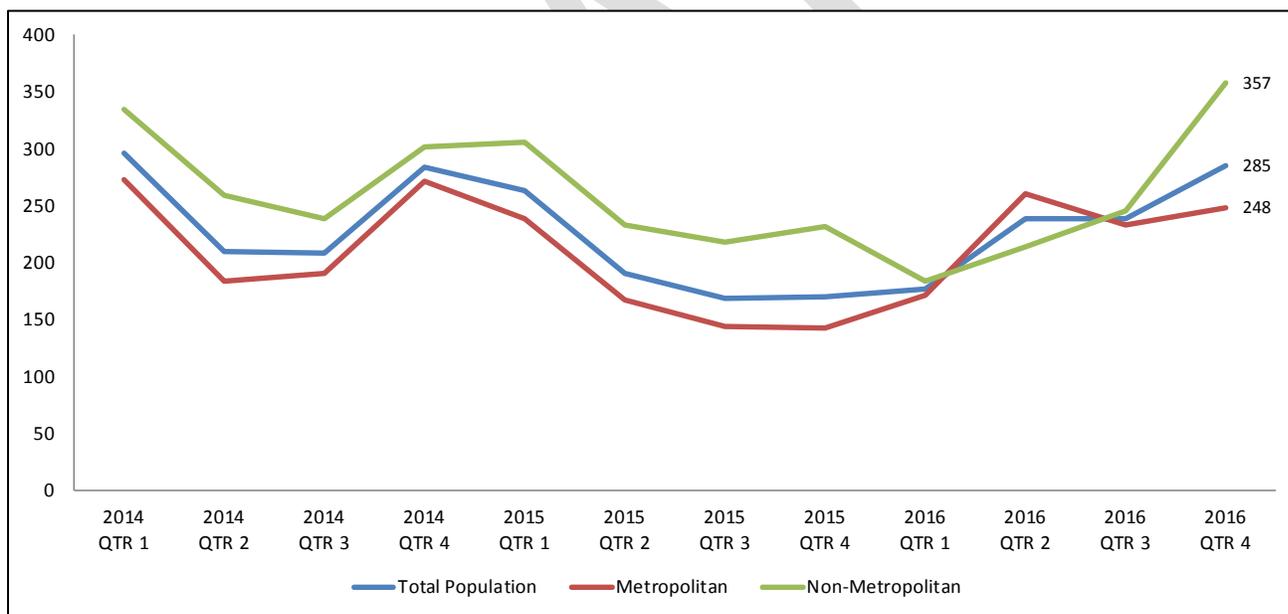
**Figure 16. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Radiology Providers, CY 2014-2016**



**Figure 17. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Surgery Providers, CY 2014-2016**



**Figure 18. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Home Health Providers, CY 2014-2016**



Note: The number of active home health providers was less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 active home health providers). Please use caution when interpreting results.

## Utilization of Services

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

Figures in this section show the utilization trends in quarterly use of key physician and hospital services by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data<sup>10</sup>. Rates are the number of FFS visits in the quarter divided by the number of FFS beneficiary months for the quarter times 1,000. The data in the figures are presented by quarter and are broken down by age and eligibility groupings, and also broken down by metropolitan and non-metropolitan areas of the State (to take a special look at areas with a potentially greater sensitivity to access problems).

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

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

Measures presented in this section are:

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

### **Physician/APRN/Clinic Utilization**

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

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

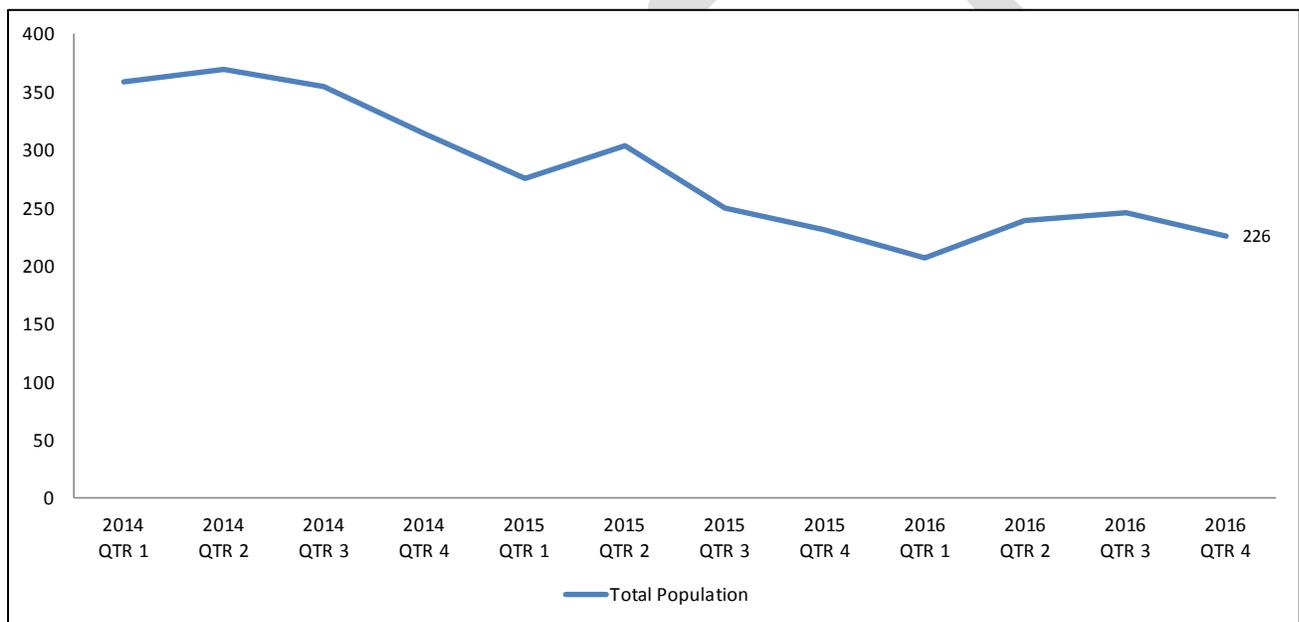
#### **Results**

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<sup>10</sup>Excluding Medicare dual eligibles, and those beneficiaries known to have other medical insurance, as their physician care is nearly always paid for by third parties, not NH Medicaid.

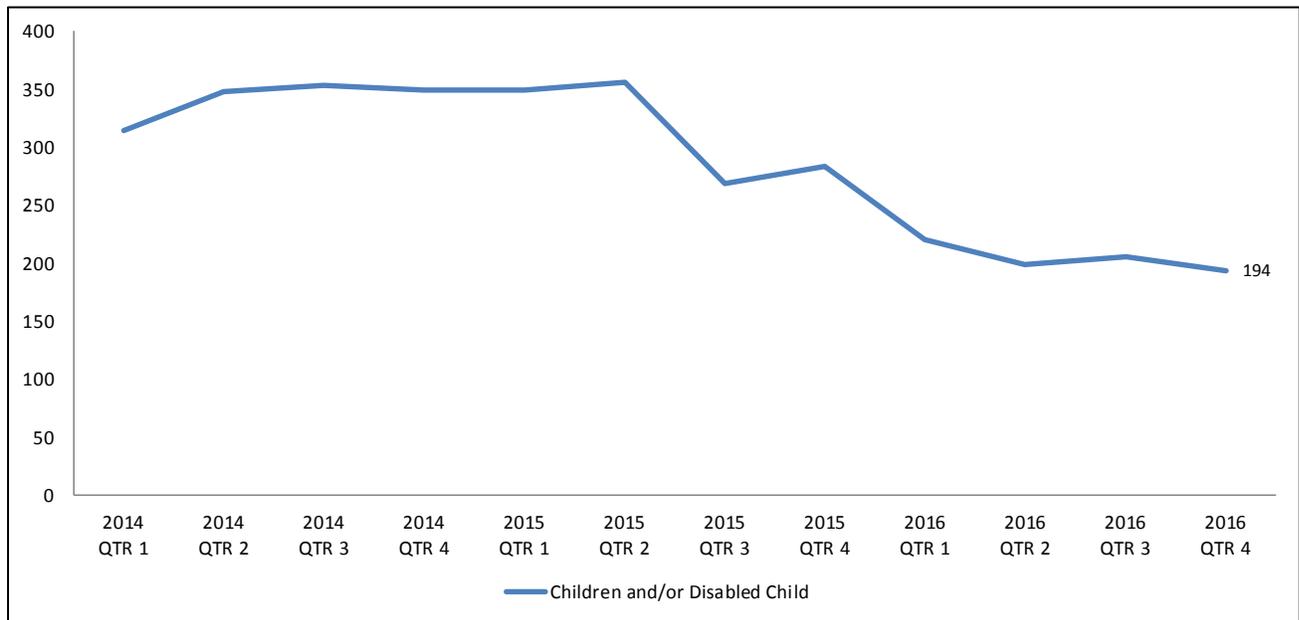
- All figures for this measure show a downward trend between 2014 and 2015 and then becomes more stabilized in 2016.
- The 2014 to 2016 FFS population consisted of a considerable amount of Plan Selection Period beneficiaries (refer to Figure 10) who stayed in FFS temporarily for less than 60 days and then transitioned to the Medicaid managed care program. Figure 23 indicates that these Plan Selection Period beneficiaries had much lower physician/APRN/clinic utilization. In addition, Figure 28 in this report shows that the Plan Selection Period beneficiaries generally had a higher rate of emergency department utilization for conditions potentially treatable in primary care, which indicated that the Plan Selection Period beneficiaries did have access to care provided in emergency departments, but may not through physician/APRN/clinics due to the short stay in FFS.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP<sup>11</sup> segment of the NHHPP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 23.

**Figure 19. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

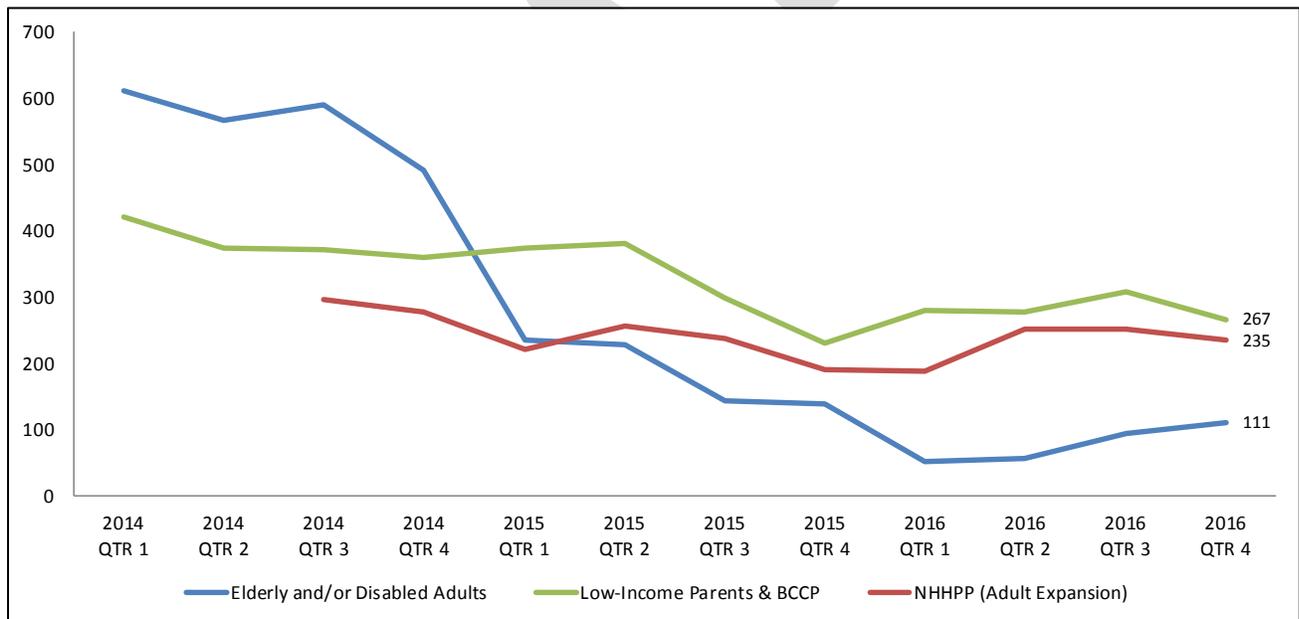


<sup>11</sup> An early component of the New Hampshire Health Protection Program was a mandatory assessment of access to cost-effective employer sponsored coverage through a Health Insurance Premium Payment (HIPP) program. During the assessment period the member was held in FFS. This assessment period has ended and members move into employee sponsored health care.

**Figure 20. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

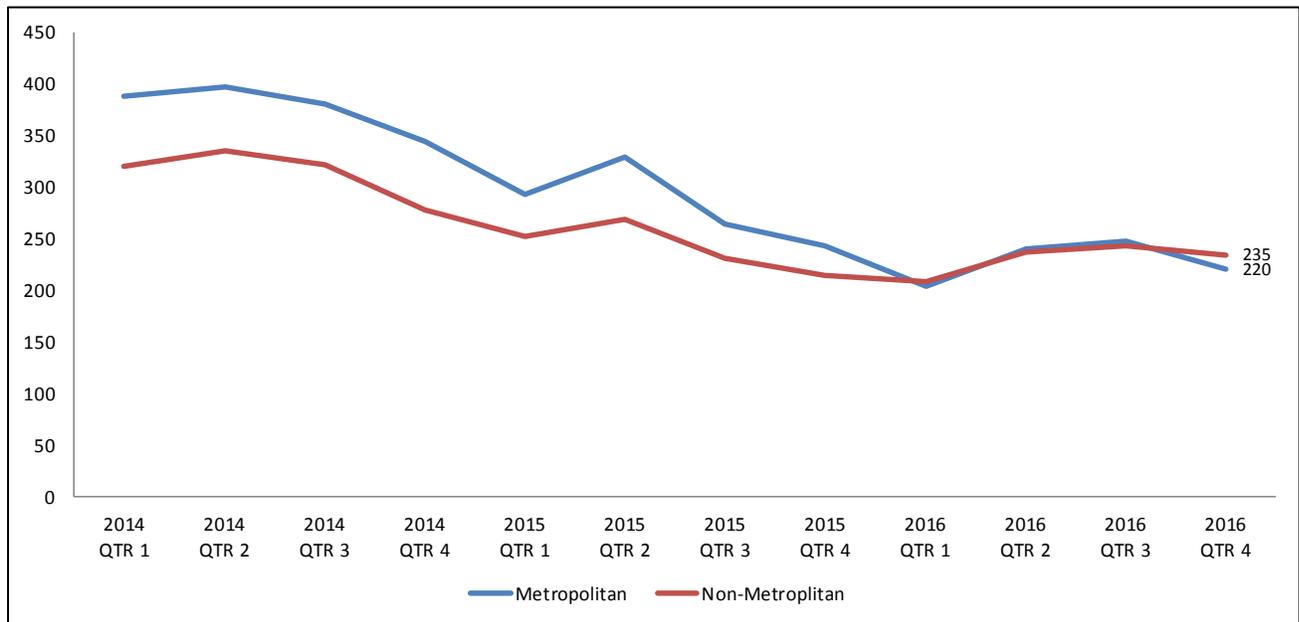


**Figure 21. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

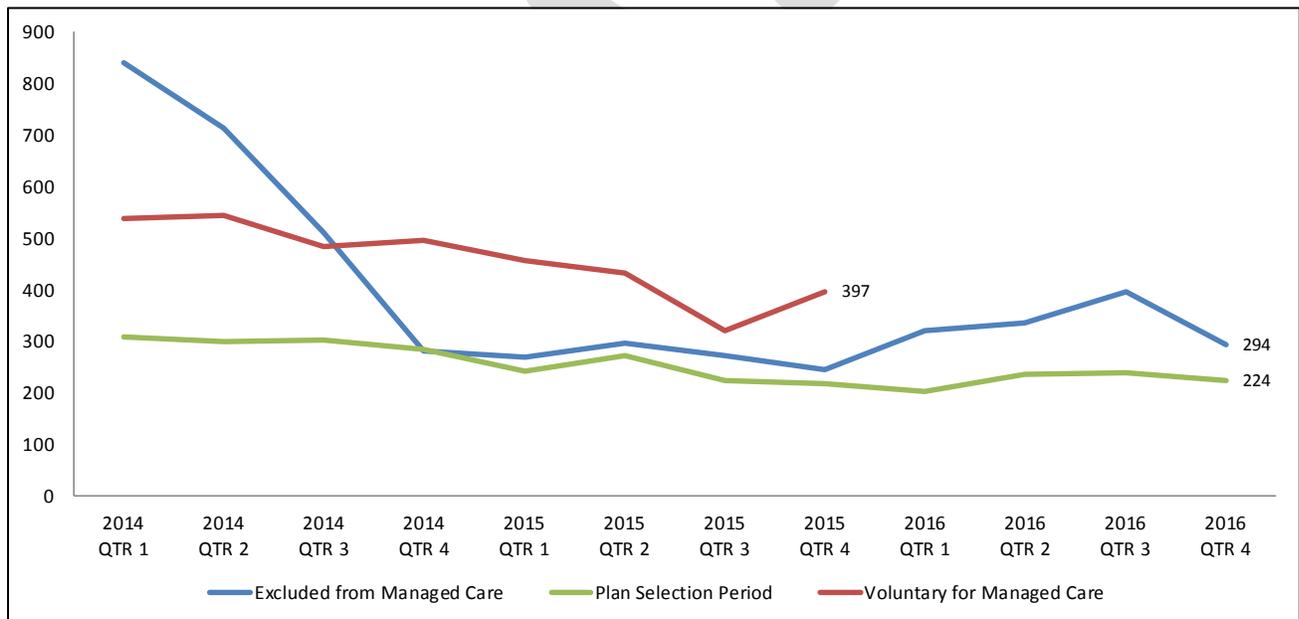


Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, the visit count in Quarter 2 of 2016 for the elderly and/or disabled adults group was less than 30. Please use caution when interpreting the results.

**Figure 22. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 23. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016.

### Emergency Department Utilization for Conditions Potentially Treatable in Primary Care

Figures 24 through 28 demonstrate the trends in quarterly use of hospital emergency departments for conditions that might have been more appropriately treated in primary care (e.g., upper respiratory infections) as indicated by Medicaid claims data.

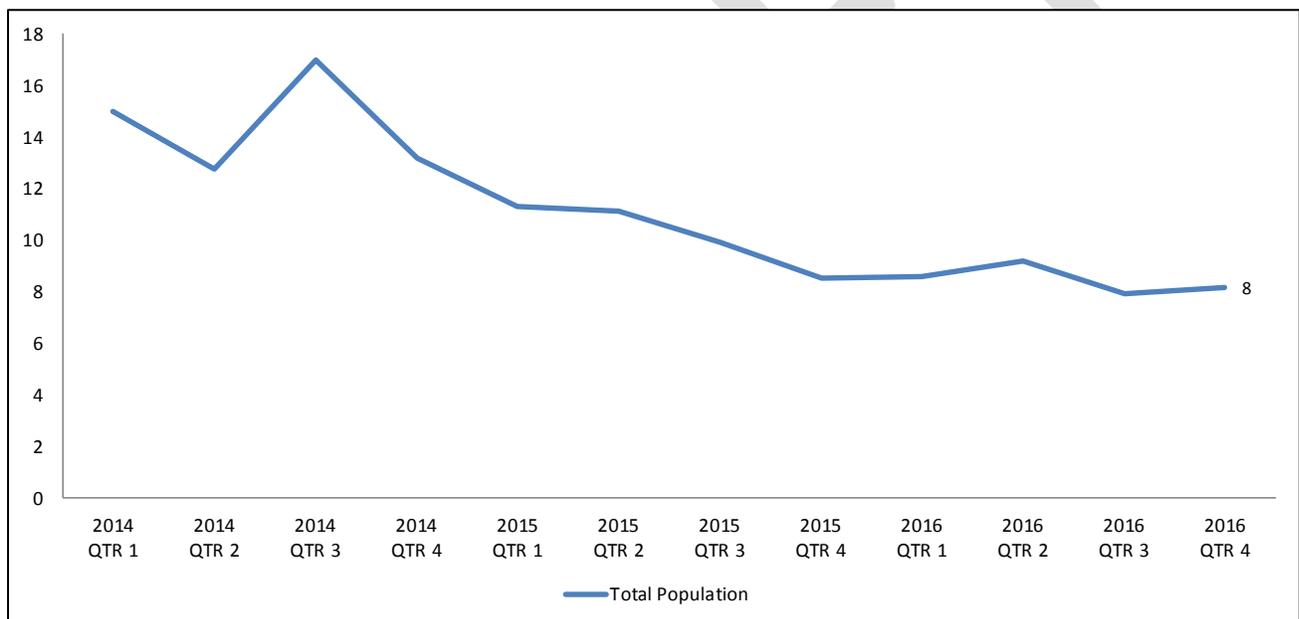
Data are presented for the total Medicaid FFS population, broken down by age and eligibility groupings, and broken down by metropolitan and non-metropolitan areas of the State where supported by sufficient data needed to produce reliable results.

