



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

New Hampshire Department of Health and Human Services  
August 16, 2019

*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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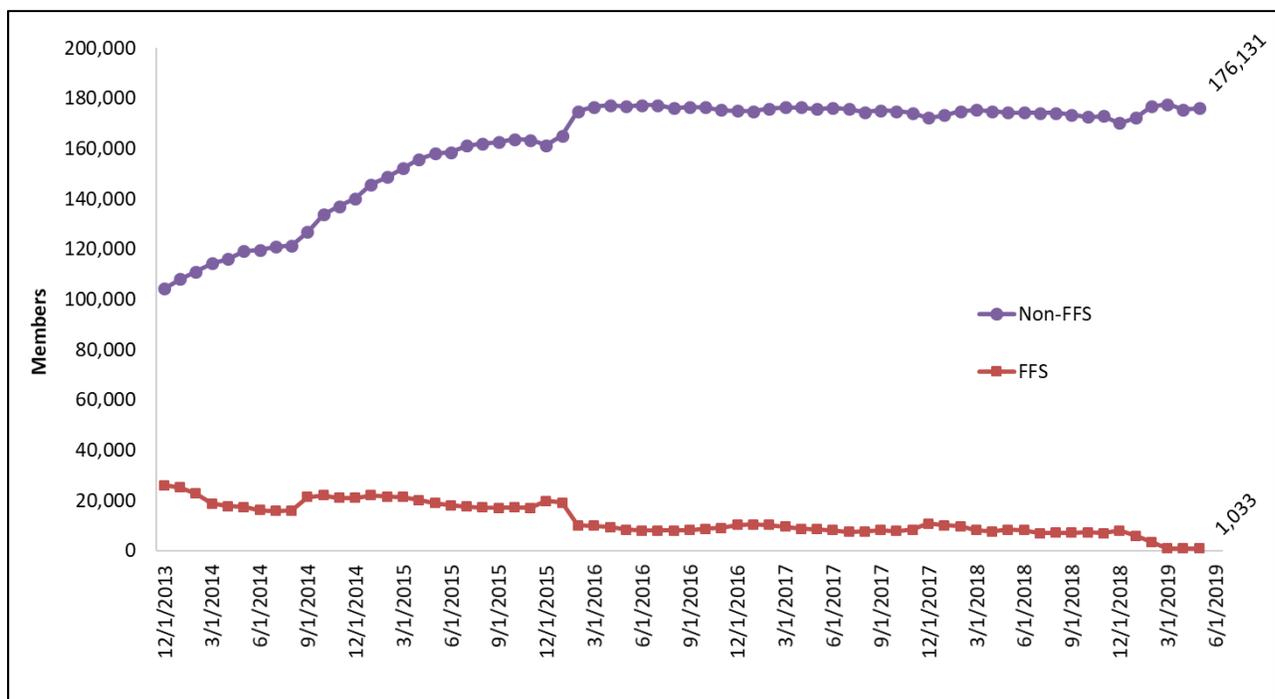
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# 1. Executive Summary

Ensuring access to care for New Hampshire Medicaid beneficiaries is a priority of the NH Department of Health and Human Services and this report describes the Department’s efforts to conduct those access-monitoring activities federally required by the Centers for Medicare and Medicaid Services (CMS). Previously the Department created a comprehensive system of monitoring access for Medicaid beneficiaries who receive their benefits from the Fee for Service (FFS) delivery system. Since the Department moved to same-day enrollment in Managed Care, the FFS population has decreased to only 0.5% of the total NH Medicaid population. As a result, the previous methods for monitoring access are no longer valid for the smaller population.

Executive Summary Figure 1: FFS Only and Non-FFS Enrollment 12/1/2013 – 5/1/2019



NH’s system has evolved to a process of routinely monitoring member demographics and member complaints for potential access issues. Confirmed issues receive rigorous analysis for root causes and corrective action if warranted. This document is the Department’s third annual report, which includes newly added results for 2018 consistent with the CMS rules governing FFS access monitoring. Existing data continues to demonstrate that NH Medicaid FFS beneficiaries do not experience access problems.

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 Division of Medicaid Services (DMS), the Bureau of Quality Assurance and Improvement (BQAI), 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 2018 to report on the level of FFS provider availability and utilization of healthcare by Medicaid FFS beneficiaries. When available, data that are more recent are 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. Since 2014, non-disabled childless adults have been covered by Medicaid through the NH Health Protection Program (NH's adult Medicaid Expansion program). Beginning in December 2013 and continuing in staged rollouts, New Hampshire requires enrollment in managed care for all but a very small percent of beneficiaries, through state plan authority and a 1915(b) waiver. The following beneficiaries are excluded from Managed Care Organization (MCO) enrollment:<sup>1</sup>

- Are in a presumptive eligibility period or with retroactive coverage;
- Receive certain financial Veterans Affairs (VA) benefits;
- Participate in the New Hampshire Health Insurance Premium Payment (HIPP) Program;
- Beneficiaries with very limited Medicaid benefits (Medicare savings program partial duals and family planning only); and
- Beneficiaries who are in a spend-down category and routinely gain Medicaid coverage mid-month.

Medicaid services provided through Medicaid managed care plans include medical, pharmacy, and behavioral health services (i.e., mental health and substance misuse). As of October 2019, excluded services include dental care and long-term care services, including nursing home and long-term care waiver services.