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

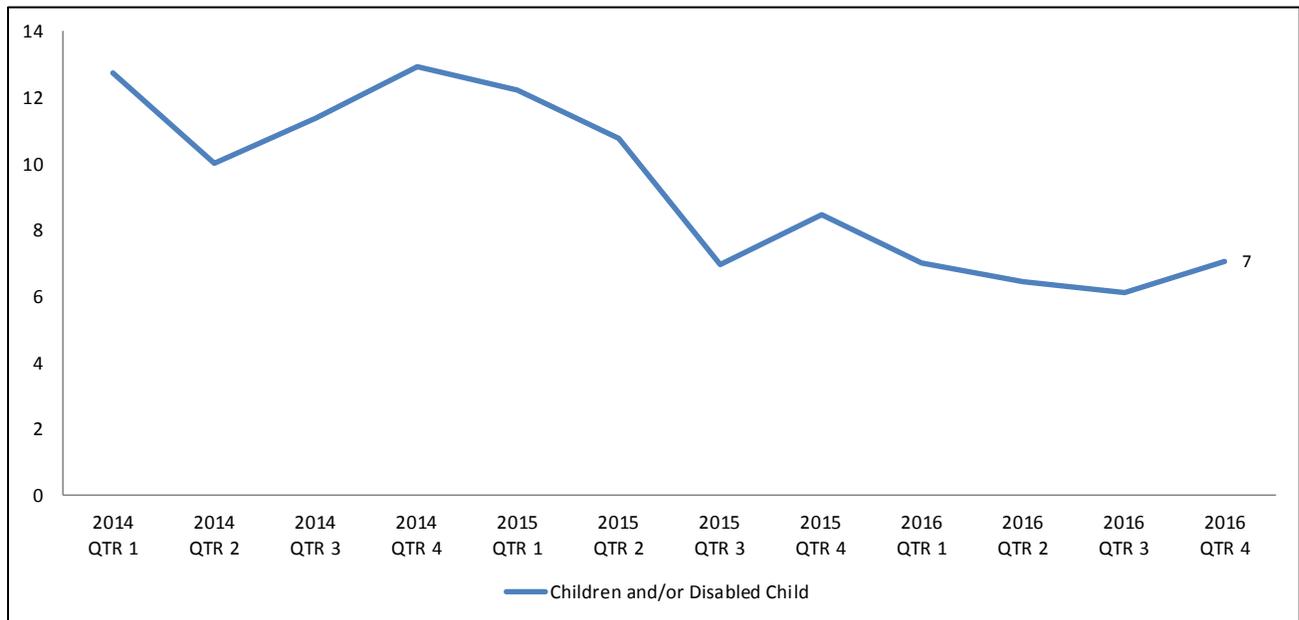
Results

- All figures for this measure show a downward trend between 2014 and 2015 and then become more stabilized in 2016. While lower utilization is generally the goal for this measure, DHHS will continue monitoring these trends in future access reports.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 28.

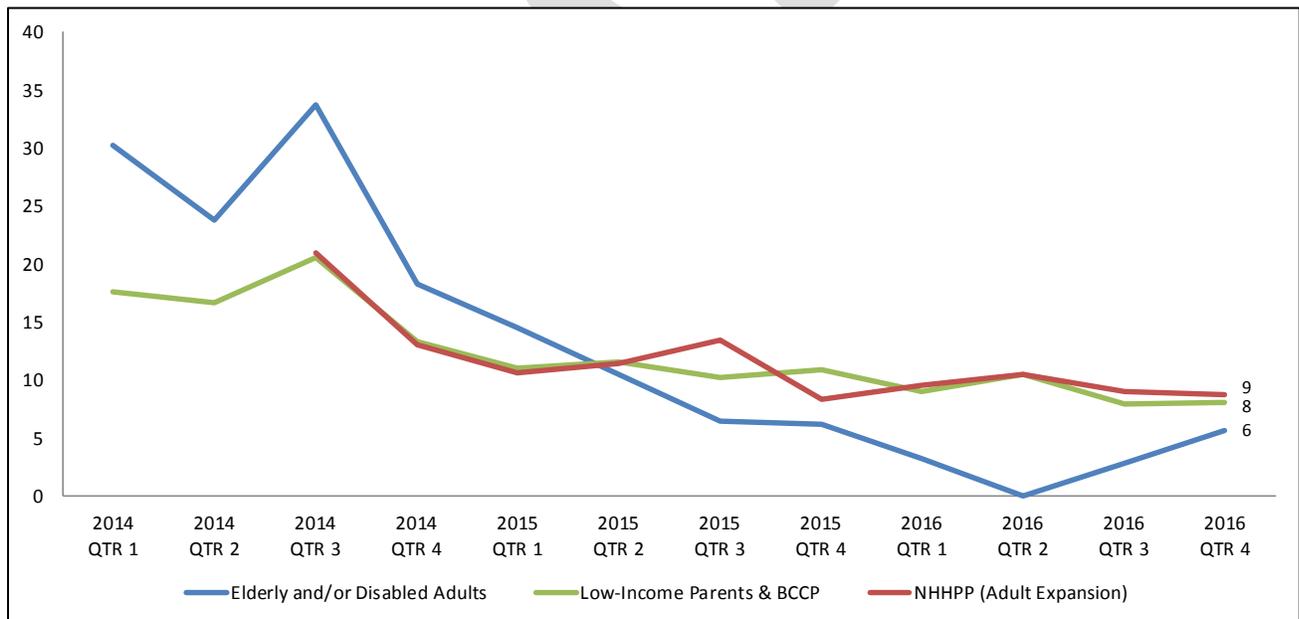
**Figure 24. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**



**Figure 25. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

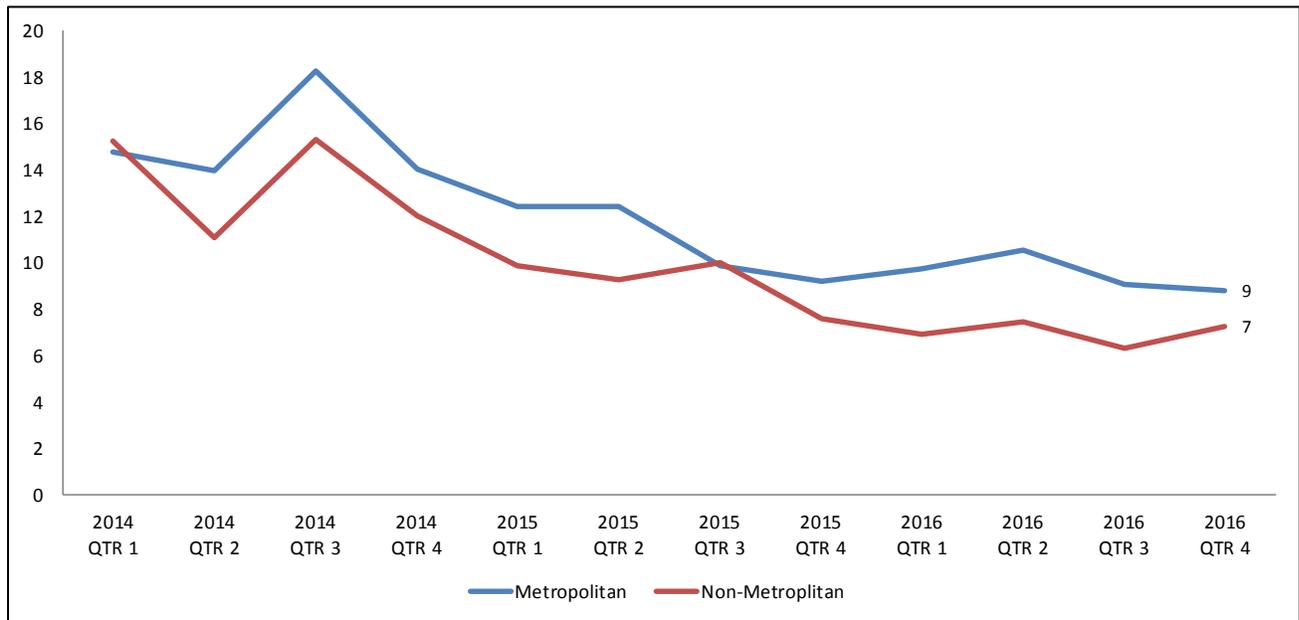


**Figure 26. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

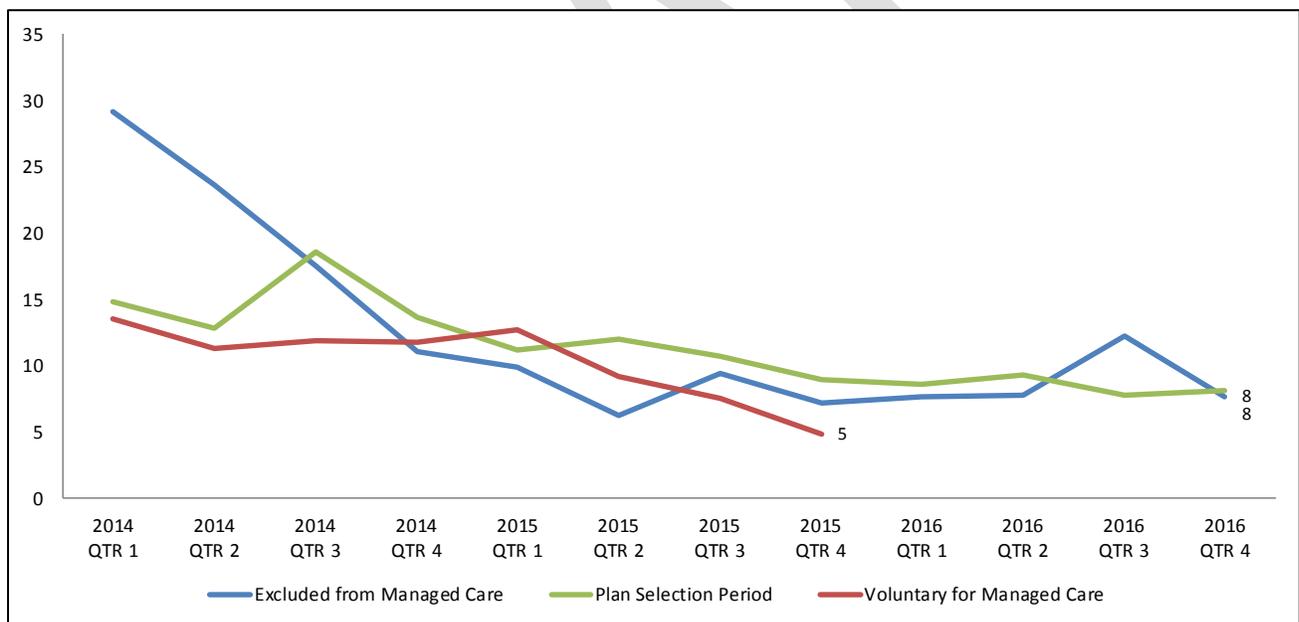


Note: The visit counts for the elderly and/or disabled adults and low-income parents & BCCP groups were less than 30 for some of the quarters (e.g., refer to Appendix B for the list of quarters with less than 30 visits). Please use caution when interpreting results. In addition, the NHHPP (adult expansion)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

**Figure 27. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 28. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: For the Excluded from Managed Care category, the visit counts in all quarters were less than 30. In addition, for the Voluntary for Managed Care category, the visit counts in Quarter 4 of 2015 were less than 30 and there were no beneficiaries in 2016. Please use caution when interpreting the results.

### Total Emergency Department Utilization

Figures 29 through 33 demonstrate the trends in quarterly use of hospital emergency departments by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data. Data are presented for the

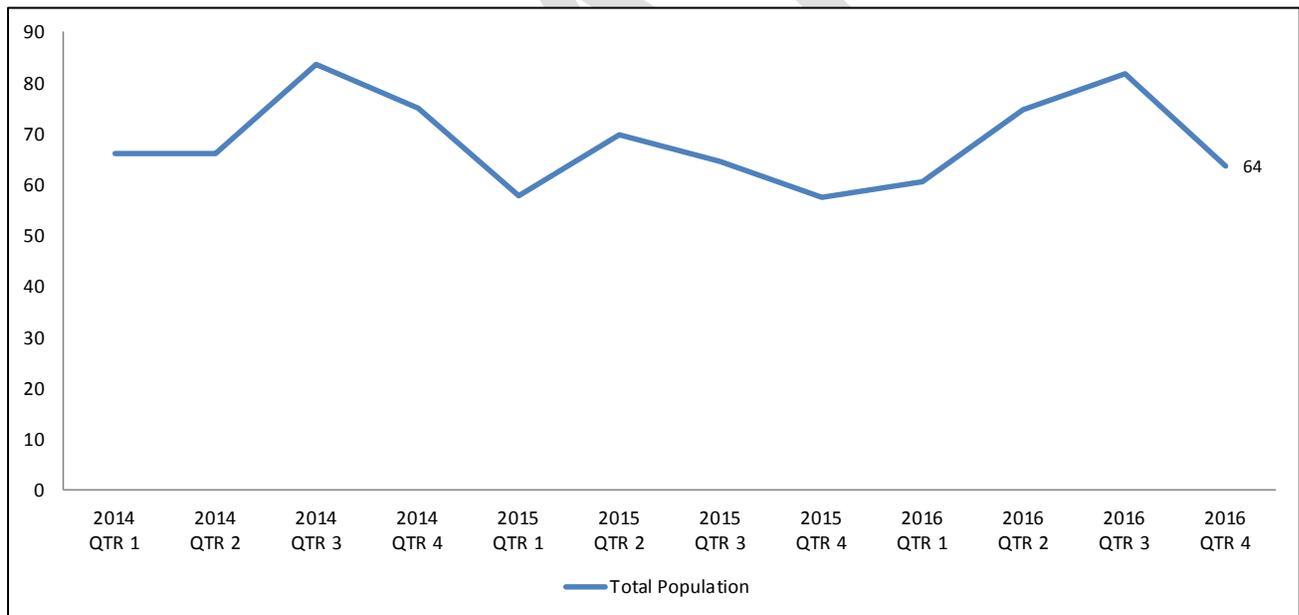
total Medicaid FFS population, broken down by age and eligibility groupings, and broken down by metropolitan and non-metropolitan areas of the State.

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

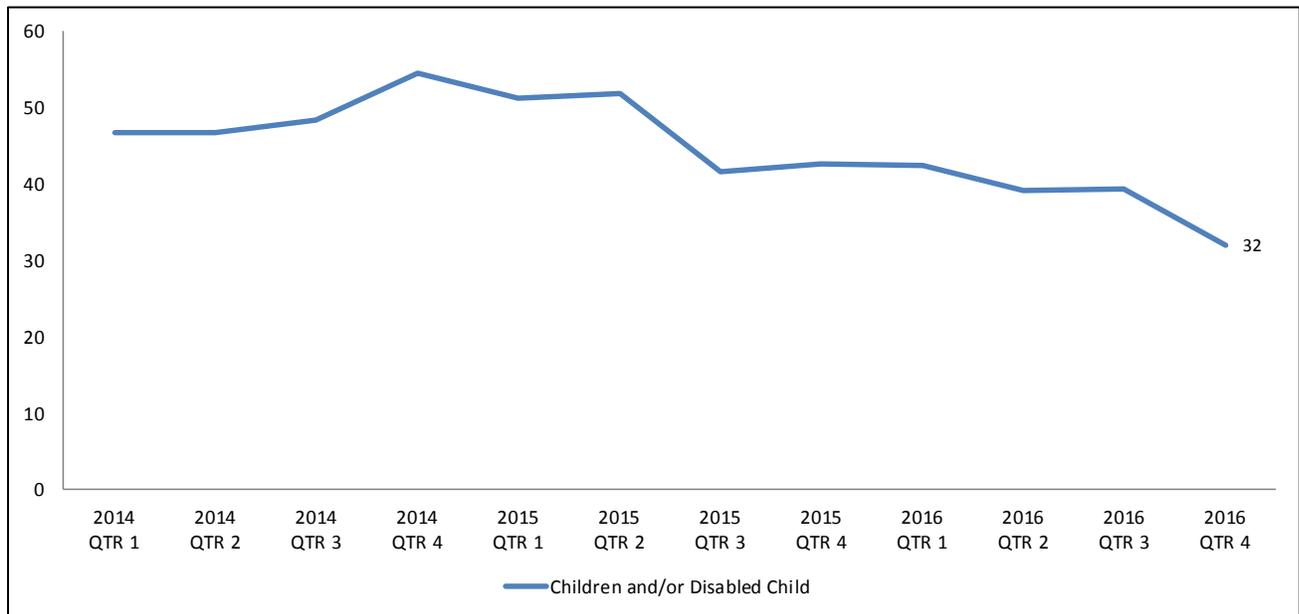
Results

- The utilization trend in 2016 was similar to that in 2014. i.e., Quarter 3 had the highest utilization in a calendar year. DHHS will continue to monitor this trend and determine whether seasonality should be considered when developing control limits.
- Figure 31 and Figure 33 show relatively large changes in rates from CY 2014 to CY 2015 for the elderly and/or disabled adults and Excluded from Managed Care groups. The drop in emergency department utilization for the elderly and/or disabled adults be impacted by the increase in primary care utilization noted in Figure 21. The change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 33.

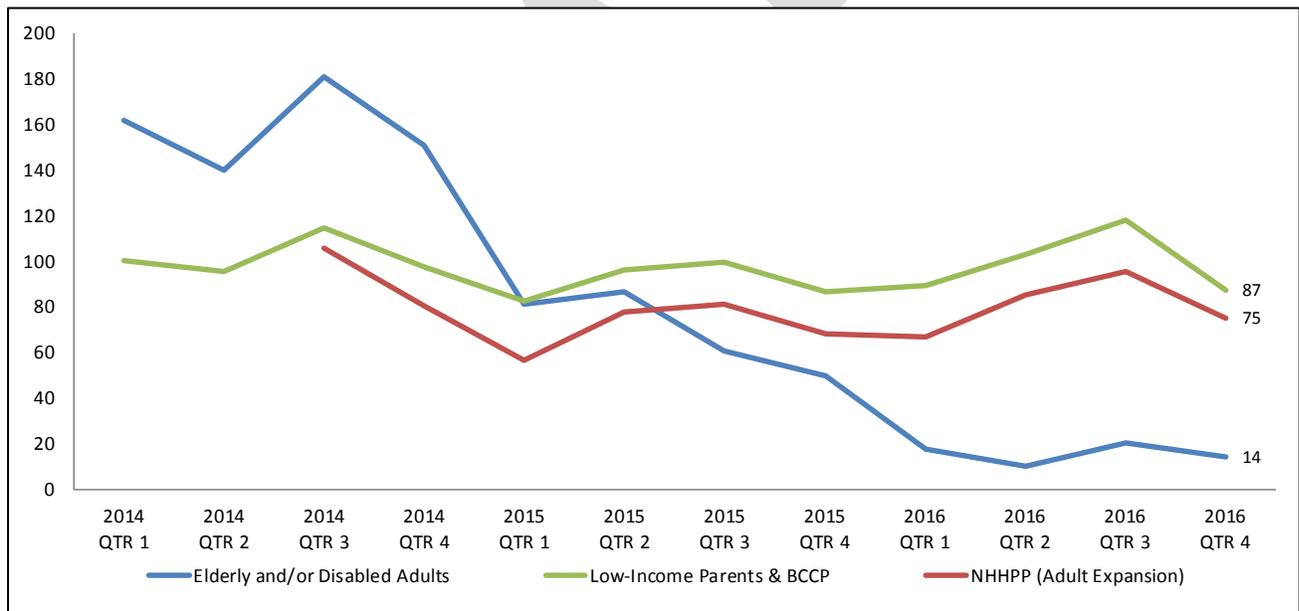
**Figure 29. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**



**Figure 30. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

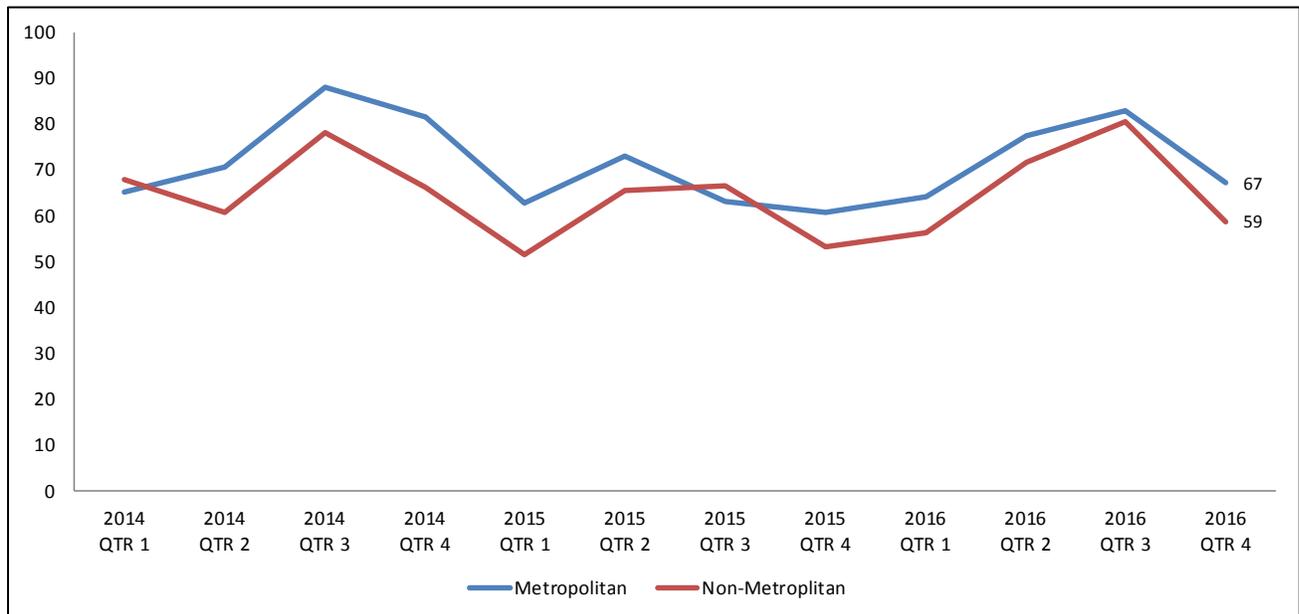


**Figure 31. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

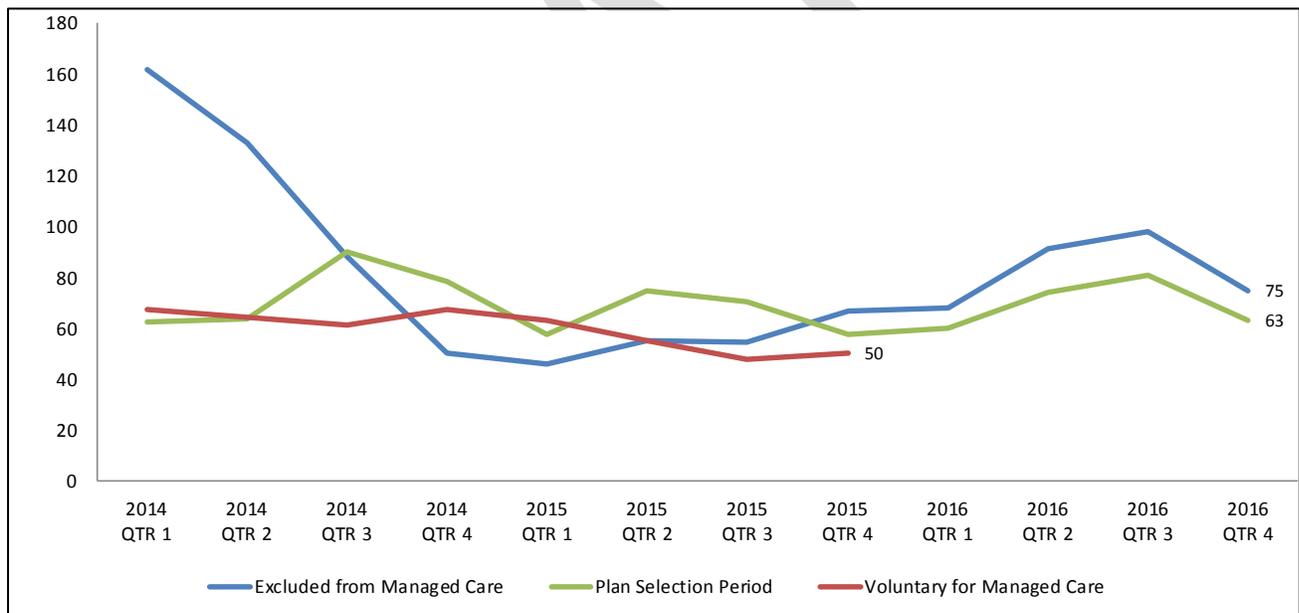


Note: The visit counts for the elderly and/or disabled adults group were less than 30 for all quarters in 2016. Please use caution when interpreting results. In addition, the NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014.

**Figure 32. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 33. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016.

### Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions

Figure 34 demonstrates the trend in quarterly use of inpatient hospitals for ambulatory care sensitive conditions (ACSC) by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data. Rates of hospitalization for an ACSC can be considered as measure of appropriate primary healthcare delivery. While not all admissions for these conditions are avoidable, appropriate ambulatory care can help prevent, or control, acute exacerbations and improve the management of these illnesses or conditions. A disproport-

tionately high rate of ACSC admissions may reflect underutilization of appropriate primary care. The ambulatory care sensitive conditions included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis and are commonly grouped together as ACSC.<sup>12</sup>

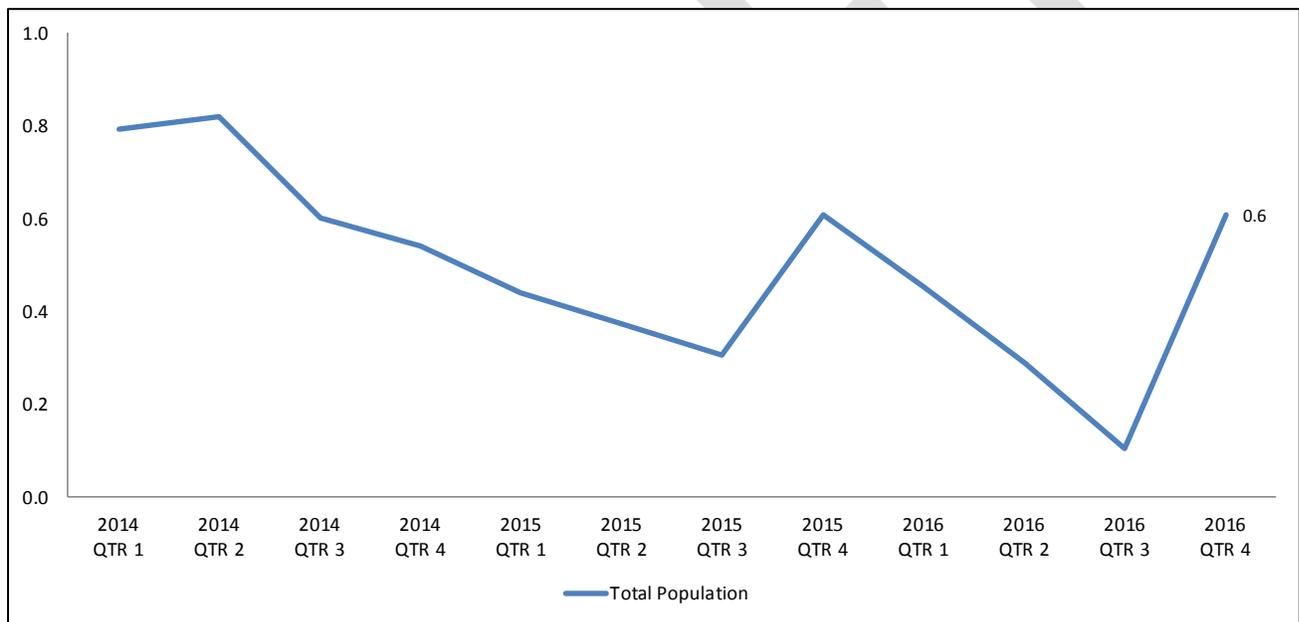
Data are only presented for the total Medicaid population due to the small number of cases that occur each quarter when broken down by age, eligibility groupings, or metropolitan and non-metropolitan areas of the state.

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

Results

- Since the FFS population became much smaller after the Medicaid managed care program transition, the numerators in each quarter for this measure were all less than 30 visits, which means there is a larger variation. Results may not be reliable.

**Figure 34. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**



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

**Total Inpatient Hospital Utilization**

Figures 35 and 36 demonstrate the trends in quarterly use of general inpatient hospitals by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

<sup>12</sup> Agency for Healthcare Research and Quality overall Prevention Quality Indicator Composite [http://www.qualityindicators.ahrq.gov/Modules/PQI\\_TechSpec\\_ICD10\\_v60.aspx](http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v60.aspx)

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

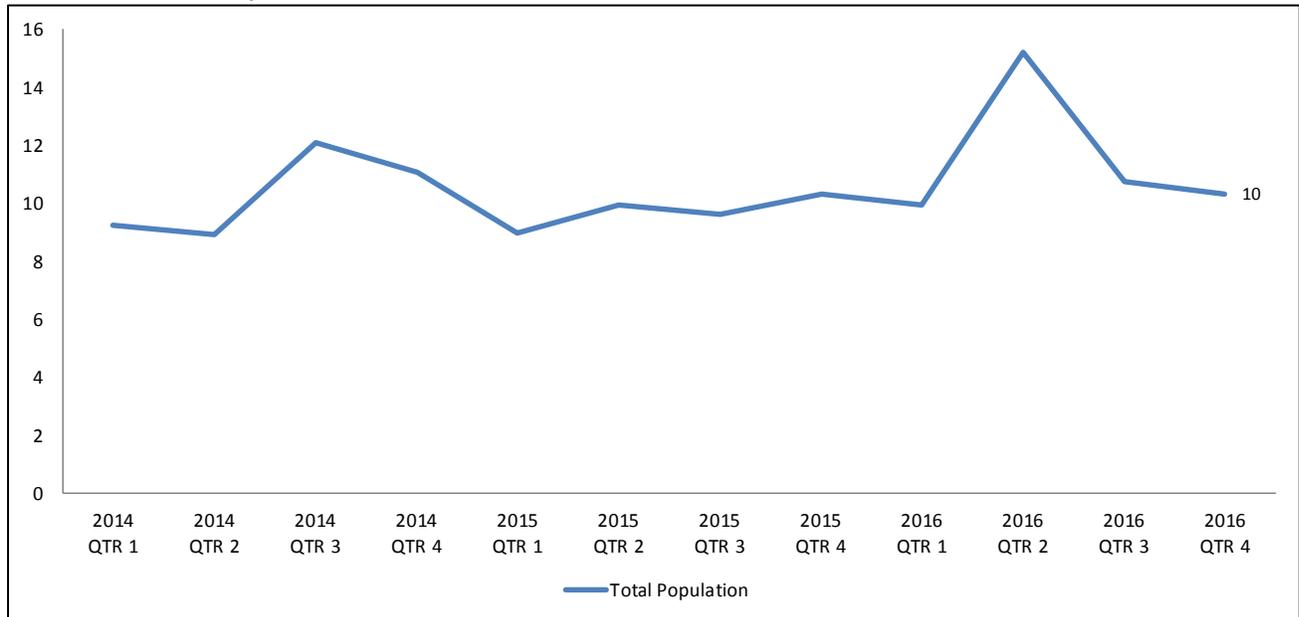
Maternity discharges (both mothers and newborns) have been removed due to declining birth rates in the Medicaid and general population. Given how common these services are in the New Hampshire Medicaid population, including them would skew the results and could lead to misinterpretations.

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

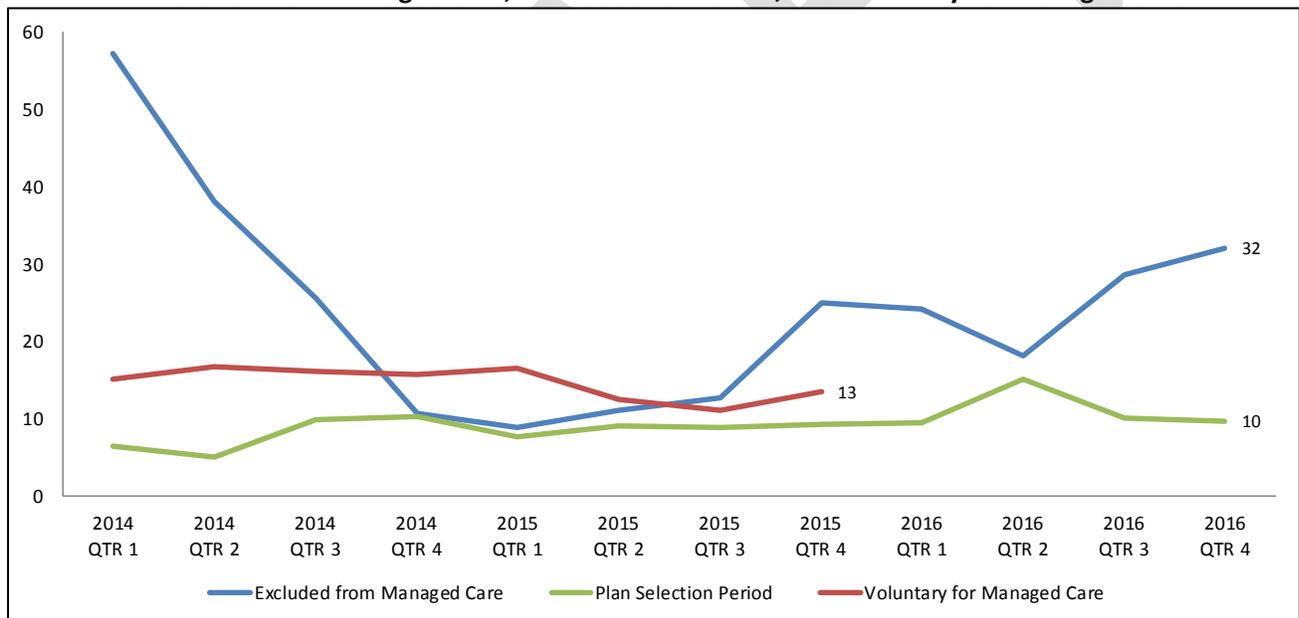
### Results

- The rates shown in Figure 35 for the total FFS population are all above the historical upper control limit.
- While the trend over time for the total population was similar to the Plan Selection Period category, the rates for the Excluded from Managed Care and Voluntary for Managed Care categories were generally higher than the Plan Selection Period category.
- During 2014 and 2015, the Voluntary for Managed Care category was primarily comprised of disabled children and adults who had opted-out of the Medicaid managed care program and more likely to have a higher baseline number of inpatient admissions.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 36.

**Figure 35. Inpatient Hospital Utilization<sup>13</sup> per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**



**Figure 36. Inpatient Hospital Utilization<sup>14</sup> per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: For the Excluded from Managed Care category, the visit counts were less than 30 for all quarters except the first quarter of 2014. In addition, there were no beneficiaries in the Voluntary for Managed Care category in 2016.

### Utilization of Cardiology Providers

Figures 37 through 41 demonstrate the trends in quarterly use of services from cardiology providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

<sup>13</sup> Excludes maternity

<sup>14</sup> Excludes maternity

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

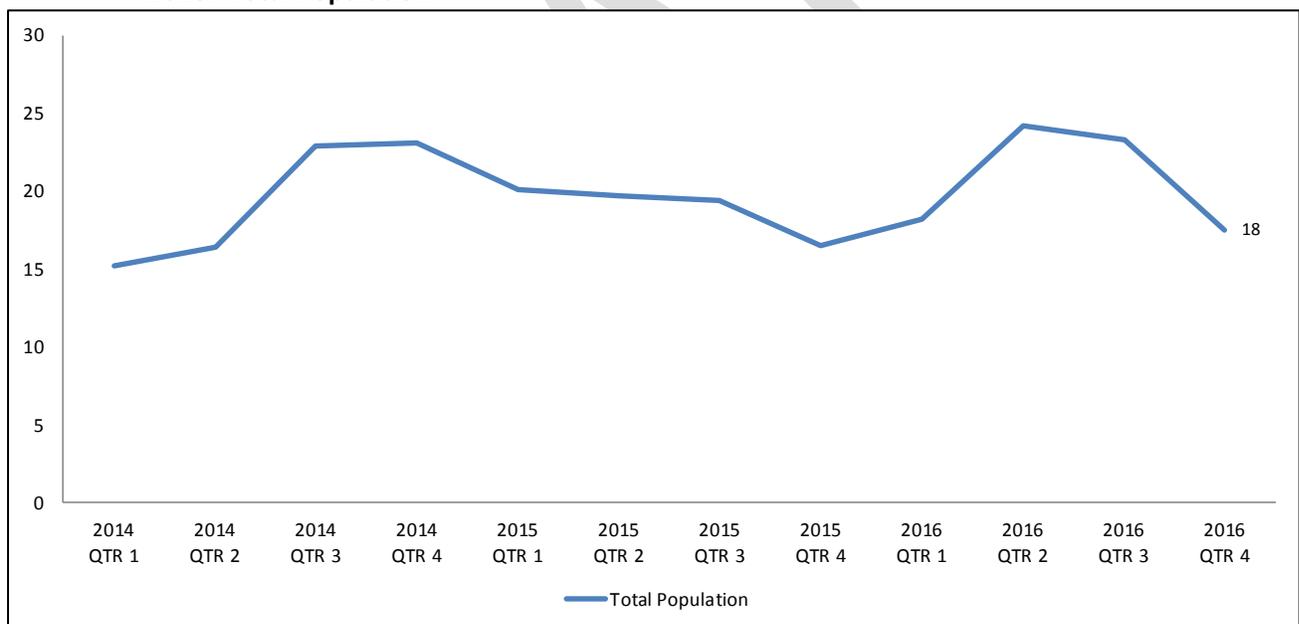
Note: because the FFS population changed dramatically after transitioning to Medicaid managed care program, new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

### Results

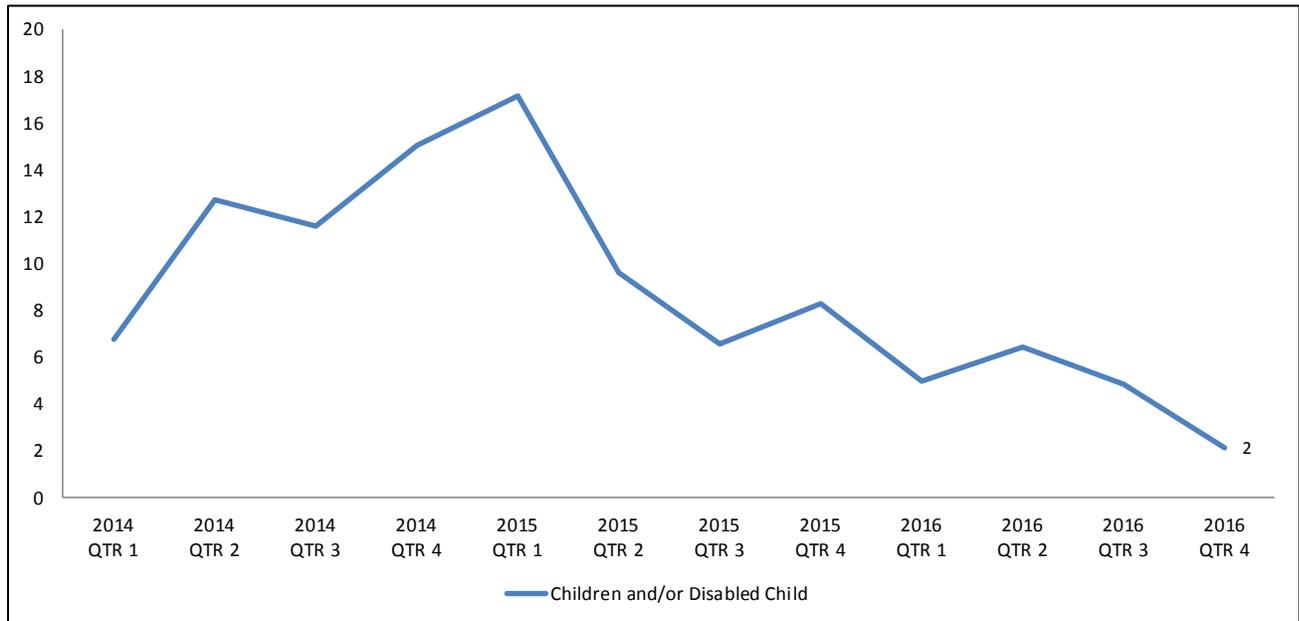
As this is the initial data collection phase, these results will be treated as baseline data and will be used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- Due to frequent changes to the FFS population between 2014 and 2016, the utilization over time was not stable and contained sudden changes.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 41.

**Figure 37. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

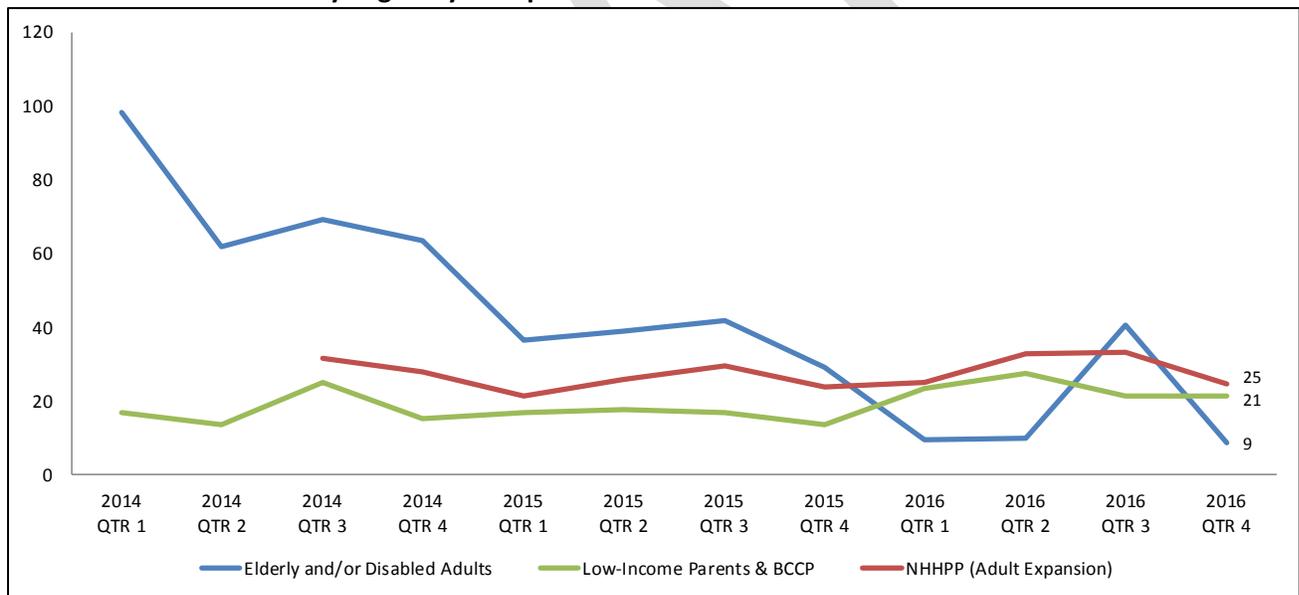


**Figure 38. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**



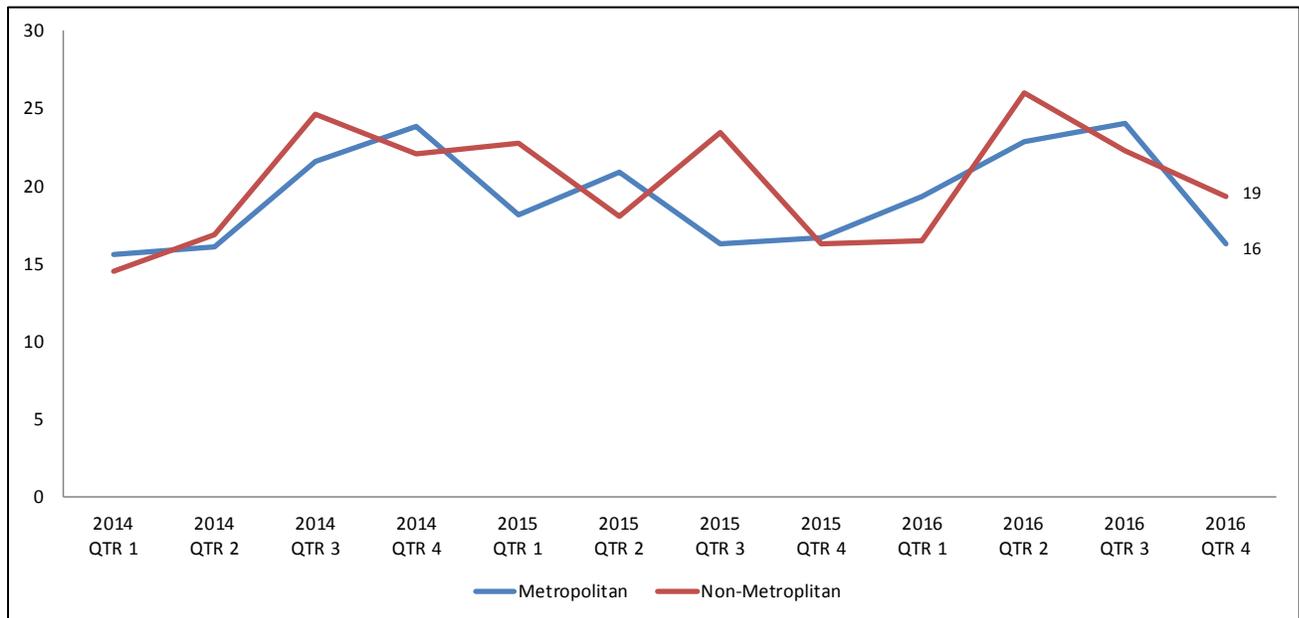
Note: The visit counts were less than 30 for Quarter 3 and Quarter 4 of 2016. Please use caution when interpreting results.