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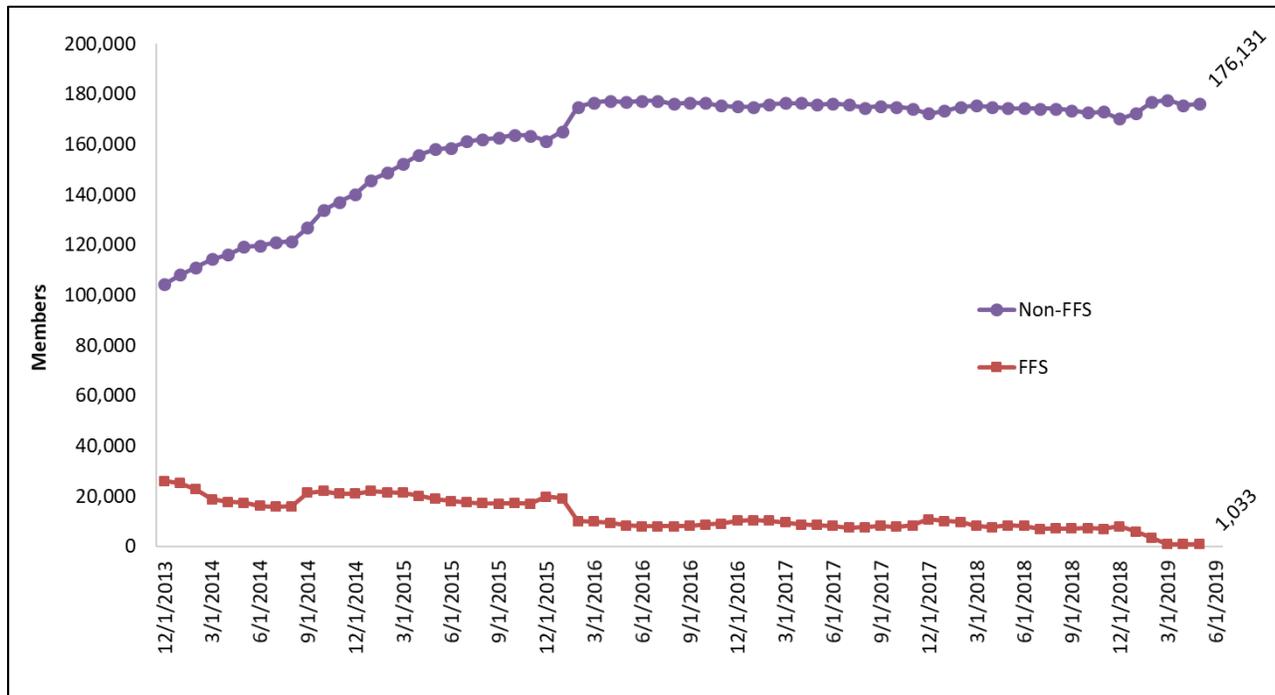
### Medicaid Transition to Managed Care

As of May 1, 2019, 99.5% of NH Medicaid beneficiaries are enrolled in 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. The FFS-only population further declined after January 1, 2019, as newly eligible members became mandatory to enroll in a managed care program the same day they were determined eligible.

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

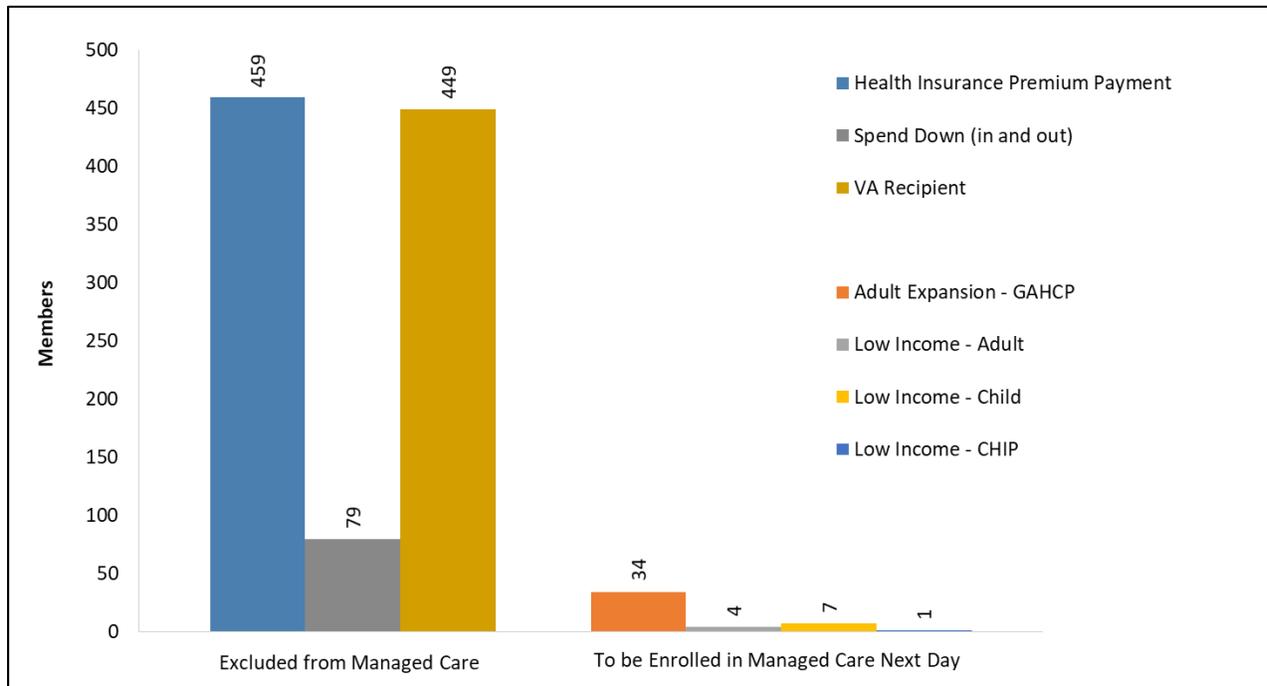
**Figure 1. New Hampshire FFS Only and Non-FFS Enrollment, 12/1/2013 - 5/1/2019**



## Medicaid Fee-For-Service Population

As of May 1, 2019, 0.5% of the Medicaid beneficiaries with full benefits are covered by the FFS-only program. Figure 2 illustrates the distribution of eligibility status among the FFS-only population. As of May 1, 2019, New Hampshire beneficiaries receiving medical services through the FFS-only program are primarily comprised of beneficiaries in the “Excluded from Managed Care” category. The “Excluded from Managed Care” category refers to those FFS beneficiaries who are not eligible for any Medicaid managed care programs. On May 1, 2019, there were a total of 1,033 FFS beneficiaries with 96% (987) of those being Excluded from Managed Care beneficiaries. They are primarily beneficiaries in the HIPPA program, those receiving medical benefits with Veterans Affairs, and those who receive benefits through Spenddown deductible program. The remaining 4% (46) beneficiaries are in the FFS program until they begin coverage in managed care the following day.

**Figure 2. New Hampshire Medicaid FFS Beneficiaries, 5/1/2019**



Note: VA: Veteran’s Administration coverage; GAHCP: Granite Advantage Health Care Program

In the previous Access to Care Monitoring report, the data analysis has been stratified by Excluded from Managed Care, and Plan Selection Period. Because 96% of the remaining FFS population are in the Excluded from Managed Care group, the majority of measures in this report will be focused on the FFS Excluded from Managed Care beneficiaries.