**Figure 39. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

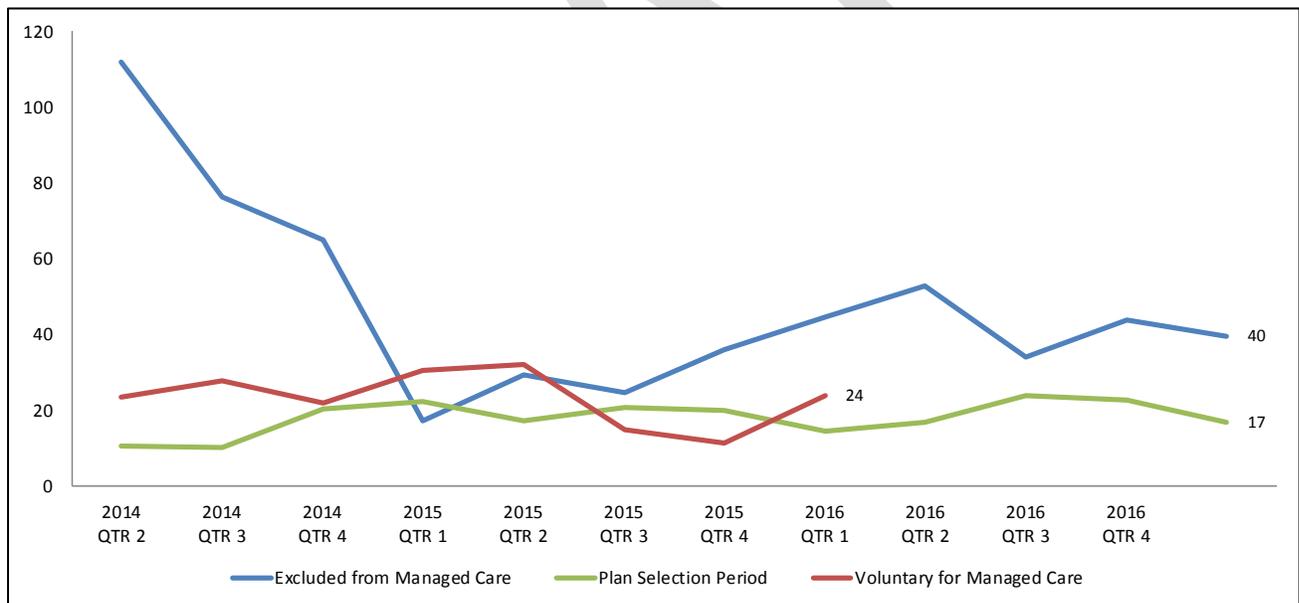


Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, for the elderly and/or disabled adults group, the visit counts were less than 30 for all quarters in 2016. Please use caution when interpreting results.

**Figure 40. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 41. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016. In addition, the visit counts for the Excluded from Managed Care category were less than 30 for Quarter 2 and Quarter 4 of 2016. Please use caution when interpreting results.

### Utilization of Radiology Providers

Figures 42 through 46 demonstrate the trends in quarterly use of services from radiology providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

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

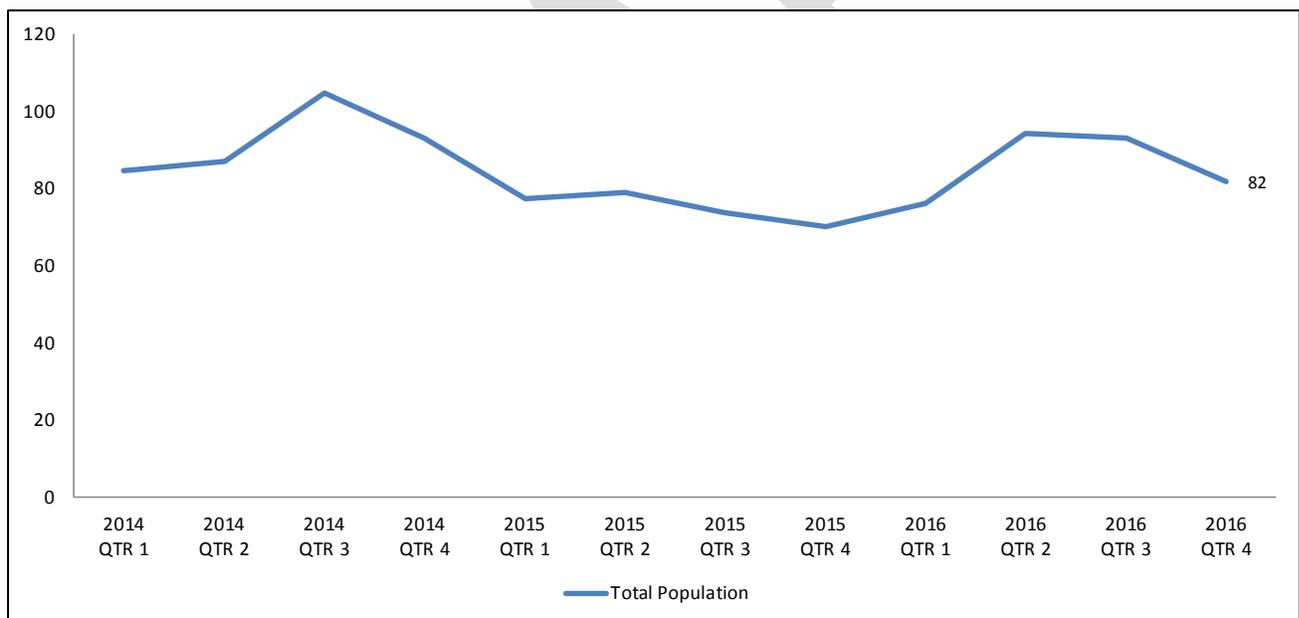
Note: because the FFS population changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

### Results

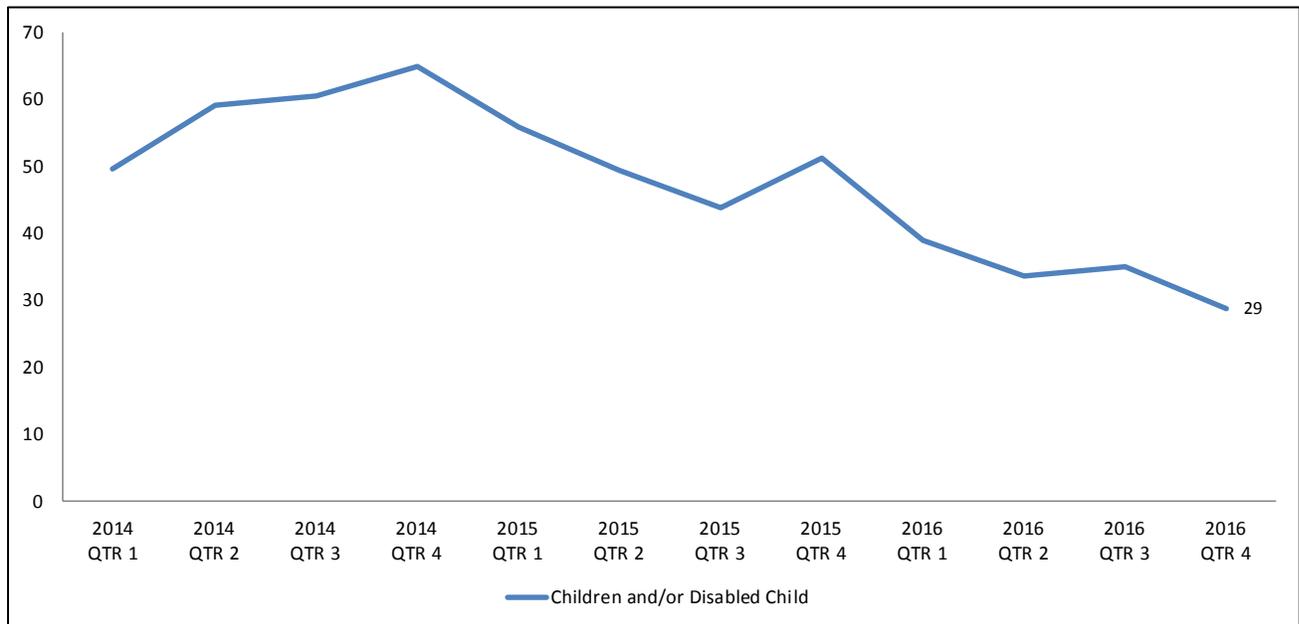
Since this is the initial data collection phase, these results will be treated as baseline data and will be used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- Due to frequent changes to the FFS population between 2014 and 2016, the utilization over time was not stable and contained sudden changes.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPPP segment of the NHHPP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 46.

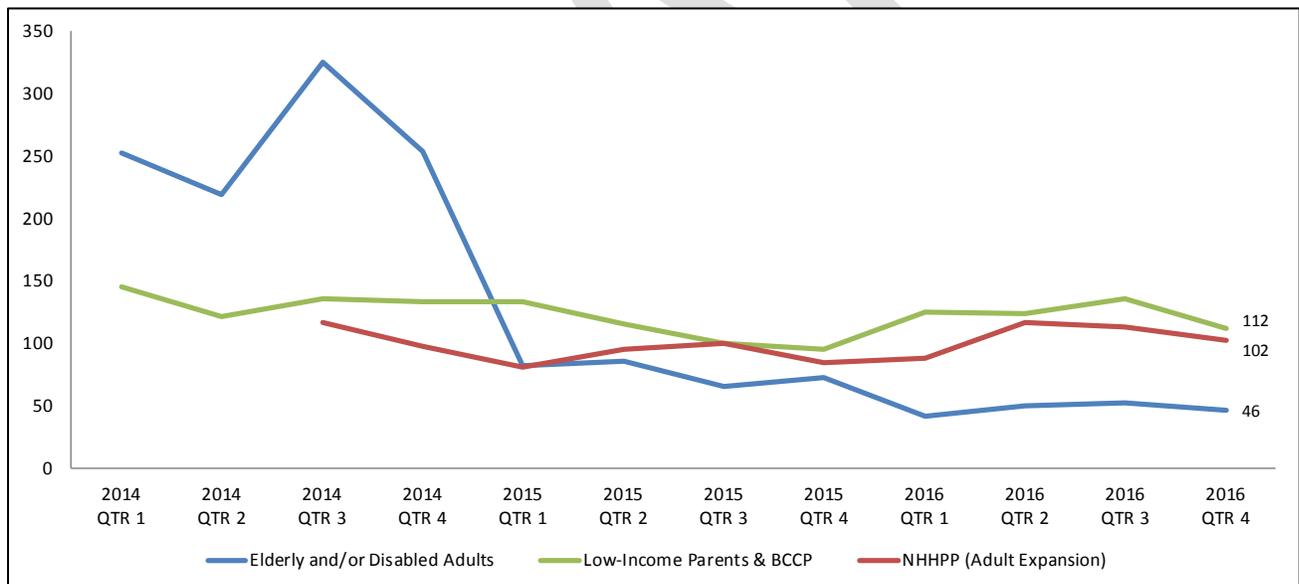
**Figure 42. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**



**Figure 43. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

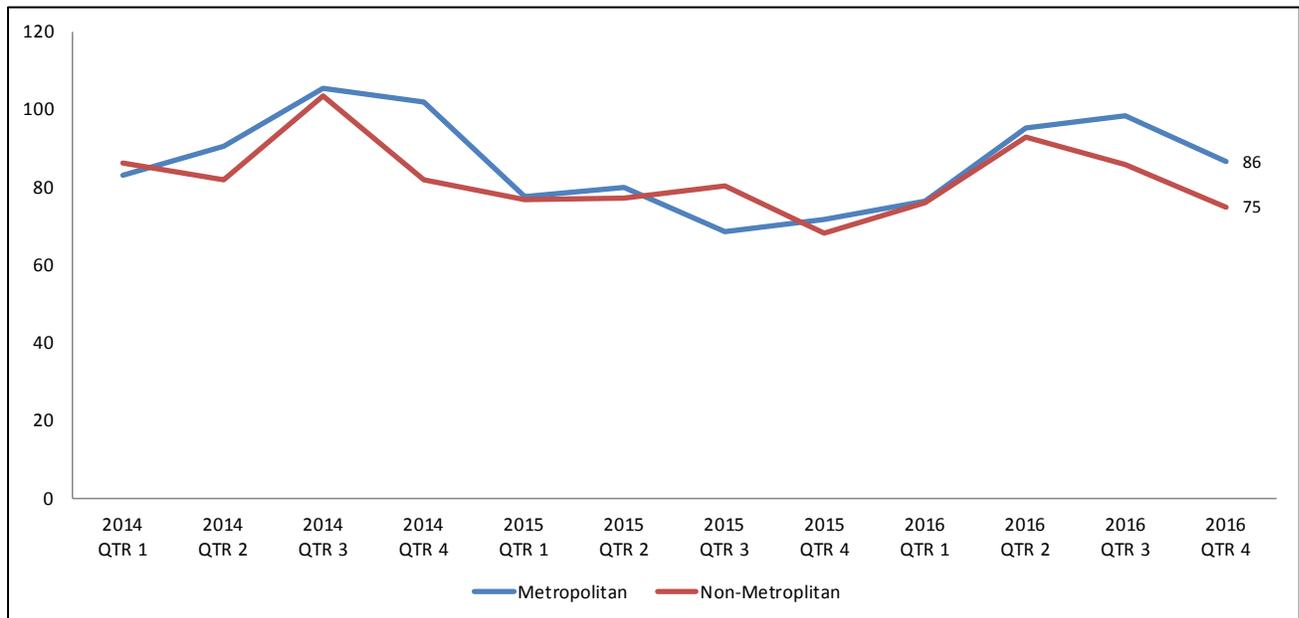


**Figure 44. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

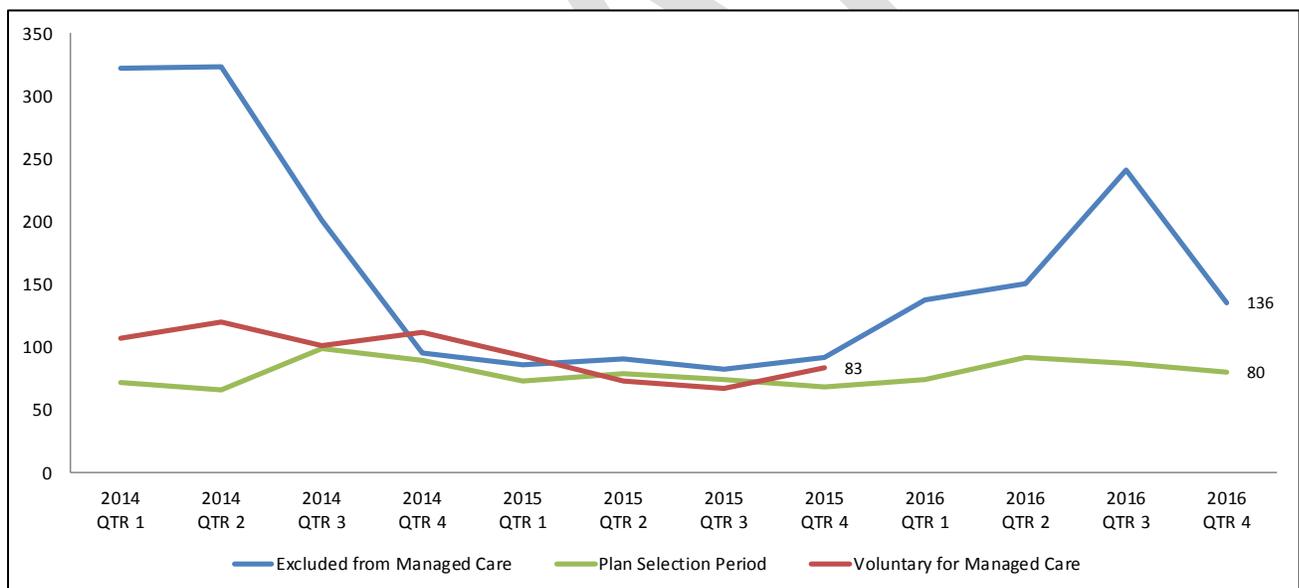


Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, for the elderly and/or disabled adults group, the visit counts were less than 30 for all quarters in 2016. Please use caution when interpreting results

**Figure 45. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 46. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016.