# 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.

The previous plan and report were designed to align with the Methods for Assuring Access to Covered Medicaid Services Final Rule (Final Rule),<sup>2</sup> and were robust in the data monitoring necessary to assure access to care for the 6,786 members subject to monitoring on May 1, 2016. As a result of program changes, FFS-only members are enrolled in managed care on the same day they are determined eligible for NH Medicaid. The change has resulted in only 337 members subject to access monitoring as of May 1, 2019. With the decrease in FFS-only members, the previous monitoring activities are no longer valid due to the small population of members. To fully assess the utility of previous monitoring, DHHS conducted all previous monitoring activities and Section 6 *Summary, Conclusions and Efforts* describe how the low numbers of FFS members will impact monitoring plan efforts moving forward.

At this time, the most appropriate method to monitor access to care for the reduced population is for the Department to use grievances captured by the Department’s Division of Client Services and Division of Medicaid 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

Bureau 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;
- Member grievances; and
- Actual or estimated levels of commercial and other provider payments.

### Characteristics of the FFS Beneficiary Population

The Bureau of Quality Assurance and Improvement monitors enrollment trends for New Hampshire FFS Medicaid beneficiaries through monthly measurement. 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

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<sup>2</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.

20% over the baseline period, the Bureau of Quality Assurance and Improvement will reexamine the health services availability and utilization to conduct additional analysis as needed. The Division 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.)

### **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>3</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.

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 Bureau 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.

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<sup>3</sup> New England Medicaid rates gathered from individual state websites.

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 Bureau 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 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, provider, and recipient impact and make recommendations accordingly. MCAC ensures communication between MCAC members and the New Hampshire Medicaid leadership.

The New Hampshire MCAC 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.

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### Provider Relations

The New Hampshire Medicaid Provider Relations Manager engages with providers on a daily basis to determine and assist with needs. Medicaid Provider Relations is a single point of entry for provider calls and is also responsible for monitoring potential trends and problems as phone calls alert staff to potential access issues.

Specifically the group 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.

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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 approaches for implementation.

While only 0.5% of NH Medicaid participants are currently receiving state plan services under FFS, those services are primarily delivered by providers participating in the NH Medicaid Managed Care Organization's provider networks. The state's contract with the MCOs was competitively re-procured in August of 2018. Prior to the release of the procurement, the Department conducted six (6) public forums throughout the state of New Hampshire to solicit feedback about the current Medicaid program that could inform the new procurement. The result was a request for proposal that was developed to challenge its MCO partners to work more responsively with the provider community and Members to improve access to care and promote healthy behaviors.

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## **Customer Services for Medicaid Beneficiaries**

The New Hampshire Division of Medicaid Services works collaboratively with the Division of Client Services to assist 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 issues. 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. New Hampshire's managed care organizations 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 – 2018 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 that were conducted prior to NH State Fiscal Year 2020. 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 five-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. In the previous report, 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. Because the number of FFS Excluded from Managed Care beneficiaries without Medicare or other insurance was very small and they were the focus of the utilization analysis, this report stratified the utilization results by geographic regions only.

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 previous access report included FFS beneficiaries in the following three categories:

- The Excluded from Managed Care category included beneficiaries for whom Medicaid Managed Care is not (and would never be) mandatory, such as beneficiaries receiving medical benefits from the Office of Veterans Affairs).
- The Plan Selection Period category included beneficiaries in their plan selection period who would shortly move to a Medicaid managed care program or a QHP within the next two months.
- The Voluntary for Managed Care category included beneficiaries who initially opted out of a Medicaid managed care program before February 1, 2016 and then transitioned into a Medicaid managed care program in February 1, 2016 due to the implementation of New Hampshire's 1915b waiver. Because the previous report was the first to include the post-waiver time period, this category was included to show the impact to total trends from their shift to managed care.

Because 96% of the FFS population as of May 1, 2019 are in the Excluded from Managed Care category, the beneficiary and utilization trend results in this report only focus on beneficiaries who are in the Excluded from Managed Care category.

In addition, the populations included in the beneficiary and utilization trend data are FFS Excluded from Managed Care 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 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 to September 2017, the report will include all claims paid through March 31, 2018).

## 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 each grouping are contiguous, with the Metropolitan area counties located in the south-eastern part of the State. Historically, a small number of beneficiaries with out-of-state addresses are excluded from the report, however, for this year's report no beneficiaries with out-of-state addresses were identified in the data abstracted for the study.

### **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 results, the volume of data is too small to allow for meaningful reporting. Rates based on small numbers are more unstable 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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## **New Hampshire Medicaid FFS Beneficiaries**

### **Overview of New Hampshire Medicaid FFS Beneficiaries**

Figures 3 and 4 are based on the 1,263<sup>4</sup> Medicaid FFS Excluded from Managed Care population and show the distribution of beneficiaries by age, eligibility group, and gender as of May 1, 2019.

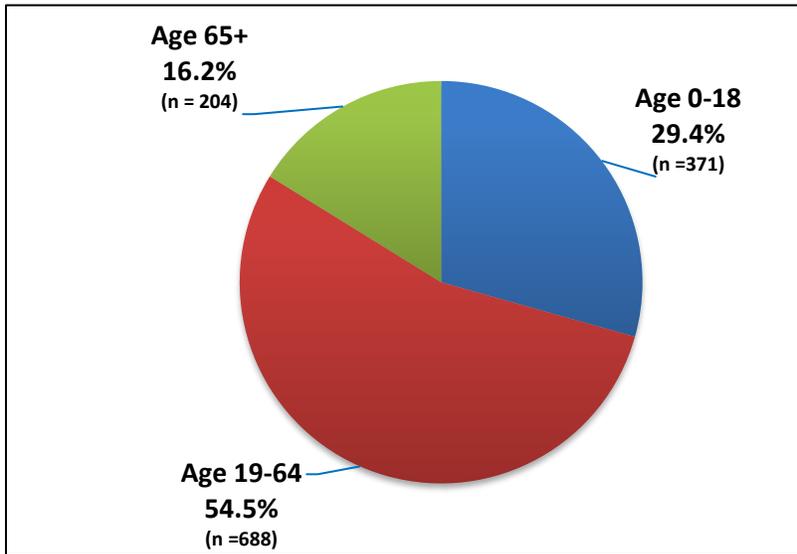
Figure 3 shows that children (beneficiaries 18 years or less) make up 29.4% of the New Hampshire Medicaid FFS population. Beneficiaries age 19 to 64 represent 54.5% of beneficiaries and the remaining 16.2% are beneficiaries aged 65 plus.

Figure 4 shows that males account for 57.9% of FFS Medicaid beneficiaries. Gender differences are observed in all of the eligibility categories with males predominating the children and/or disabled child (53.9%), the elderly and/or disabled adults category (61.3%), low-income parent & Breast and Cervical Cancer Program category (50.1%), and the largest difference are observed in the Granite Advantage Program (71.4%).

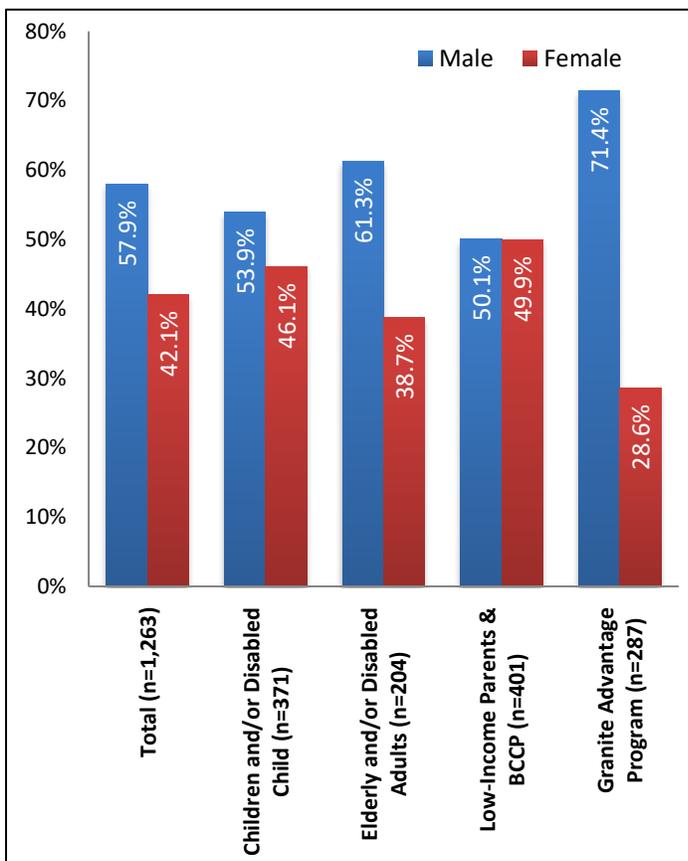
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<sup>4</sup> The enrollment data used to calculate Figures 1 to 2 were extracted at a different time than the data used to calculate Figures 3 to 5; therefore, the number of FFS beneficiaries in Figures 3 to 5 is slightly different than those in Figures 1 to 2.

**Figure 3. NH Medicaid FFS Excluded from Managed Care Beneficiaries by Age Categories, May 1, 2019**



**Figure 4. NH Medicaid FFS Excluded from Managed Care Beneficiaries by Gender and Eligibility Category, May 1, 2019**

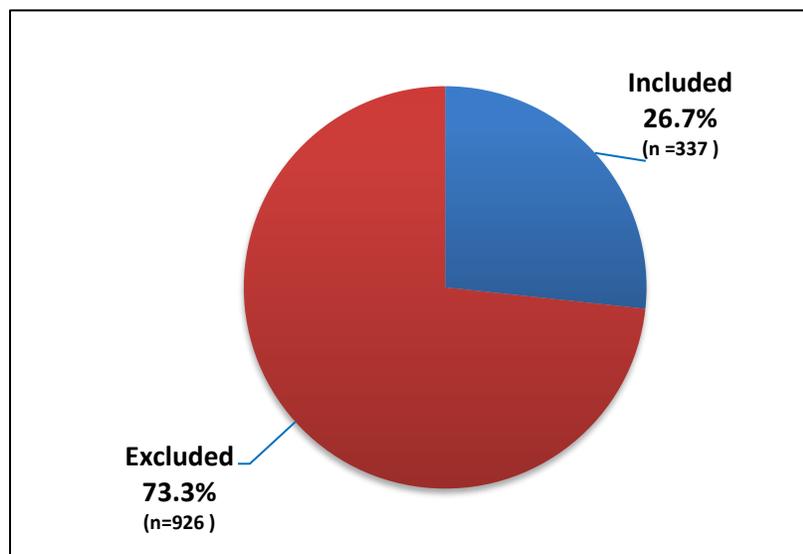


### Population Subject to Access Monitoring

Figure 5 demonstrates that 73.3% of the Excluded from Managed Care beneficiaries are not included in monitoring as of May 1, 2019 due to Medicare and/or other medical insurance as noted above. 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. The remaining sections (e.g., enrollment trend, time/distance analysis, ratio analysis, and utilization analysis) of this report will focus on these FFS Excluded from Managed Care beneficiaries without Medicare and/or other medical insurance.

**Figure 5. NH Medicaid FFS Excluded from Managed Care Beneficiaries Subject to Access Monitoring Plan, May 1, 2019**



### New Hampshire Medicaid FFS Beneficiary Enrollment Trends

This section reviews trends in average monthly enrollment by quarter of New Hampshire FFS Medicaid Excluded from Managed Care beneficiaries without Medicare and/or other medical insurance. The data in the figures<sup>5</sup> are presented by quarter and stratified by metropolitan and non-metropolitan areas of the State.

Figures for enrollment trends indicate that the FFS population continued to change between 2014 and 2018 due to the following:

#### Results Based on Prior Data

- NHHPP began in Quarter 3 of 2014, which led to an increase in the Excluded from Managed Care population, as shown in Figures 6 and 7, due to efforts to increase use of the Health Insurance Premium Payment (HIPP) Program as required by the state statute that implemented the NHHPP.