### Utilization of Surgery Providers

Figures 47 through 51 demonstrate the trends in quarterly use of services from surgery providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

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

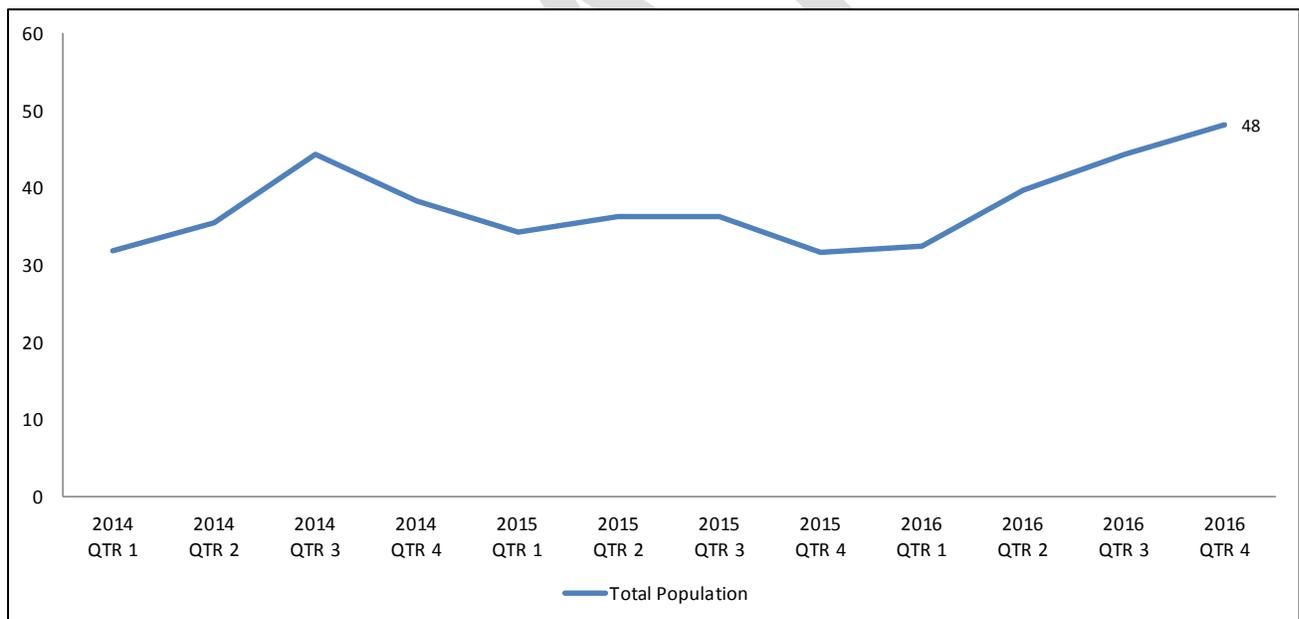
Note: because the FFS population changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

Results

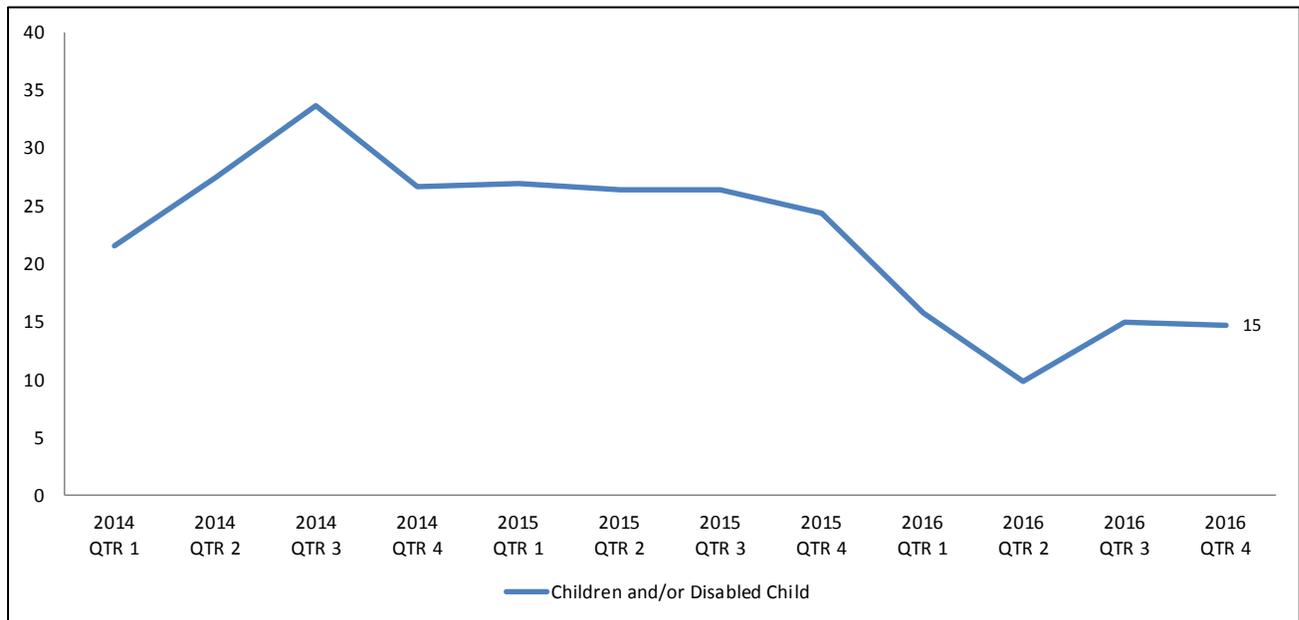
Since this is the initial data collection phase, these results will be treated as baseline data and used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- Due to frequent changes to the FFS population between 2014 and 2016, the utilization over time was not stable and contained sudden changes.
- The sudden change in the utilization trend may be due to change(s) in the underlying population characteristics. For example, the new HIPP segment of the NHHPP program prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from 2014 QTR 3 to 2014 QTR 4, which contributed to the sudden change in Figure 51.
- The increasing trend in 2016 was due to high utilization from some beneficiaries in the non-metropolitan counties. i.e., there were 12 beneficiaries with more than 10 services from surgery providers in Quarter 4 of 2016.

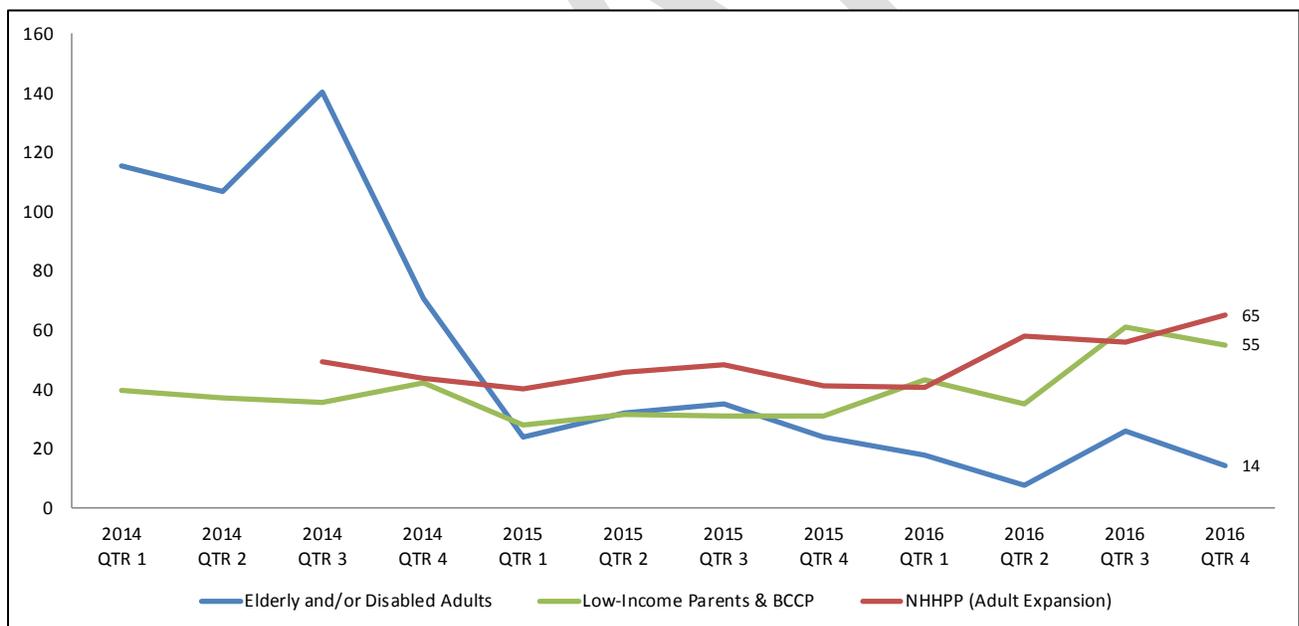
**Figure 47. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**



**Figure 48. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

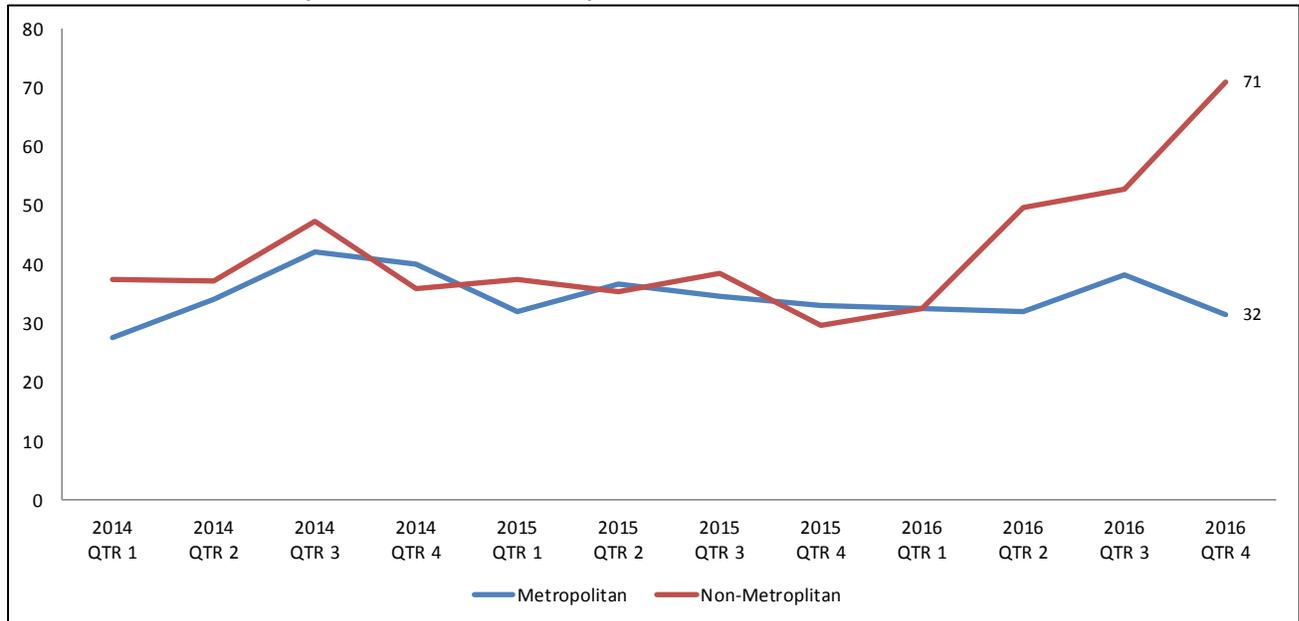


**Figure 49. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

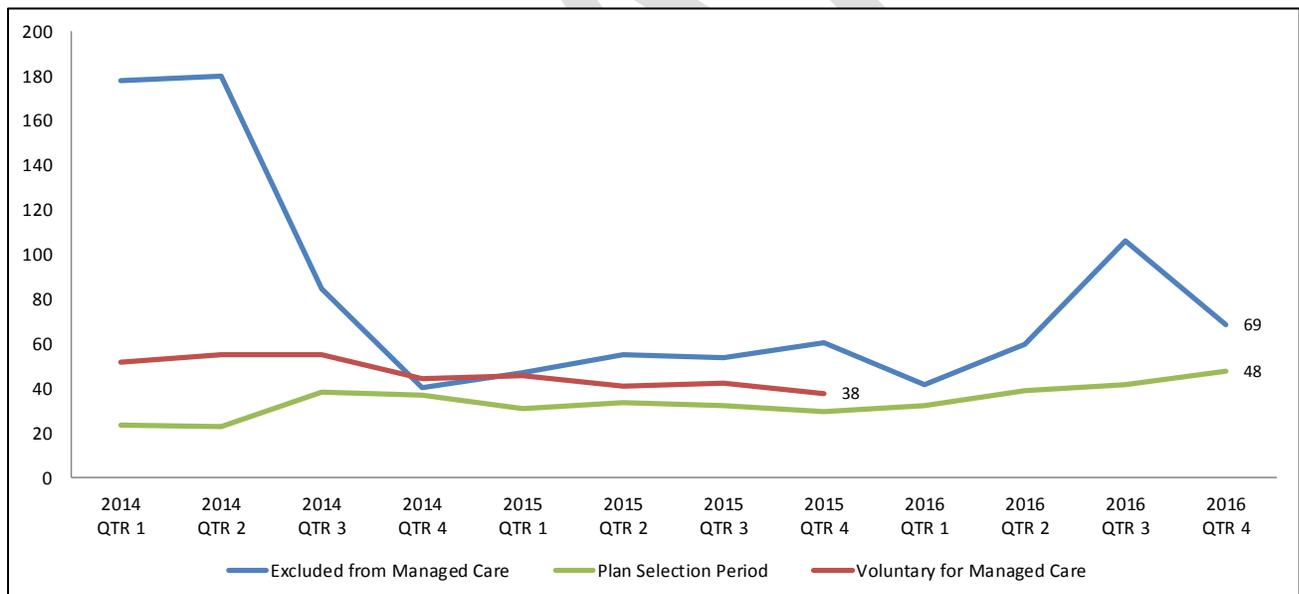


Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, the visits from the elderly and/or disabled adults category were less than 30 for Quarter 1 of 2015 and all quarters in 2016. Please use caution when interpreting these results.

**Figure 50. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 51. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016.

### Utilization of Home Health Providers

Figures 52 through 56 demonstrate the trends in quarterly use of services from home health providers by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data.

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

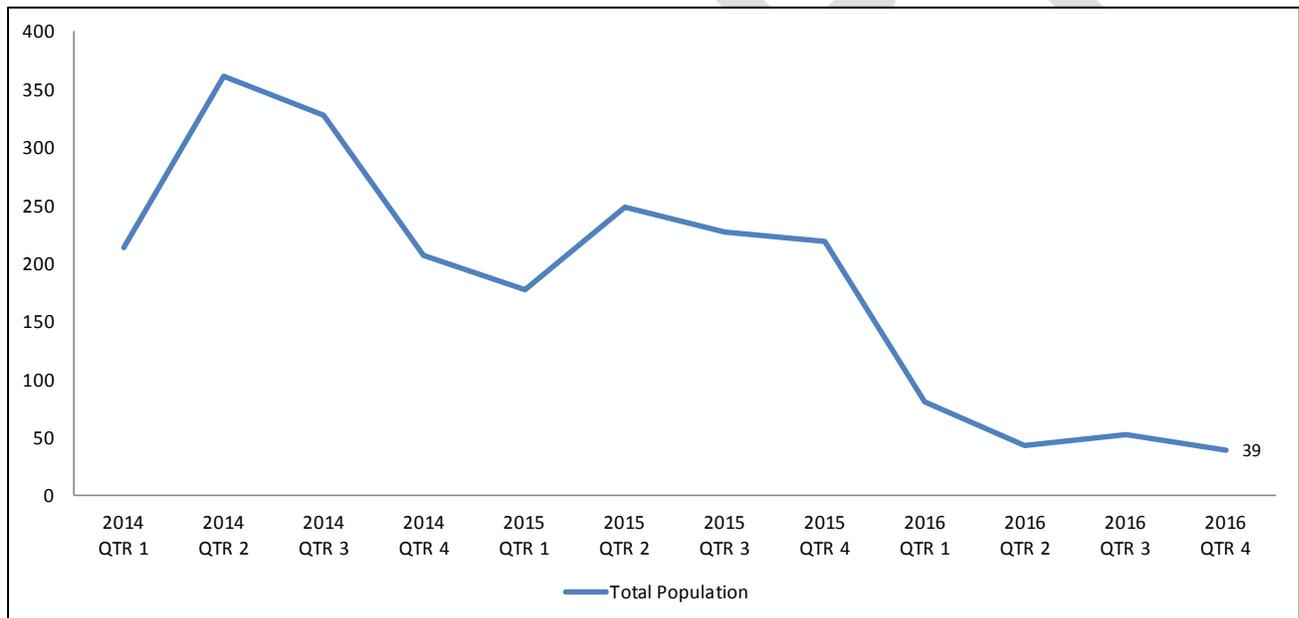
Note: because the FFS population changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

### Results

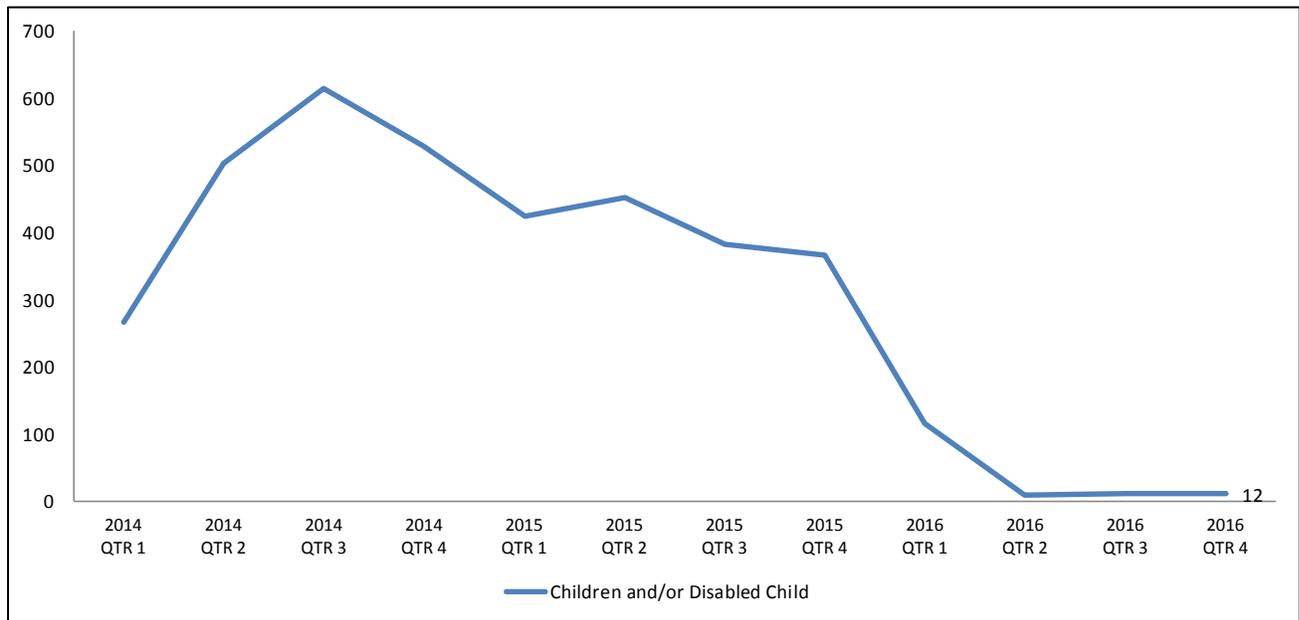
Since this is the initial data collection phase, these results will be treated as baseline data and used to develop control limits and seasonality adjustments as the FFS population stabilizes and sufficient data are collected in future reports. Below are some general findings:

- The high utilization in 2014 and 2015 was primarily from the children and/or disabled child and Voluntary for Managed Care groups.
- Because there were no beneficiaries in the Voluntary for Managed Care category in 2016 (refer to Figure 10), the utilization rates for home health services in 2016 were much lower than those in 2014.
- Due to frequent changes to the FFS population between 2014 and 2016, the utilization over time was not stable and contained sudden changes.

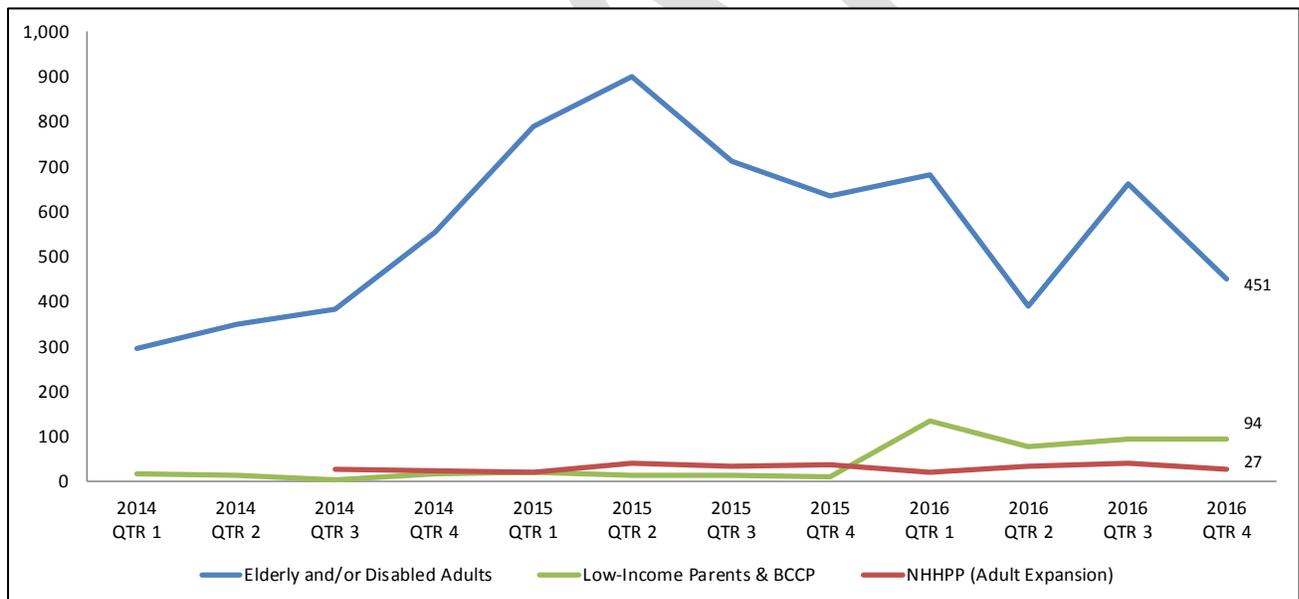
**Figure 52. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**



**Figure 53. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

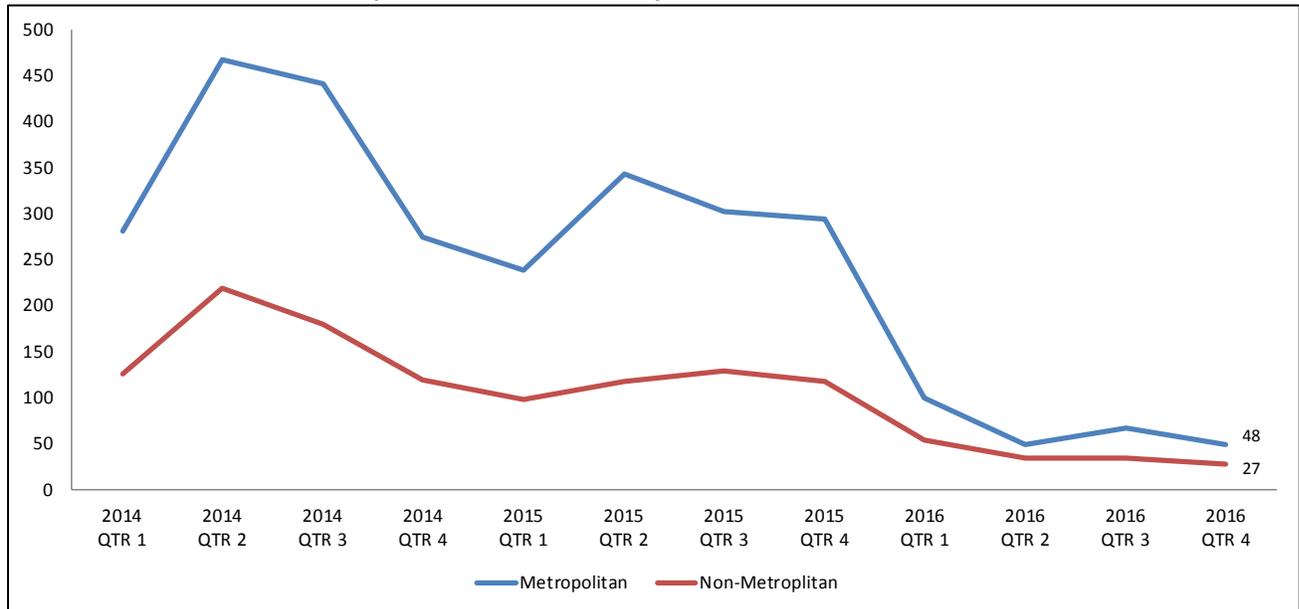


**Figure 54. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

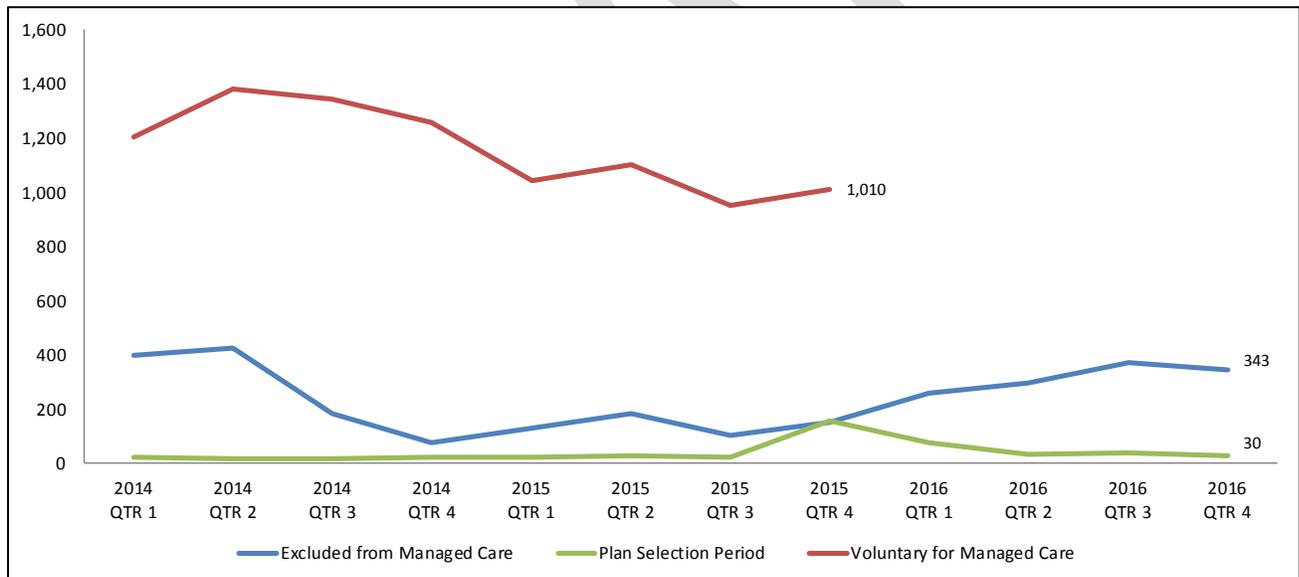


Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, the visits from the elderly and/or disabled adults group were less than 30 for all quarters in 2016. Please use caution when interpreting these results.