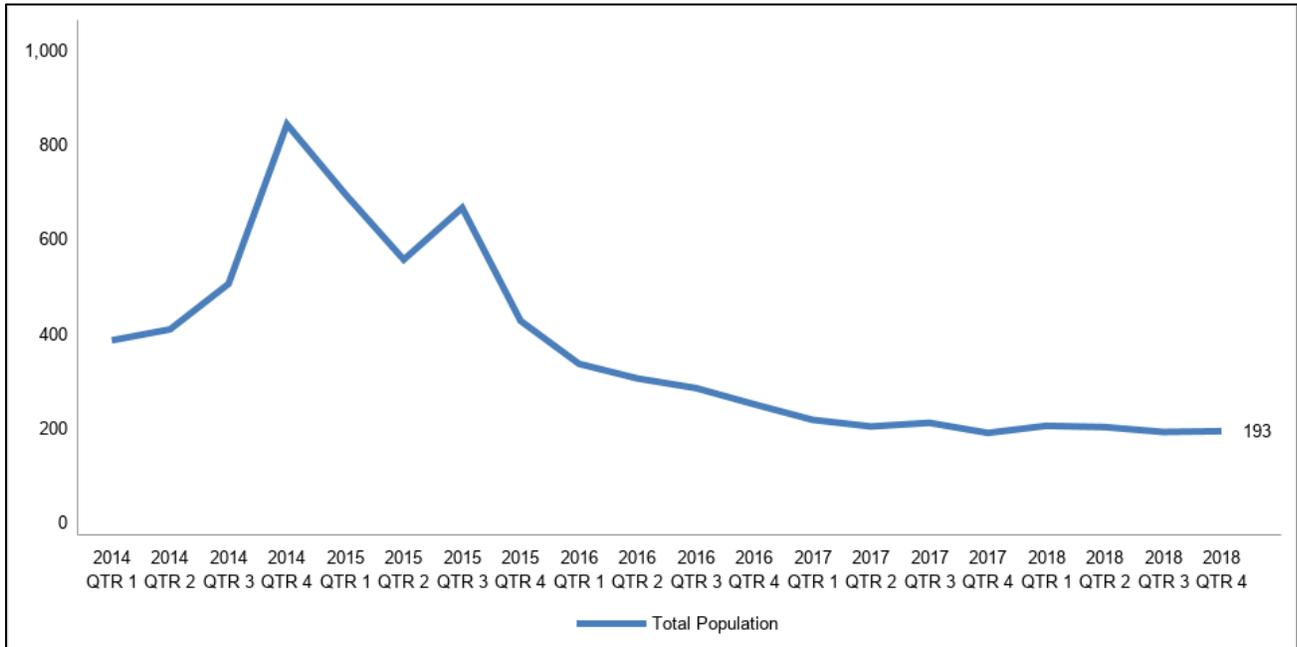
#### Results Based on 2018 Data

- For both Figures 6 and 7, the variation in 2018 is much smaller than those in 2014 and 2015.

<sup>5</sup> Background data for Figures 6 to 34 may be found in the Appendix.

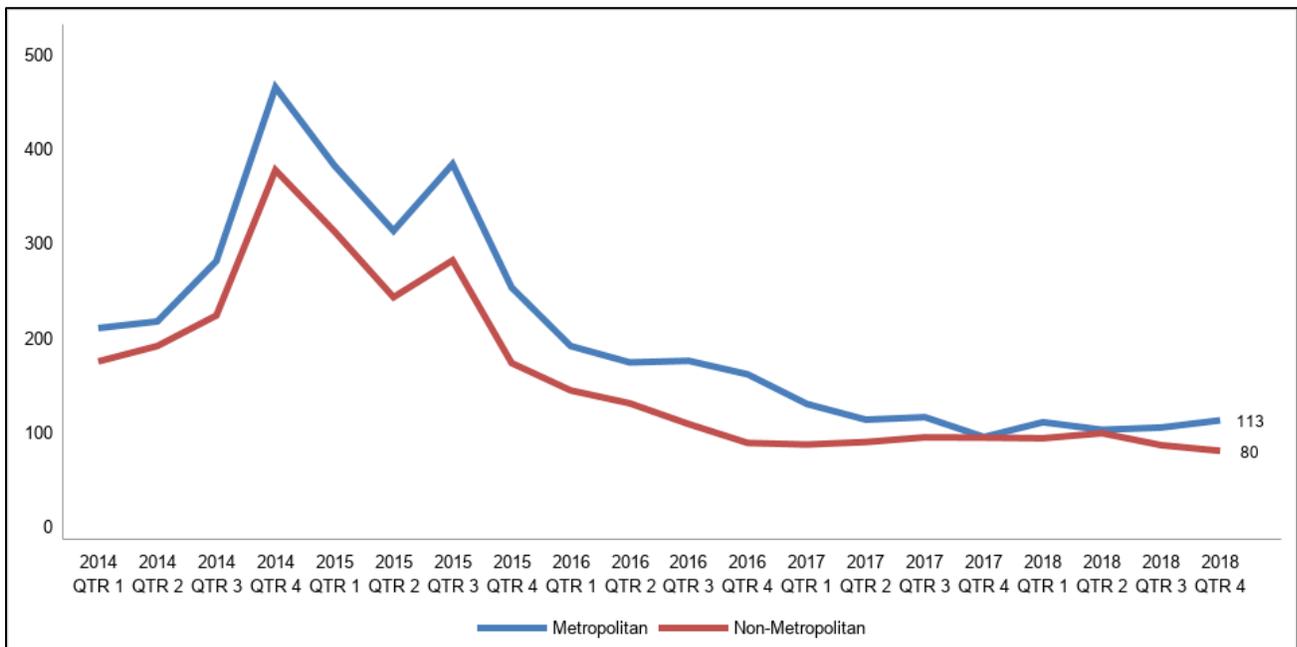
**Figure 6. NH Medicaid FFS Excluded from Managed Care Enrollment, CY 2014-2018, Average Beneficiaries in Quarter: Total Population**

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



**Figure 7. NH Medicaid FFS Excluded from Managed Care Enrollment, CY 2014-2018, Average Beneficiaries in Quarter: Metropolitan and Non-Metropolitan Counties**

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



## FFS Provider Availability

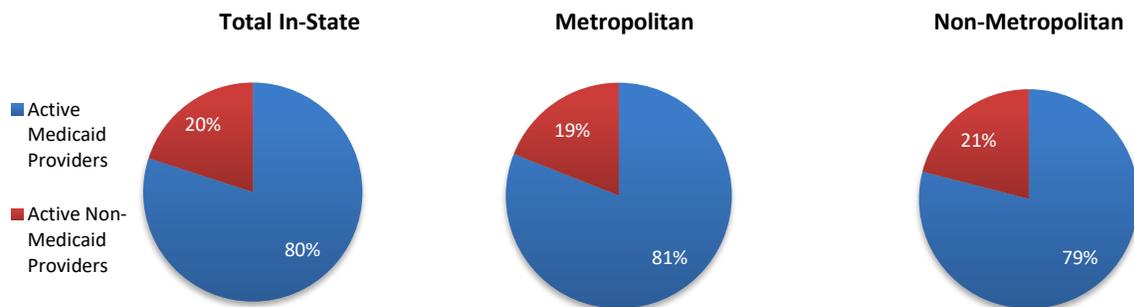
The provider availability analysis focuses on whether healthcare services are accessible to Medicaid beneficiaries. Measures are included on provider participation in the New Hampshire Medicaid FFS Program, percent of active providers from all enrolled FFS providers for Quarter 4 of 2018, time/distance 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 8 provides information on the most recently available data on enrollment by active licensed providers. As can be seen in Figure 8, the majority (80%) of the in-state licensed practicing physicians are also active (at least one FFS paid claims in 2018) New Hampshire Medicaid FFS providers. The same is true for both the metropolitan (81%) and non-metropolitan counties (79%). These results are similar to those in previous reports. In order to ensure providers stayed enrolled with FFS after the transition to managed care, New Hampshire included provisions in its contracts that required all providers enrolled with MCOs to also be enrolled in FFS.

**Figure 8. Active NH Medicaid In-State FFS Physician Providers Compared to Licensed Providers With NH Billing Address, 2018**



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 1.36 million<sup>6</sup> people, and a total of 4,328 licensed practicing physicians for a ratio of 314 people per licensed physician, while there are 8,068 Medicaid FFS beneficiaries (FFS beneficiaries as of December 1, 2018 from Figure 1) and a total of 3,462 active (at least one FFS paid claims in 2018) physicians for a ratio of 2.3 people per physician for the New Hampshire Medicaid FFS population.

<sup>6</sup> Data Source: <https://www.census.gov/quickfacts/fact/table/NH,US/PST045216>, accessed on July 25, 2019.

Lastly, providers from adjacent states also increased the provider network capacity for the FFS program. For example, after adding active FFS providers from surrounding states such as Massachusetts, Maine, and Vermont, there were 6,078 active FFS providers in 2018.

### Percent of Medicaid FFS Providers with Claims in Quarter 4 of 2018

For the in-state providers participating in the New Hampshire Medicaid FFS program, the following table displays that the percentage of active providers (i.e., those with a least one FFS paid claim in Quarter 4 of 2018) vary from 43.7% (Surgery) to 80.5% (Home Health). This indicates that more than one third of the in-state Medicaid FFS providers provided services to the FFS population (i.e., had at least one FFS paid claim with date of service in Quarter 4 of 2018) for the provider types listed in the table below. These rates are higher than those from Quarter 4 of 2016, which is primarily because beneficiaries eligible for QHPs were temporarily held in FFS in Quarter 4 of 2018.

Provider Type	Total In-State Medicaid FFS Providers	In-State Medicaid FFS Providers with Claims in Quarter 4 of 2018	Percent
Cardiology	172	115	66.9%
Home Health	77	62	80.5%
Obstetricians/Gynecologists <sup>7</sup>	3,358	1,736	51.7%
Pediatricians	421	284	67.5%
Primary Care Providers	3,612	1,991	55.1%
Radiology	290	156	53.8%
Surgery	788	344	43.7%

### 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 Excluded from Managed Care beneficiaries to have access to specific provider types. These standards were applied to FFS Excluded from Managed Care beneficiaries as of May 1, 2019, to monitor time and distance to Primary Care Providers, Pediatricians, and Maternity providers. The table below shows that all corresponding FFS Excluded from Managed Care beneficiaries without Medicare and/or other medical insurance had access to Primary Care, Pediatrician, and Maternity providers within the time/distance standards as of May 1, 2019.

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 Excluded from Managed Care beneficiaries as of May 1, 2019	Met
Pediatricians <i>Two (2) within forty (40) minutes or fifteen (15) miles</i>	FFS Excluded from Managed Care beneficiaries 18 years of age or younger as of May 1, 2019	Met
Obstetricians/Gynecologists <i>One (1) within sixty (60) minutes or forty-five (45) miles</i>	Female FFS Excluded from Managed Care beneficiaries 13 years of age or older as of May 1, 2019	Met

<sup>7</sup> Includes some primary care providers since they may provide some services offered by obstetricians/gynecologists.

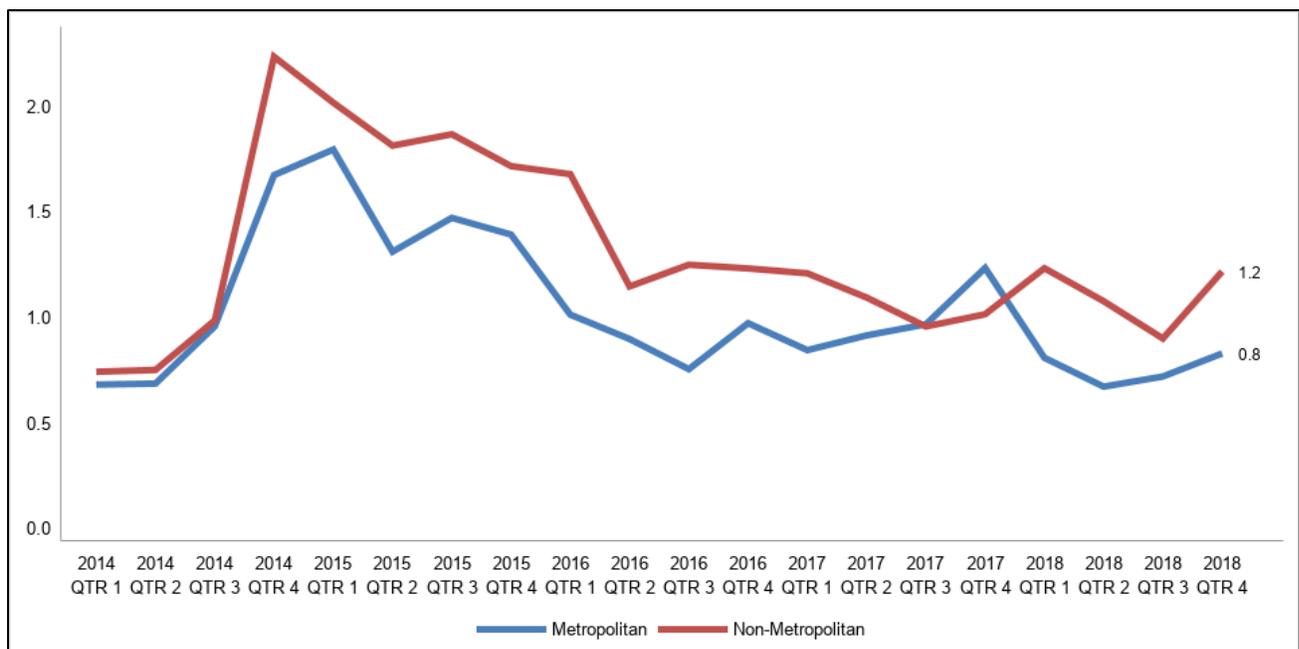
## Active FFS Primary Care Providers, Pediatricians, and Maternity Provider Ratios

Figures 9 through 10 demonstrate the trends in FFS Excluded from Managed Care beneficiaries without Medicare and/or other medical insurance to active providers (those with one claim in the quarter). One figure each is presented for Primary Care Providers and Pediatricians, respectively. For each figure, there are two trend lines: one for metropolitan area data and one for non-metropolitan area data.