**Figure 55. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 56. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016.

### Mental Health Utilization

Figures 57 through 61 demonstrate the trends in quarterly use of mental health services by New Hampshire Medicaid FFS beneficiaries as indicated by Medicaid FFS claims data. The mental health services were de-

defined based on the National Committee for Quality Assurance (NCQA) measure *Mental Health Utilization* from the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®15</sup>) 2016.

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

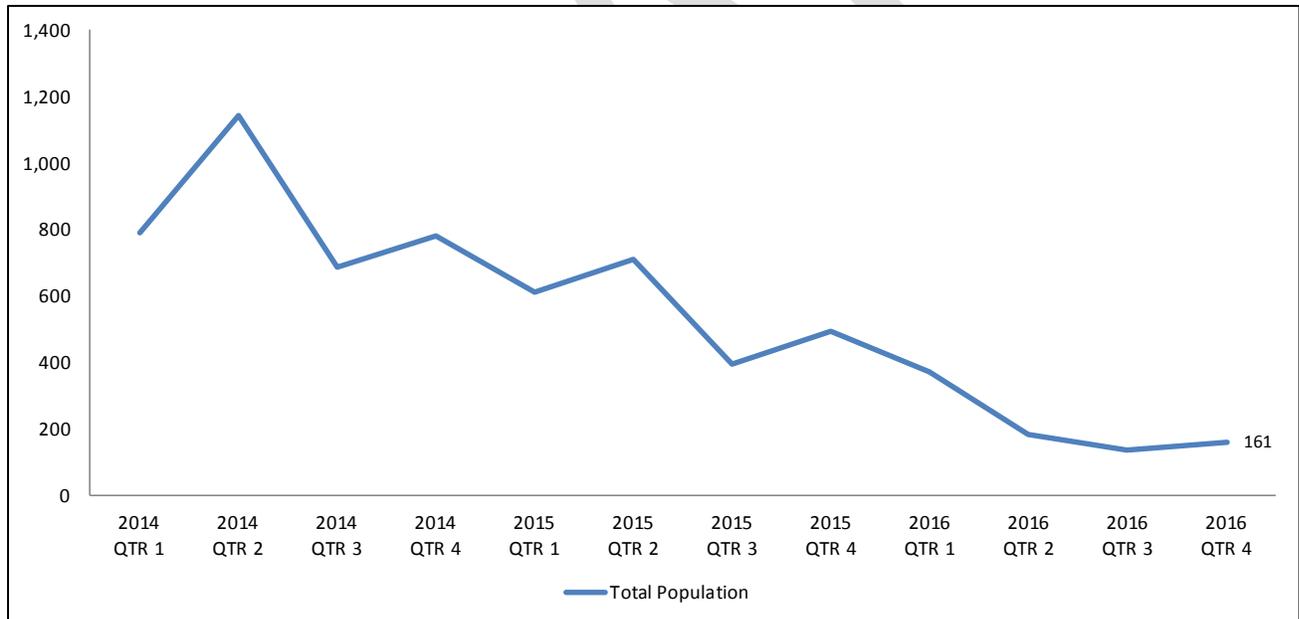
Note: because the FFS population changed dramatically after transitioning to the Medicaid managed care program new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

### Results

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

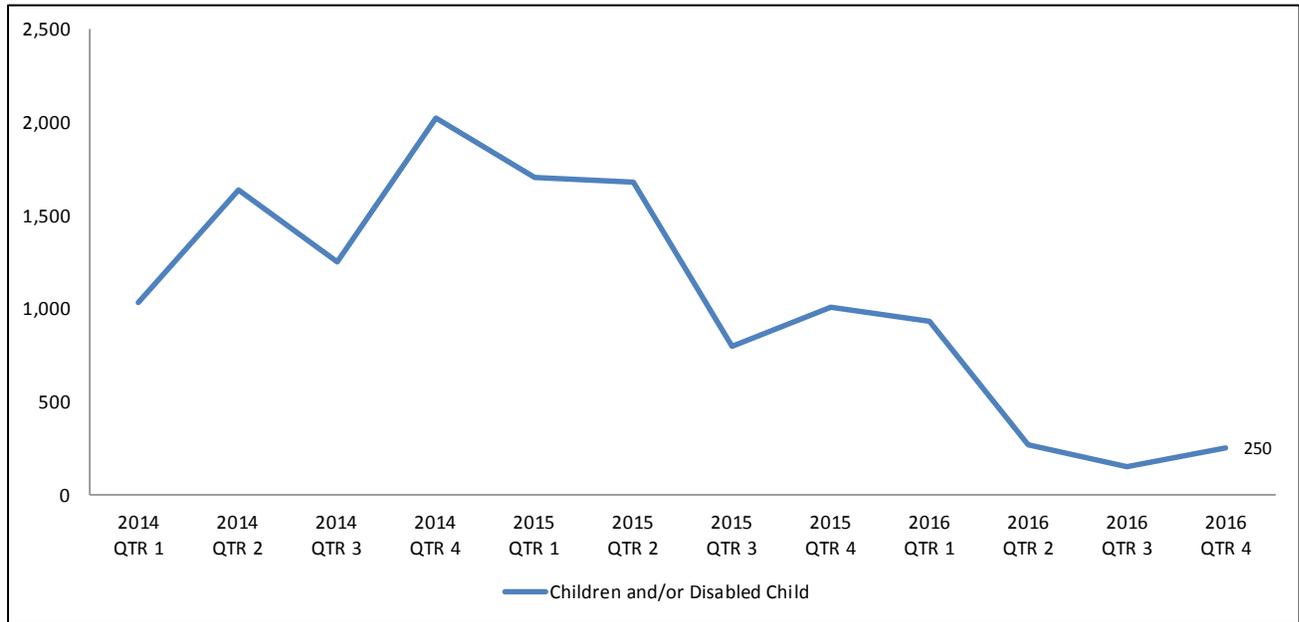
- Due to frequent changes to the FFS population between 2014 and 2016, the utilization over time was not stable and contained sudden changes.
- There were no beneficiaries in the Voluntary for Managed Care category in 2016 (refer to Figure 10). Because most mental health utilization was from this category, utilization rates in 2016 for the overall FFS population decreased considerably from those in 2014.

**Figure 57. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

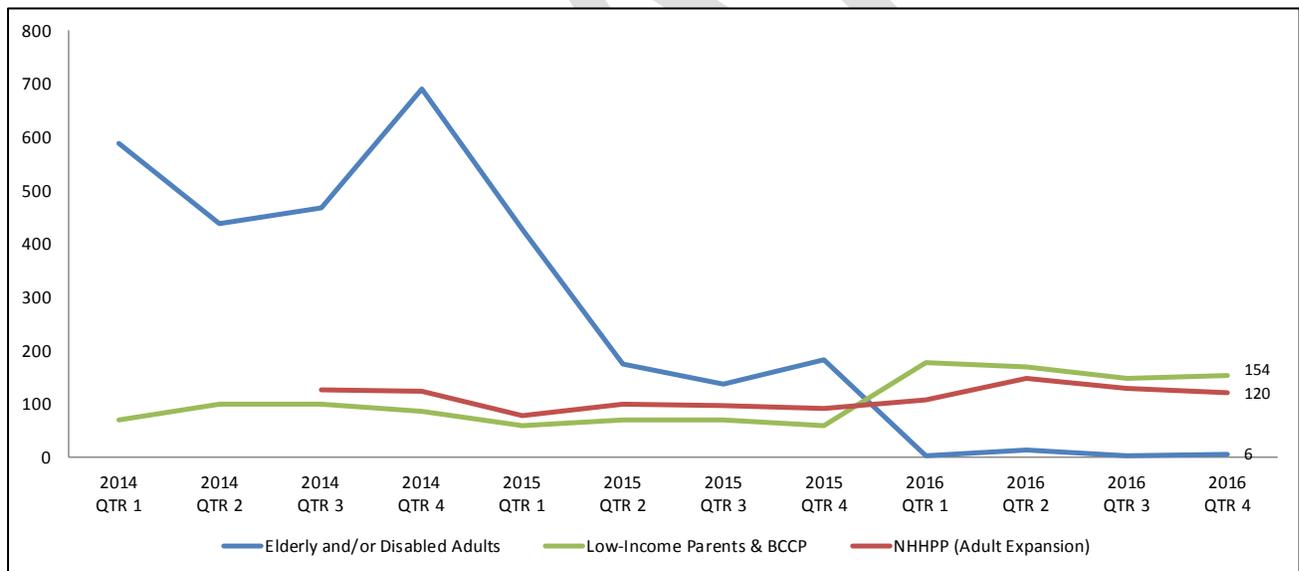


<sup>15</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

**Figure 58. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

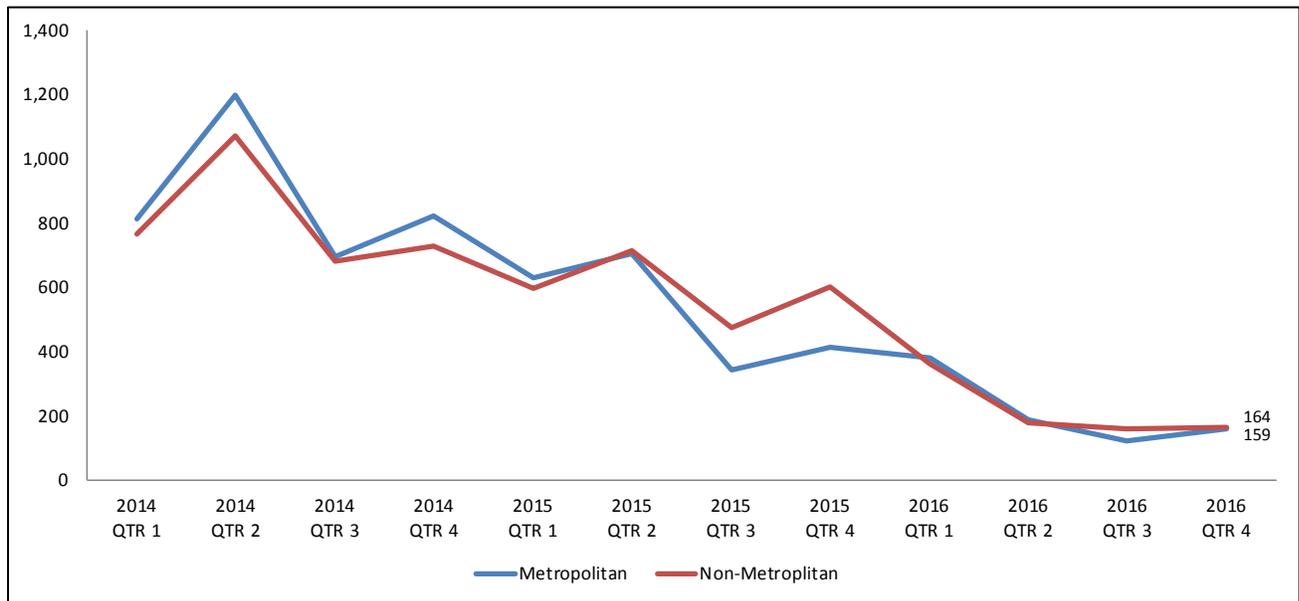


**Figure 59. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

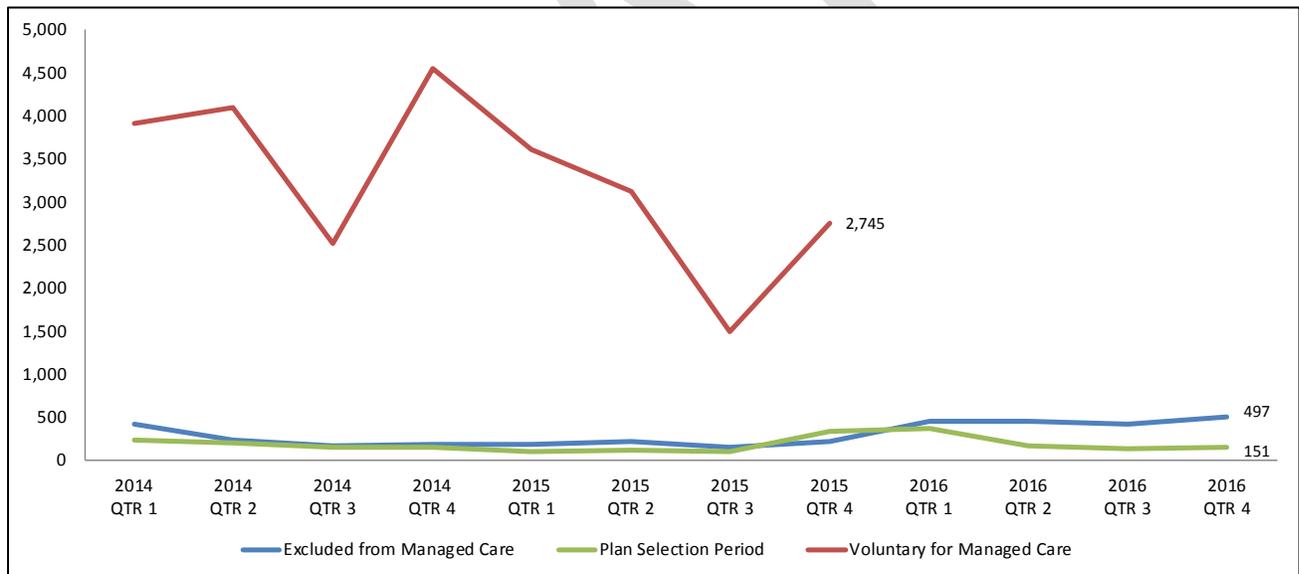


Note: The NHHPP (adult expansion) eligibility group became effective in Quarter 3 of 2014; therefore, no results were presented for the first two quarters of 2014. In addition, the visits from the elderly and/or disabled adults group were less than 30 for all quarters in 2016. Please use caution when interpreting these results.

**Figure 60. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**



**Figure 61. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**



Note: There were no beneficiaries in the Voluntary for Managed Care category in 2016.

## 6. Summary, Conclusion and Efforts to Improve Access

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Ensuring access to care is a priority of the New Hampshire Medicaid program. The foregoing report provides specific data and analysis that establish the 2014 to 2016 access levels for physician services, inpatient and outpatient services.

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

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

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

- **Beneficiary enrollment:** After transitioning to the Medicaid managed care program in December 2013, the size of the FFS population became much smaller and continued to change from 2014 to 2016. This reduction in the FFS population, that continues into 2016, necessitates focus on more recent data for the FFS population than historical data prior to 2013.
- **Provider network:** The majority (75%) of licensed practicing physicians were also active New Hampshire Medicaid providers for the FFS population in 2016. In addition, while the FFS population became much smaller in size, one-third to one-half of the FFS provider types monitored in this report were still servicing the FFS population (i.e., submit at least one claim in Quarter 4 of 2016) for the provider types evaluated in the report.
- **Time/distance analysis:** When applying MCO contract time/distance standards for the primary care providers, pediatricians, and obstetricians/gynecologists to FFS beneficiaries as of May 1, 2017, all FFS beneficiaries met the standard for each of the three types of providers.
- **Beneficiaries to active providers ratio:** The beneficiaries to active primary care providers and pediatricians ratios from CY 2014 to 2016 were much lower than the historical ratios and do not indicate any access to care concerns. These lower ratios are due to the large reduction in the FFS population.
- **Quarterly service utilization:** The 2014 to 2016 FFS population consisted of a considerable amount of Plan Selection Period beneficiaries who stayed in FFS temporarily for a few months and then transitioned to the Medicaid managed care program. These Plan Selection Period beneficiaries generally had lower physician/APRN/clinic utilization, but higher rates of emergency department utilization

for conditions potentially treatable in primary care. However, this may not indicate potential issues for access to care, rather beneficiaries were waiting until managed care enrollment was complete before engaging with primary care providers. DHHS will continue monitoring the rates and will develop new control limits for the new FFS population as the FFS population stabilizes and sufficient data are collected in future access reports.

- Other measures included in this report are beneficiaries to active cardiology, radiology, surgery, and home health provider ratios; and quarterly service utilization from cardiology, radiology, surgery, and home health providers in addition to mental health utilization. Since this is the second time presenting these results, they were presented for informational purposes only and will be used to develop control limits as the FFS population stabilizes and sufficient data are collected in future reports.
- Members from the Voluntary for Managed Care category were required to enroll in managed care beginning February 1, 2016. Because most mental health utilization and home health services was from this category, utilization rates in 2016 for the overall FFS population decreased considerably from those in 2014.

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

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

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## **Current Efforts to Improve Access to Care**

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

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

Recognizing issues surrounding the workforce shortage of health care professionals, including personnel providing substance use disorder services, the Governor created the Commission on Health Care Workforce in April 2016. The Commission brings together experts from nursing, child and elderly care, developmental

and long-term services, the broader health care community, and education to make short- and long-term recommendations on how to resolve the workforce shortage. As part of the Governor's Commission, the Healthcare Task Force will work to engage providers and health systems to prevent and address substance misuse.

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

Additionally, New Hampshire is finalizing the monitoring strategy to comply with the final Medicaid/CHIP parity rule which applies most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to coverage provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs). The strategy will include the evaluation of utilization trends that may indicate access issues or barriers resulting from parity issues between behavioral health and medical services.

New Hampshire continues to semi-annually monitor the Medicaid Managed Care Organization's compliance with network adequacy time and distance standards. The monitoring system will continue to evolve to comply with CMS Managed Care final rules related to network adequacy monitoring that are effective for July 1, 2018. New Hampshire also anticipates the new External Quality Review mandatory activity of validating Managed Care Organization's provider networks. Once CMS protocols have been established, NH will implement the new process as an additional tool to the overall system for monitoring for member access to care.