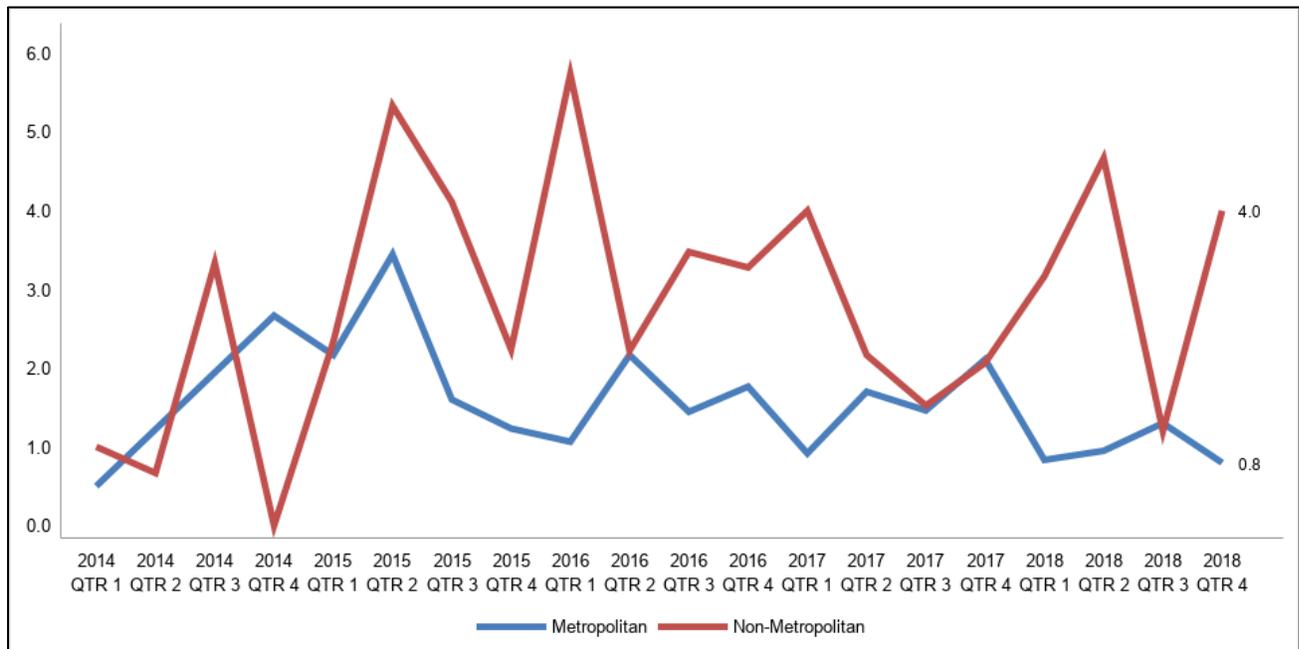
### Results

- While the trends for the beneficiaries to active primary care providers ratios in Figure 9 were similar to the corresponding beneficiary enrollment trends in Figure 7, ratios for all quarters are less than 3.0 for both the metropolitan and non-metropolitan areas. This means that on average each active primary care providers serves less than three FFS Excluded from Managed Care beneficiaries without Medicare and/or other medical insurance.
- While the trends for the beneficiaries to active pediatric providers ratios in Figure 10 vary up and down, ratios for all quarters are less than 6.0 for both the metropolitan and non-metropolitan areas. This means that on average each active pediatric provider serves less than six FFS Excluded from Managed Care beneficiaries less than 18 years of age without Medicare and/or other medical insurance.

**Figure 9. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians), CY 2014-2018**



**Figure 10. Ratio of NH Medicaid FFS Excluded from Managed Care Child Beneficiaries to Active In-State Pediatricians, CY 2014-2018**



Note: The number of active providers was less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 active pediatric providers). Please use caution when interpreting results. In addition, the Metropolitan denominators for Quarters 2 and 3 of 2014 were zero and the trend between Quarter 1 of 2014 and Quarter 4 of 2014 were only based on the results from Quarters 1 and 4 of 2014. Similarly, the non-Metropolitan denominator for Quarter 4 of 2014 was zero and the trend between Quarter 3 of 2014 and Quarter 1 of 2015 was only based on the results from Quarter 3 of 2014 and Quarter 1 of 2015.

The deliveries-to-delivery provider ratio compares active providers to deliveries, as opposed to the general female population-to-providers, which accounts for changes in fertility rates in the population. Because the number of deliveries for at least half of the quarters is zero and the number of deliveries for the remaining quarters are less than five, the deliveries-to-delivery provider ratio is displayed in a table below.

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Deliveries	Ratio	Providers	Deliveries	Ratio
2014 QTR 1	1	1	1	1	1	1
2014 QTR 2	0	0	—	0	0	—
2014 QTR 3	0	0	—	0	0	—
2014 QTR 4	0	0	—	0	0	—
2015 QTR 1	0	0	—	1	1	1
2015 QTR 2	2	2	1	1	1	1
2015 QTR 3	2	2	1	1	1	1
2015 QTR 4	0	0	—	0	0	—
2016 QTR 1	1	1	1	0	0	—
2016 QTR 2	1	1	1	0	0	—
2016 QTR 3	0	0	—	1	1	1
2016 QTR 4	4	4	1	0	0	—
2017 QTR 1	1	1	1	2	2	1
2017 QTR 2	1	1	1	0	0	—
2017 QTR 3	1	1	1	0	0	—
2017 QTR 4	0	0	—	0	0	—
2018 QTR 1	0	0	—	0	0	—
2018 QTR 2	3	3	1	0	0	—

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Deliveries	Ratio	Providers	Deliveries	Ratio
2018 QTR 3	0	0	—	1	1	1
2018 QTR 4	0	0	—	1	1	1

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

Figures 11 through 14 demonstrate the trends in the ratio of FFS Excluded from Managed Care beneficiaries without Medicare and/or other medical insurance to active cardiology, radiology, surgery, and home health providers (those with one claim in the quarter). For each figure, the metropolitan trend is presented together with the non-metropolitan trend. In general, a lower ratio indicates fewer FFS beneficiaries served by each active provider; therefore, a better provider network capacity.