## 7. Appendices

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## Appendix A: Definitions

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

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

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

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

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

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

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

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

## Appendix B: Tabular Version of Data in Trend Charts

**Figure 6. NH Medicaid Enrollment: Total Population**

Time Period	Average Members
2014 QTR 1	10,068
2014 QTR 2	6,089
2014 QTR 3	6,656
2014 QTR 4	10,486
2015 QTR 1	11,325
2015 QTR 2	8,927
2015 QTR 3	7,594
2015 QTR 4	7,655
2016 QTR 1	8,829
2016 QTR 2	6,900
2016 QTR 3	6,425
2016 QTR 4	7,688

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

Time Period	Average Members
2014 QTR 1	7,159
2014 QTR 2	4,029
2014 QTR 3	3,224
2014 QTR 4	3,577
2015 QTR 1	3,655
2015 QTR 2	3,431
2015 QTR 3	3,254
2015 QTR 4	3,312
2016 QTR 1	2,761
2016 QTR 2	1,858
2016 QTR 3	1,850
2016 QTR 4	2,222

**Figure 8. NH Medicaid Enrollment: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults	Low-Income Parents & BCCP	NHHPP (Adult Expansion)
2014 QTR 1	672	2,237	0
2014 QTR 2	421	1,639	0
2014 QTR 3	375	1,230	1,826
2014 QTR 4	236	1,025	5,648
2015 QTR 1	391	942	6,337
2015 QTR 2	540	803	4,153
2015 QTR 3	516	714	3,110
2015 QTR 4	533	760	3,050
2016 QTR 1	206	1,078	4,784
2016 QTR 2	134	1,337	3,571
2016 QTR 3	115	1,083	3,377
2016 QTR 4	117	1,155	4,194

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

Time Period	Metropolitan	Non-Metropolitan
2014 QTR 1	5,717	4,351
2014 QTR 2	3,497	2,592
2014 QTR 3	3,799	2,856
2014 QTR 4	5,964	4,522
2015 QTR 1	6,427	4,898
2015 QTR 2	5,193	3,734
2015 QTR 3	4,330	3,263
2015 QTR 4	4,412	3,243
2016 QTR 1	5,156	3,673
2016 QTR 2	3,914	2,986
2016 QTR 3	3,734	2,691
2016 QTR 4	4,472	3,217

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

Time Period	Excluded from Managed Care	Plan Selection Period	Voluntary for Managed Care
2014 QTR 1	274	8,264	1,531
2014 QTR 2	183	4,431	1,475
2014 QTR 3	324	4,818	1,513
2014 QTR 4	749	8,214	1,523
2015 QTR 1	640	9,028	1,657
2015 QTR 2	477	6,698	1,752
2015 QTR 3	600	5,364	1,630
2015 QTR 4	373	5,772	1,511
2016 QTR 1	303	8,526	0
2016 QTR 2	256	6,644	0
2016 QTR 3	245	6,180	0
2016 QTR 4	219	7,470	0

**Figure 11. Active NH Medicaid In-State Physician Providers Compared to Licensed Providers With NH Billing Address, 2016**

Geographic Area	Active Medicaid Providers	Active Non-Medicaid Providers
Total In-State	3,152	1,040
Metropolitan	1,723	494
Non-Metropolitan	1,429	546

**Figure 12. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians), CY 2014-2016**

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	1,718	10,068	6	970	5,717	6	748	4,351	6
2014 QTR 2	1,454	6,089	4	832	3,497	4	622	2,592	4
2014 QTR 3	1,654	6,656	4	933	3,799	4	721	2,856	4
2014 QTR 4	1,848	10,486	6	1,040	5,964	6	808	4,522	6
2015 QTR 1	1,809	11,325	6	1,010	6,427	6	799	4,898	6
2015 QTR 2	1,687	8,927	5	963	5,193	5	724	3,734	5
2015 QTR 3	1,493	7,594	5	839	4,330	5	654	3,263	5
2015 QTR 4	1,473	7,655	5	856	4,412	5	617	3,243	5
2016 QTR 1	1,629	8,829	5	951	5,156	5	678	3,673	5
2016 QTR 2	1,559	6,900	4	884	3,914	4	675	2,986	4
2016 QTR 3	1,523	6,425	4	851	3,734	4	672	2,691	4
2016 QTR 4	1,504	7,688	5	871	4,472	5	633	3,217	5

**Figure 13. Ratio of NH Medicaid FFS Child Beneficiaries to Active In-State Pediatricians, CY 2014-2016**

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	0 to 18 Members	Ratio	Providers	0 to 18 Members	Ratio	Providers	0 to 18 Members	Ratio
2014 QTR 1	296	7,159	24	179	4,126	23	117	3,033	26
2014 QTR 2	281	4,029	14	168	2,362	14	113	1,667	15
2014 QTR 3	275	3,224	12	167	1,877	11	108	1,348	12
2014 QTR 4	289	3,577	12	177	2,110	12	112	1,467	13
2015 QTR 1	294	3,655	12	178	2,152	12	116	1,504	13
2015 QTR 2	283	3,431	12	175	2,016	12	108	1,415	13
2015 QTR 3	271	3,254	12	167	1,879	11	104	1,374	13
2015 QTR 4	265	3,312	12	159	1,920	12	106	1,392	13
2016 QTR 1	259	2,761	11	163	1,641	10	96	1,120	12
2016 QTR 2	212	1,858	9	136	1,117	8	76	741	10
2016 QTR 3	231	1,850	8	141	1,081	8	90	769	9
2016 QTR 4	227	2,222	10	143	1,325	9	84	897	11

**Figure 14. Ratio of FFS Deliveries to Active Delivery FFS Providers, CY 2014-2016**

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Deliveries	Ratio	Providers	Deliveries	Ratio	Providers	Deliveries	Ratio
2014 QTR 1	63	83	1.3	37	52	1.4	26	31	1.2
2014 QTR 2	34	41	1.2	19	25	1.3	15	16	1.1
2014 QTR 3	29	36	1.2	15	19	1.3	14	17	1.2
2014 QTR 4	20	22	1.1	9	10	1.1	11	12	1.1
2015 QTR 1	37	41	1.1	14	17	1.2	23	24	1.0
2015 QTR 2	20	21	1.1	9	9	1.0	11	12	1.1
2015 QTR 3	34	39	1.1	24	27	1.1	10	12	1.2
2015 QTR 4	24	24	1.0	8	8	1.0	16	16	1.0
2016 QTR 1	34	36	1.1	22	22	1.0	12	14	1.2
2016 QTR 2	19	23	1.2	10	14	1.4	9	9	1.0
2016 QTR 3	35	38	1.1	21	23	1.1	14	15	1.1
2016 QTR 4	26	32	1.2	15	18	1.2	11	14	1.3

**Figure 15. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Cardiology Providers, CY 2014-2016**

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	83	10,068	121	43	5,717	133	40	4,351	109
2014 QTR 2	61	6,089	100	32	3,497	109	29	2,592	89
2014 QTR 3	85	6,656	78	44	3,799	86	41	2,856	70
2014 QTR 4	98	10,486	107	51	5,964	117	47	4,522	96
2015 QTR 1	89	11,325	127	48	6,427	134	41	4,898	119
2015 QTR 2	91	8,927	98	49	5,193	106	42	3,734	89
2015 QTR 3	95	7,594	80	50	4,330	87	45	3,263	73
2015 QTR 4	77	7,655	99	47	4,412	94	30	3,243	108
2016 QTR 1	91	8,829	97	51	5,156	101	40	3,673	92
2016 QTR 2	91	6,900	76	49	3,914	80	42	2,986	71
2016 QTR 3	95	6,425	68	52	3,734	72	43	2,691	63
2016 QTR 4	91	7,688	84	52	4,472	86	39	3,217	82

**Figure 16. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Radiology Providers, CY 2014-2016**

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	145	10,068	69	69	5,717	83	76	4,351	57
2014 QTR 2	135	6,089	45	66	3,497	53	69	2,592	38
2014 QTR 3	139	6,656	48	66	3,799	58	73	2,856	39
2014 QTR 4	146	10,486	72	69	5,964	86	77	4,522	59
2015 QTR 1	147	11,325	77	69	6,427	93	78	4,898	63
2015 QTR 2	145	8,927	62	73	5,193	71	72	3,734	52
2015 QTR 3	143	7,594	53	76	4,330	57	67	3,263	49
2015 QTR 4	141	7,655	54	73	4,412	60	68	3,243	48
2016 QTR 1	148	8,829	60	79	5,156	65	69	3,673	53
2016 QTR 2	148	6,900	47	75	3,914	52	73	2,986	41
2016 QTR 3	142	6,425	45	73	3,734	51	69	2,691	39
2016 QTR 4	135	7,688	57	65	4,472	69	70	3,217	46

**Figure 17. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Surgery Providers, CY 2014-2016**

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	266	10,068	38	125	5,717	46	141	4,351	31
2014 QTR 2	192	6,089	32	89	3,497	39	103	2,592	25
2014 QTR 3	255	6,656	26	124	3,799	31	131	2,856	22
2014 QTR 4	321	10,486	33	154	5,964	39	167	4,522	27
2015 QTR 1	308	11,325	37	154	6,427	42	154	4,898	32
2015 QTR 2	264	8,927	34	127	5,193	41	137	3,734	27
2015 QTR 3	259	7,594	29	127	4,330	34	132	3,263	25
2015 QTR 4	230	7,655	33	127	4,412	35	103	3,243	31
2016 QTR 1	272	8,829	32	138	5,156	37	134	3,673	27
2016 QTR 2	247	6,900	28	124	3,914	32	123	2,986	24

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2016 QTR 3	273	6,425	24	139	3,734	27	134	2,691	20
2016 QTR 4	258	7,688	30	124	4,472	36	134	3,217	24

**Figure 18. Ratio of NH Medicaid FFS Beneficiaries to Active In-State Home Health Providers, CY 2014-2016**

Time Period	Total			Metropolitan			Non-Metropolitan		
	Providers	Average Members	Ratio	Providers	Average Members	Ratio	Providers	Average Members	Ratio
2014 QTR 1	34	10,068	296	21	5,717	272	13	4,351	335
2014 QTR 2	29	6,089	210	19	3,497	184	10	2,592	259
2014 QTR 3	32	6,656	208	20	3,799	190	12	2,856	238
2014 QTR 4	37	10,486	283	22	5,964	271	15	4,522	301
2015 QTR 1	43	11,325	263	27	6,427	238	16	4,898	306
2015 QTR 2	47	8,927	190	31	5,193	168	16	3,734	233
2015 QTR 3	45	7,594	169	30	4,330	144	15	3,263	218
2015 QTR 4	45	7,655	170	31	4,412	142	14	3,243	232
2016 QTR 1	50	8,829	177	30	5,156	172	20	3,673	184
2016 QTR 2	29	6,900	238	15	3,914	261	14	2,986	213
2016 QTR 3	27	6,425	238	16	3,734	233	11	2,691	245
2016 QTR 4	27	7,688	285	18	4,472	248	9	3,217	357

**Figure 19. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	10,827	30,205	358
2014 QTR 2	6,762	18,267	370
2014 QTR 3	7,089	19,967	355
2014 QTR 4	9,911	31,459	315
2015 QTR 1	9,356	33,975	275
2015 QTR 2	8,138	26,781	304
2015 QTR 3	5,697	22,781	250
2015 QTR 4	5,308	22,966	231
2016 QTR 1	5,467	26,487	206
2016 QTR 2	4,945	20,701	239
2016 QTR 3	4,736	19,275	246
2016 QTR 4	5,217	23,065	226

**Figure 20. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	6,762	21,478	315
2014 QTR 2	4,203	12,088	348
2014 QTR 3	3,424	9,673	354
2014 QTR 4	3,751	10,731	350
2015 QTR 1	3,825	10,966	349
2015 QTR 2	3,664	10,292	356
2015 QTR 3	2,626	9,761	269
2015 QTR 4	2,820	9,936	284
2016 QTR 1	1,822	8,282	220
2016 QTR 2	1,112	5,574	199
2016 QTR 3	1,142	5,549	206
2016 QTR 4	1,295	6,666	194

**Figure 21. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,233	2,015	612	2,832	6,712	422	0	0	—

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 2	716	1,262	567	1,843	4,917	375	0	0	—
2014 QTR 3	665	1,125	591	1,373	3,690	372	1,627	5,479	297
2014 QTR 4	348	709	491	1,105	3,075	359	4,707	16,944	278
2015 QTR 1	276	1,173	235	1,060	2,825	375	4,195	19,011	221
2015 QTR 2	371	1,621	229	917	2,410	380	3,186	12,458	256
2015 QTR 3	223	1,547	144	639	2,143	298	2,209	9,330	237
2015 QTR 4	223	1,600	139	525	2,279	230	1,740	9,151	190
2016 QTR 1	32	619	52	908	3,233	281	2,705	14,353	188
2016 QTR 2	23	402	57	1,110	4,011	277	2,700	10,714	252
2016 QTR 3	33	346	95	1,005	3,249	309	2,556	10,131	252
2016 QTR 4	39	350	111	925	3,466	267	2,958	12,583	235

**Figure 22. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	6,649	17,151	388	4,178	13,054	320
2014 QTR 2	4,159	10,492	396	2,603	7,775	335
2014 QTR 3	4,335	11,398	380	2,754	8,569	321
2014 QTR 4	6,146	17,892	344	3,765	13,567	278
2015 QTR 1	5,648	19,282	293	3,708	14,693	252
2015 QTR 2	5,124	15,579	329	3,014	11,202	269
2015 QTR 3	3,433	12,991	264	2,264	9,790	231
2015 QTR 4	3,216	13,237	243	2,092	9,729	215
2016 QTR 1	3,162	15,467	204	2,305	11,020	209
2016 QTR 2	2,819	11,743	240	2,126	8,958	237
2016 QTR 3	2,770	11,203	247	1,966	8,072	244
2016 QTR 4	2,951	13,415	220	2,266	9,650	235

**Figure 23. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	690	822	839	7,669	24,791	309	2,468	4,592	537
2014 QTR 2	392	550	713	3,968	13,293	299	2,402	4,424	543
2014 QTR 3	496	972	510	4,390	14,455	304	2,203	4,540	485
2014 QTR 4	635	2,248	282	7,014	24,642	285	2,262	4,569	495
2015 QTR 1	520	1,920	271	6,558	27,084	242	2,278	4,971	458
2015 QTR 2	425	1,432	297	5,446	20,093	271	2,267	5,256	431
2015 QTR 3	490	1,799	272	3,631	16,091	226	1,576	4,891	322
2015 QTR 4	274	1,118	245	4,384	20,212	217	650	1,636	397
2016 QTR 1	293	910	322	5,174	25,577	202	0	0	—
2016 QTR 2	258	768	336	4,687	19,933	235	0	0	—
2016 QTR 3	292	734	398	4,444	18,541	240	0	0	—
2016 QTR 4	193	656	294	5,024	22,409	224	0	0	—

**Figure 24. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	453	30,205	15
2014 QTR 2	233	18,267	13
2014 QTR 3	339	19,967	17
2014 QTR 4	414	31,459	13
2015 QTR 1	385	33,975	11
2015 QTR 2	298	26,781	11
2015 QTR 3	226	22,781	10
2015 QTR 4	196	22,966	9
2016 QTR 1	227	26,487	9
2016 QTR 2	191	20,701	9
2016 QTR 3	153	19,275	8

Time Period	Visits	Member Months	Rate per 1,000
2016 QTR 4	188	23,065	8

**Figure 25. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	274	21,478	13
2014 QTR 2	121	12,088	10
2014 QTR 3	110	9,673	11
2014 QTR 4	139	10,731	13
2015 QTR 1	134	10,966	12
2015 QTR 2	111	10,292	11
2015 QTR 3	68	9,761	7
2015 QTR 4	84	9,936	8
2016 QTR 1	58	8,282	7
2016 QTR 2	36	5,574	6
2016 QTR 3	34	5,549	6
2016 QTR 4	47	6,666	7

**Figure 26. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	61	2,015	30	118	6,712	18	0	0	—
2014 QTR 2	30	1,262	24	82	4,917	17	0	0	—
2014 QTR 3	38	1,125	34	76	3,690	21	115	5,479	21
2014 QTR 4	13	709	18	41	3,075	13	221	16,944	13
2015 QTR 1	17	1,173	14	31	2,825	11	203	19,011	11
2015 QTR 2	17	1,621	10	28	2,410	12	142	12,458	11
2015 QTR 3	10	1,547	6	22	2,143	10	126	9,330	14
2015 QTR 4	10	1,600	6	25	2,279	11	77	9,151	8
2016 QTR 1	2	619	3	29	3,233	9	138	14,353	10
2016 QTR 2	0	402	0	42	4,011	10	113	10,714	11
2016 QTR 3	1	346	3	26	3,249	8	92	10,131	9
2016 QTR 4	2	350	6	28	3,466	8	111	12,583	9

**Figure 27. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	254	17,151	15	199	13,054	15
2014 QTR 2	147	10,492	14	86	7,775	11
2014 QTR 3	208	11,398	18	131	8,569	15
2014 QTR 4	251	17,892	14	163	13,567	12
2015 QTR 1	240	19,282	12	145	14,693	10
2015 QTR 2	194	15,579	12	104	11,202	9
2015 QTR 3	128	12,991	10	98	9,790	10
2015 QTR 4	122	13,237	9	74	9,729	8
2016 QTR 1	151	15,467	10	76	11,020	7
2016 QTR 2	124	11,743	11	67	8,958	7
2016 QTR 3	102	11,203	9	51	8,072	6
2016 QTR 4	118	13,415	9	70	9,650	7

**Figure 28. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	24	822	29	367	24,791	15	62	4,592	14

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 2	13	550	24	170	13,293	13	50	4,424	11
2014 QTR 3	17	972	17	268	14,455	19	54	4,540	12
2014 QTR 4	25	2,248	11	335	24,642	14	54	4,569	12
2015 QTR 1	19	1,920	10	303	27,084	11	63	4,971	13
2015 QTR 2	9	1,432	6	241	20,093	12	48	5,256	9
2015 QTR 3	17	1,799	9	172	16,091	11	37	4,891	8
2015 QTR 4	8	1,118	7	180	20,212	9	8	1,636	5
2016 QTR 1	7	910	8	220	25,577	9	0	0	—
2016 QTR 2	6	768	8	185	19,933	9	0	0	—
2016 QTR 3	9	734	12	144	18,541	8	0	0	—
2016 QTR 4	5	656	8	183	22,409	8	0	0	—

**Figure 29. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	2,000	30,205	66
2014 QTR 2	1,210	18,267	66
2014 QTR 3	1,672	19,967	84
2014 QTR 4	2,356	31,459	75
2015 QTR 1	1,964	33,975	58
2015 QTR 2	1,869	26,781	70
2015 QTR 3	1,473	22,781	65
2015 QTR 4	1,321	22,966	58
2016 QTR 1	1,609	26,487	61
2016 QTR 2	1,549	20,701	75
2016 QTR 3	1,577	19,275	82
2016 QTR 4	1,466	23,065	64

**Figure 30. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,002	21,478	47
2014 QTR 2	564	12,088	47
2014 QTR 3	469	9,673	48
2014 QTR 4	586	10,731	55
2015 QTR 1	562	10,966	51
2015 QTR 2	534	10,292	52
2015 QTR 3	407	9,761	42
2015 QTR 4	423	9,936	43
2016 QTR 1	351	8,282	42
2016 QTR 2	218	5,574	39
2016 QTR 3	219	5,549	39
2016 QTR 4	213	6,666	32

**Figure 31. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	325	2,015	161	673	6,712	100	0	0	—
2014 QTR 2	176	1,262	139	470	4,917	96	0	0	—
2014 QTR 3	203	1,125	180	422	3,690	114	578	5,479	105
2014 QTR 4	107	709	151	299	3,075	97	1,364	16,944	81
2015 QTR 1	95	1,173	81	233	2,825	82	1,074	19,011	56
2015 QTR 2	140	1,621	86	231	2,410	96	964	12,458	77
2015 QTR 3	94	1,547	61	213	2,143	99	759	9,330	81
2015 QTR 4	79	1,600	49	197	2,279	86	622	9,151	68
2016 QTR 1	11	619	18	288	3,233	89	959	14,353	67
2016 QTR 2	4	402	10	414	4,011	103	913	10,714	85
2016 QTR 3	7	346	20	384	3,249	118	967	10,131	95
2016 QTR 4	5	350	14	303	3,466	87	945	12,583	75

**Figure 32. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,115	17,151	65	885	13,054	68
2014 QTR 2	739	10,492	70	471	7,775	61
2014 QTR 3	1,002	11,398	88	670	8,569	78
2014 QTR 4	1,457	17,892	81	899	13,567	66
2015 QTR 1	1,209	19,282	63	755	14,693	51
2015 QTR 2	1,135	15,579	73	734	11,202	66
2015 QTR 3	821	12,991	63	652	9,790	67
2015 QTR 4	802	13,237	61	519	9,729	53
2016 QTR 1	990	15,467	64	619	11,020	56
2016 QTR 2	909	11,743	77	640	8,958	71
2016 QTR 3	928	11,203	83	649	8,072	80
2016 QTR 4	899	13,415	67	567	9,650	59

**Figure 33. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	133	822	162	1,557	24,791	63	310	4,592	68
2014 QTR 2	73	550	133	852	13,293	64	285	4,424	64
2014 QTR 3	86	972	88	1,308	14,455	90	278	4,540	61
2014 QTR 4	113	2,248	50	1,935	24,642	79	308	4,569	67
2015 QTR 1	89	1,920	46	1,560	27,084	58	315	4,971	63
2015 QTR 2	79	1,432	55	1,500	20,093	75	290	5,256	55
2015 QTR 3	98	1,799	54	1,140	16,091	71	235	4,891	48
2015 QTR 4	75	1,118	67	1,164	20,212	58	82	1,636	50
2016 QTR 1	62	910	68	1,547	25,577	60	0	0	—
2016 QTR 2	70	768	91	1,479	19,933	74	0	0	—
2016 QTR 3	72	734	98	1,505	18,541	81	0	0	—
2016 QTR 4	49	656	75	1,417	22,409	63	0	0	—

**Figure 34. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	24	30,205	0.8
2014 QTR 2	15	18,267	0.8
2014 QTR 3	12	19,967	0.6
2014 QTR 4	17	31,459	0.5
2015 QTR 1	15	33,975	0.4
2015 QTR 2	10	26,781	0.4
2015 QTR 3	7	22,781	0.3
2015 QTR 4	14	22,966	0.6
2016 QTR 1	12	26,487	0.5
2016 QTR 2	6	20,701	0.3
2016 QTR 3	2	19,275	0.1
2016 QTR 4	14	23,065	0.6

**Figure 35. Inpatient Hospital Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

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

Time Period	Visits	Member Months	Rate per 1,000
2015 QTR 4	237	22,966	10
2016 QTR 1	264	26,487	10
2016 QTR 2	315	20,701	15
2016 QTR 3	207	19,275	11
2016 QTR 4	238	23,065	10

Note: excludes maternity and newborns

**Figure 36. Inpatient Hospital Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	47	822	57	162	24,791	7	70	4,592	15
2014 QTR 2	21	550	38	68	13,293	5	74	4,424	17
2014 QTR 3	25	972	26	144	14,455	10	73	4,540	16
2014 QTR 4	24	2,248	11	253	24,642	10	72	4,569	16
2015 QTR 1	17	1,920	9	207	27,084	8	82	4,971	16
2015 QTR 2	16	1,432	11	184	20,093	9	66	5,256	13
2015 QTR 3	23	1,799	13	142	16,091	9	54	4,891	11
2015 QTR 4	28	1,118	25	187	20,212	9	22	1,636	13
2016 QTR 1	22	910	24	242	25,577	9	0	0	—
2016 QTR 2	14	768	18	301	19,933	15	0	0	—
2016 QTR 3	21	734	29	186	18,541	10	0	0	—
2016 QTR 4	21	656	32	217	22,409	10	0	0	—

**Figure 37. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	458	30,205	15
2014 QTR 2	300	18,267	16
2014 QTR 3	457	19,967	23
2014 QTR 4	725	31,459	23
2015 QTR 1	683	33,975	20
2015 QTR 2	527	26,781	20
2015 QTR 3	441	22,781	19
2015 QTR 4	379	22,966	17
2016 QTR 1	481	26,487	18
2016 QTR 2	501	20,701	24
2016 QTR 3	449	19,275	23
2016 QTR 4	404	23,065	18

**Figure 38. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	145	21,478	7
2014 QTR 2	154	12,088	13
2014 QTR 3	112	9,673	12
2014 QTR 4	161	10,731	15
2015 QTR 1	188	10,966	17
2015 QTR 2	99	10,292	10
2015 QTR 3	64	9,761	7
2015 QTR 4	82	9,936	8
2016 QTR 1	41	8,282	5
2016 QTR 2	36	5,574	6
2016 QTR 3	27	5,549	5
2016 QTR 4	14	6,666	2

**Figure 39. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Elderly and/or Disabled Adults	Low-Income Parents & BCCP	NHHP (Adult Expansion)
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Time Period	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	198	2,015	98	115	6,712	17	0	0	—
2014 QTR 2	78	1,262	62	68	4,917	14	0	0	—
2014 QTR 3	78	1,125	69	93	3,690	25	174	5,479	32
2014 QTR 4	45	709	63	47	3,075	15	472	16,944	28
2015 QTR 1	43	1,173	37	48	2,825	17	404	19,011	21
2015 QTR 2	63	1,621	39	43	2,410	18	322	12,458	26
2015 QTR 3	65	1,547	42	36	2,143	17	276	9,330	30
2015 QTR 4	47	1,600	29	31	2,279	14	219	9,151	24
2016 QTR 1	6	619	10	76	3,233	24	358	14,353	25
2016 QTR 2	4	402	10	111	4,011	28	350	10,714	33
2016 QTR 3	14	346	40	69	3,249	21	339	10,131	33
2016 QTR 4	3	350	9	74	3,466	21	313	12,583	25

**Figure 40. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	268	17,151	16	190	13,054	15
2014 QTR 2	169	10,492	16	131	7,775	17
2014 QTR 3	246	11,398	22	211	8,569	25
2014 QTR 4	426	17,892	24	299	13,567	22
2015 QTR 1	349	19,282	18	334	14,693	23
2015 QTR 2	325	15,579	21	202	11,202	18
2015 QTR 3	212	12,991	16	229	9,790	23
2015 QTR 4	221	13,237	17	158	9,729	16
2016 QTR 1	299	15,467	19	182	11,020	17
2016 QTR 2	268	11,743	23	233	8,958	26
2016 QTR 3	269	11,203	24	180	8,072	22
2016 QTR 4	218	13,415	16	186	9,650	19

**Figure 41. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	92	822	112	259	24,791	10	107	4,592	23
2014 QTR 2	42	550	76	135	13,293	10	123	4,424	28
2014 QTR 3	63	972	65	295	14,455	20	99	4,540	22
2014 QTR 4	39	2,248	17	546	24,642	22	140	4,569	31
2015 QTR 1	56	1,920	29	468	27,084	17	159	4,971	32
2015 QTR 2	35	1,432	24	414	20,093	21	78	5,256	15
2015 QTR 3	65	1,799	36	321	16,091	20	55	4,891	11
2015 QTR 4	50	1,118	45	290	20,212	14	39	1,636	24
2016 QTR 1	48	910	53	433	25,577	17	0	0	—
2016 QTR 2	26	768	34	475	19,933	24	0	0	—
2016 QTR 3	32	734	44	417	18,541	22	0	0	—
2016 QTR 4	26	656	40	378	22,409	17	0	0	—

**Figure 42. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	2,549	30,205	84
2014 QTR 2	1,586	18,267	87
2014 QTR 3	2,090	19,967	105
2014 QTR 4	2,931	31,459	93
2015 QTR 1	2,624	33,975	77
2015 QTR 2	2,110	26,781	79
2015 QTR 3	1,677	22,781	74
2015 QTR 4	1,611	22,966	70
2016 QTR 1	2,016	26,487	76
2016 QTR 2	1,949	20,701	94
2016 QTR 3	1,794	19,275	93

Time Period	Visits	Member Months	Rate per 1,000
2016 QTR 4	1,882	23,065	82

**Figure 43. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,064	21,478	50
2014 QTR 2	713	12,088	59
2014 QTR 3	584	9,673	60
2014 QTR 4	696	10,731	65
2015 QTR 1	611	10,966	56
2015 QTR 2	507	10,292	49
2015 QTR 3	427	9,761	44
2015 QTR 4	508	9,936	51
2016 QTR 1	323	8,282	39
2016 QTR 2	187	5,574	34
2016 QTR 3	194	5,549	35
2016 QTR 4	192	6,666	29

**Figure 44. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	509	2,015	253	976	6,712	145	0	0	—
2014 QTR 2	277	1,262	219	596	4,917	121	0	0	—
2014 QTR 3	365	1,125	324	501	3,690	136	640	5,479	117
2014 QTR 4	180	709	254	408	3,075	133	1,647	16,944	97
2015 QTR 1	96	1,173	82	375	2,825	133	1,542	19,011	81
2015 QTR 2	138	1,621	85	278	2,410	115	1,187	12,458	95
2015 QTR 3	101	1,547	65	213	2,143	99	936	9,330	100
2015 QTR 4	115	1,600	72	216	2,279	95	772	9,151	84
2016 QTR 1	26	619	42	405	3,233	125	1,262	14,353	88
2016 QTR 2	20	402	50	494	4,011	123	1,248	10,714	116
2016 QTR 3	18	346	52	440	3,249	135	1,142	10,131	113
2016 QTR 4	16	350	46	387	3,466	112	1,287	12,583	102

**Figure 45. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,422	17,151	83	1,127	13,054	86
2014 QTR 2	949	10,492	90	637	7,775	82
2014 QTR 3	1,203	11,398	106	887	8,569	104
2014 QTR 4	1,819	17,892	102	1,112	13,567	82
2015 QTR 1	1,498	19,282	78	1,126	14,693	77
2015 QTR 2	1,245	15,579	80	865	11,202	77
2015 QTR 3	892	12,991	69	785	9,790	80
2015 QTR 4	948	13,237	72	663	9,729	68
2016 QTR 1	1,179	15,467	76	837	11,020	76
2016 QTR 2	1,119	11,743	95	830	8,958	93
2016 QTR 3	1,101	11,203	98	693	8,072	86
2016 QTR 4	1,160	13,415	86	722	9,650	75

**Figure 46. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	265	822	322	1,791	24,791	72	493	4,592	107
2014 QTR 2	178	550	324	875	13,293	66	533	4,424	120
2014 QTR 3	196	972	202	1,435	14,455	99	459	4,540	101

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 4	214	2,248	95	2,207	24,642	90	510	4,569	112
2015 QTR 1	166	1,920	86	1,995	27,084	74	463	4,971	93
2015 QTR 2	130	1,432	91	1,597	20,093	79	383	5,256	73
2015 QTR 3	148	1,799	82	1,200	16,091	75	329	4,891	67
2015 QTR 4	103	1,118	92	1,372	20,212	68	136	1,636	83
2016 QTR 1	125	910	137	1,891	25,577	74	0	0	—
2016 QTR 2	116	768	151	1,833	19,933	92	0	0	—
2016 QTR 3	177	734	241	1,617	18,541	87	0	0	—
2016 QTR 4	89	656	136	1,793	22,409	80	0	0	—

**Figure 47. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	963	30,205	32
2014 QTR 2	648	18,267	35
2014 QTR 3	884	19,967	44
2014 QTR 4	1,205	31,459	38
2015 QTR 1	1,166	33,975	34
2015 QTR 2	971	26,781	36
2015 QTR 3	827	22,781	36
2015 QTR 4	726	22,966	32
2016 QTR 1	863	26,487	33
2016 QTR 2	821	20,701	40
2016 QTR 3	856	19,275	44
2016 QTR 4	1,110	23,065	48

**Figure 48. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	464	21,478	22
2014 QTR 2	332	12,088	27
2014 QTR 3	325	9,673	34
2014 QTR 4	286	10,731	27
2015 QTR 1	295	10,966	27
2015 QTR 2	272	10,292	26
2015 QTR 3	258	9,761	26
2015 QTR 4	242	9,936	24
2016 QTR 1	131	8,282	16
2016 QTR 2	55	5,574	10
2016 QTR 3	83	5,549	15
2016 QTR 4	98	6,666	15

**Figure 49. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	232	2,015	115	267	6,712	40	0	0	—
2014 QTR 2	135	1,262	107	181	4,917	37	0	0	—
2014 QTR 3	158	1,125	140	132	3,690	36	269	5,479	49
2014 QTR 4	50	709	71	130	3,075	42	739	16,944	44
2015 QTR 1	28	1,173	24	79	2,825	28	764	19,011	40
2015 QTR 2	52	1,621	32	76	2,410	32	571	12,458	46
2015 QTR 3	54	1,547	35	66	2,143	31	449	9,330	48
2015 QTR 4	38	1,600	24	71	2,279	31	375	9,151	41
2016 QTR 1	11	619	18	140	3,233	43	581	14,353	40
2016 QTR 2	3	402	7	140	4,011	35	623	10,714	58
2016 QTR 3	9	346	26	198	3,249	61	566	10,131	56
2016 QTR 4	5	350	14	191	3,466	55	816	12,583	65

**Figure 50. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	474	17,151	28	489	13,054	37
2014 QTR 2	359	10,492	34	289	7,775	37
2014 QTR 3	479	11,398	42	405	8,569	47
2014 QTR 4	718	17,892	40	487	13,567	36
2015 QTR 1	617	19,282	32	549	14,693	37
2015 QTR 2	573	15,579	37	398	11,202	36
2015 QTR 3	450	12,991	35	377	9,790	39
2015 QTR 4	437	13,237	33	289	9,729	30
2016 QTR 1	504	15,467	33	359	11,020	33
2016 QTR 2	377	11,743	32	444	8,958	50
2016 QTR 3	430	11,203	38	426	8,072	53
2016 QTR 4	424	13,415	32	686	9,650	71

**Figure 51. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	146	822	178	579	24,791	23	238	4,592	52
2014 QTR 2	99	550	180	304	13,293	23	245	4,424	55
2014 QTR 3	82	972	84	552	14,455	38	250	4,540	55
2014 QTR 4	91	2,248	40	910	24,642	37	204	4,569	45
2015 QTR 1	90	1,920	47	847	27,084	31	229	4,971	46
2015 QTR 2	79	1,432	55	677	20,093	34	215	5,256	41
2015 QTR 3	97	1,799	54	523	16,091	33	207	4,891	42
2015 QTR 4	68	1,118	61	596	20,212	29	62	1,636	38
2016 QTR 1	38	910	42	825	25,577	32	0	0	—
2016 QTR 2	46	768	60	775	19,933	39	0	0	—
2016 QTR 3	78	734	106	778	18,541	42	0	0	—
2016 QTR 4	45	656	69	1,065	22,409	48	0	0	—

**Figure 52. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	6,464	30,205	214
2014 QTR 2	6,601	18,267	361
2014 QTR 3	6,549	19,967	328
2014 QTR 4	6,530	31,459	208
2015 QTR 1	6,027	33,975	177
2015 QTR 2	6,645	26,781	248
2015 QTR 3	5,187	22,781	228
2015 QTR 4	5,031	22,966	219
2016 QTR 1	2,131	26,487	80
2016 QTR 2	884	20,701	43
2016 QTR 3	1,022	19,275	53
2016 QTR 4	901	23,065	39

**Figure 53. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	5,750	21,478	268
2014 QTR 2	6,094	12,088	504
2014 QTR 3	5,956	9,673	616
2014 QTR 4	5,685	10,731	530
2015 QTR 1	4,662	10,966	425
2015 QTR 2	4,659	10,292	453
2015 QTR 3	3,738	9,761	383
2015 QTR 4	3,651	9,936	367
2016 QTR 1	975	8,282	118

Time Period	Visits	Member Months	Rate per 1,000
2016 QTR 2	50	5,574	9
2016 QTR 3	73	5,549	13
2016 QTR 4	80	6,666	12

**Figure 54. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	599	2,015	297	115	6,712	17	0	0	—
2014 QTR 2	439	1,262	348	68	4,917	14	0	0	—
2014 QTR 3	430	1,125	382	17	3,690	5	146	5,479	27
2014 QTR 4	394	709	556	49	3,075	16	402	16,944	24
2015 QTR 1	926	1,173	789	58	2,825	21	381	19,011	20
2015 QTR 2	1,457	1,621	899	33	2,410	14	496	12,458	40
2015 QTR 3	1,103	1,547	713	27	2,143	13	319	9,330	34
2015 QTR 4	1,013	1,600	633	25	2,279	11	342	9,151	37
2016 QTR 1	421	619	680	436	3,233	135	299	14,353	21
2016 QTR 2	157	402	391	315	4,011	79	362	10,714	34
2016 QTR 3	229	346	662	301	3,249	93	419	10,131	41
2016 QTR 4	158	350	451	325	3,466	94	338	12,583	27

**Figure 55. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	4,821	17,151	281	1,643	13,054	126
2014 QTR 2	4,904	10,492	467	1,697	7,775	218
2014 QTR 3	5,016	11,398	440	1,533	8,569	179
2014 QTR 4	4,907	17,892	274	1,623	13,567	120
2015 QTR 1	4,594	19,282	238	1,433	14,693	98
2015 QTR 2	5,333	15,579	342	1,312	11,202	117
2015 QTR 3	3,923	12,991	302	1,264	9,790	129
2015 QTR 4	3,895	13,237	294	1,136	9,729	117
2016 QTR 1	1,535	15,467	99	596	11,020	54
2016 QTR 2	576	11,743	49	308	8,958	34
2016 QTR 3	750	11,203	67	272	8,072	34
2016 QTR 4	642	13,415	48	259	9,650	27

**Figure 56. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	326	822	397	616	24,791	25	5,522	4,592	1,203
2014 QTR 2	233	550	424	252	13,293	19	6,116	4,424	1,382
2014 QTR 3	181	972	186	268	14,455	19	6,100	4,540	1,344
2014 QTR 4	169	2,248	75	614	24,642	25	5,747	4,569	1,258
2015 QTR 1	251	1,920	131	602	27,084	22	5,174	4,971	1,041
2015 QTR 2	266	1,432	186	594	20,093	30	5,785	5,256	1,101
2015 QTR 3	189	1,799	105	349	16,091	22	4,649	4,891	951
2015 QTR 4	171	1,118	153	3,208	20,212	159	1,652	1,636	1,010
2016 QTR 1	234	910	257	1,897	25,577	74	0	0	—
2016 QTR 2	229	768	298	655	19,933	33	0	0	—
2016 QTR 3	274	734	373	748	18,541	40	0	0	—
2016 QTR 4	225	656	343	676	22,409	30	0	0	—

**Figure 57. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Total Population**

Time Period	Visits	Member Months	Rate per 1,000
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Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	23,905	30,205	791
2014 QTR 2	20,886	18,267	1,143
2014 QTR 3	13,727	19,967	687
2014 QTR 4	24,587	31,459	782
2015 QTR 1	20,864	33,975	614
2015 QTR 2	18,985	26,781	709
2015 QTR 3	9,068	22,781	398
2015 QTR 4	11,322	22,966	493
2016 QTR 1	9,888	26,487	373
2016 QTR 2	3,772	20,701	182
2016 QTR 3	2,626	19,275	136
2016 QTR 4	3,717	23,065	161

**Figure 58. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Children and/or Disabled Child**

Time Period	Visits	Member Months	Rate per 1,000
2014 QTR 1	22,252	21,478	1,036
2014 QTR 2	19,839	12,088	1,641
2014 QTR 3	12,136	9,673	1,255
2014 QTR 4	21,755	10,731	2,027
2015 QTR 1	18,730	10,966	1,708
2015 QTR 2	17,284	10,292	1,679
2015 QTR 3	7,801	9,761	799
2015 QTR 4	10,053	9,936	1,012
2016 QTR 1	7,751	8,282	936
2016 QTR 2	1,510	5,574	271
2016 QTR 3	836	5,549	151
2016 QTR 4	1,666	6,666	250

**Figure 59. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Adults by Eligibility Group**

Time Period	Elderly and/or Disabled Adults			Low-Income Parents & BCCP			NHHPP (Adult Expansion)		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	1,185	2,015	588	468	6,712	70	0	0	—
2014 QTR 2	553	1,262	438	494	4,917	100	0	0	—
2014 QTR 3	525	1,125	467	367	3,690	99	699	5,479	128
2014 QTR 4	490	709	691	266	3,075	87	2,076	16,944	123
2015 QTR 1	501	1,173	427	169	2,825	60	1,464	19,011	77
2015 QTR 2	282	1,621	174	169	2,410	70	1,250	12,458	100
2015 QTR 3	212	1,547	137	151	2,143	70	904	9,330	97
2015 QTR 4	293	1,600	183	138	2,279	61	838	9,151	92
2016 QTR 1	2	619	3	571	3,233	177	1,564	14,353	109
2016 QTR 2	6	402	15	675	4,011	168	1,581	10,714	148
2016 QTR 3	1	346	3	477	3,249	147	1,312	10,131	130
2016 QTR 4	2	350	6	533	3,466	154	1,516	12,583	120

**Figure 60. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	13,947	17,151	813	9,958	13,054	763
2014 QTR 2	12,553	10,492	1,196	8,333	7,775	1,072
2014 QTR 3	7,906	11,398	694	5,821	8,569	679
2014 QTR 4	14,714	17,892	822	9,873	13,567	728
2015 QTR 1	12,103	19,282	628	8,761	14,693	596
2015 QTR 2	10,984	15,579	705	8,001	11,202	714
2015 QTR 3	4,426	12,991	341	4,642	9,790	474
2015 QTR 4	5,489	13,237	415	5,833	9,729	600
2016 QTR 1	5,907	15,467	382	3,981	11,020	361
2016 QTR 2	2,203	11,743	188	1,569	8,958	175
2016 QTR 3	1,341	11,203	120	1,285	8,072	159
2016 QTR 4	2,133	13,415	159	1,584	9,650	164

**Figure 61. Mental Health Utilization per 1,000 NH Medicaid FFS Beneficiary Months, CY 2014-2016:  
Excluded from Managed Care, Plan Selection Period, and Voluntary for Managed Care**

Time Period	Excluded from Managed Care			Plan Selection Period			Voluntary for Managed Care		
	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000	Visits	Member Months	Rate per 1,000
2014 QTR 1	339	822	412	5,644	24,791	228	17,922	4,592	3,903
2014 QTR 2	131	550	238	2,687	13,293	202	18,068	4,424	4,084
2014 QTR 3	166	972	171	2,134	14,455	148	11,427	4,540	2,517
2014 QTR 4	391	2,248	174	3,461	24,642	140	20,735	4,569	4,538
2015 QTR 1	338	1,920	176	2,611	27,084	96	17,915	4,971	3,604
2015 QTR 2	304	1,432	212	2,316	20,093	115	16,365	5,256	3,114
2015 QTR 3	270	1,799	150	1,532	16,091	95	7,266	4,891	1,486
2015 QTR 4	248	1,118	222	6,583	20,212	326	4,491	1,636	2,745
2016 QTR 1	408	910	448	9,480	25,577	371	0	0	—
2016 QTR 2	342	768	445	3,430	19,933	172	0	0	—
2016 QTR 3	300	734	409	2,326	18,541	125	0	0	—
2016 QTR 4	326	656	497	3,391	22,409	151	0	0	—

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## Appendix C: Summary of Public Comments

The Monitoring Access to Care Plan for New Hampshire’s Fee-for-Service Medicaid Medical Services Program was posted for public comment on the New Hampshire Department of Health and Human Services website from August 23, 2017 until September 22, 2017. The plan was also submitted to the NH’s Medicaid Medical Care Advisory Committee (MCAC).

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