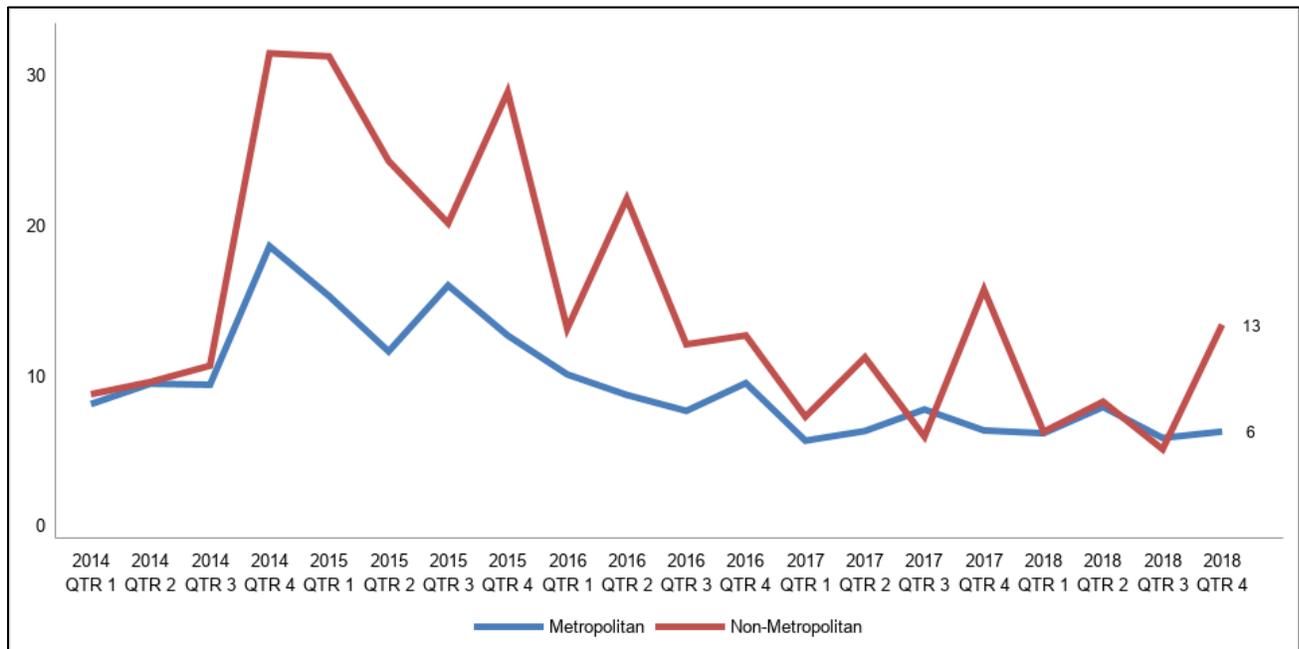
#### Results Based on Prior Data

- The statewide ratios for the four different provider types continue to vary from no more than 10 FFS Excluded from Managed Care beneficiaries per one active radiology provider in Figure 12 to no more than 100 FFS Excluded from Managed Care beneficiaries per one home health provider in Figure 14.
- The provider ratios for cardiology (Figure 11) and radiology (Figure 12) in both metropolitan and non-metropolitan areas had dropped since the last quarter of 2014, which aligned with the enrollment trends.
- For home health providers, the total number of active providers was less than 30 for all quarters. Therefore, exercise caution when reviewing results for Figure 14. For example, the high rate in Quarter 3 of 2017 was calculated based on one active home health provider.

#### Results Based on 2018 Data

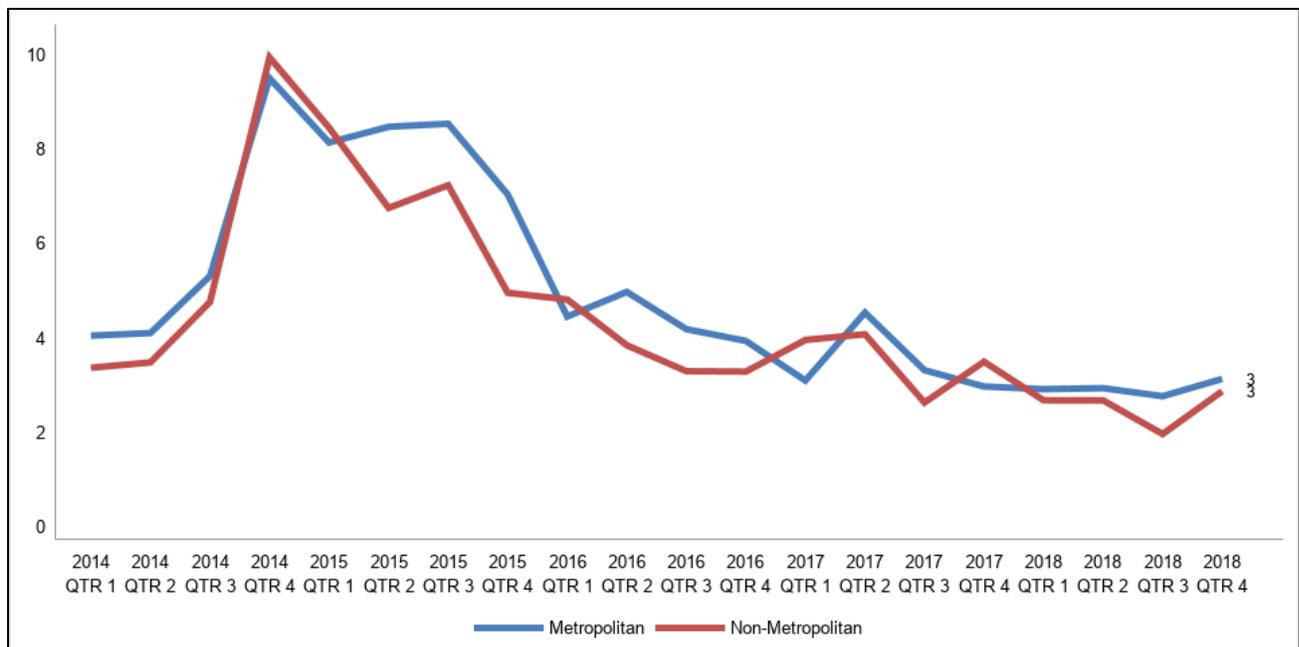
- While the ratios for cardiology providers in Figure 11 and surgery providers in Figure 13 increased in Quarter 4 of 2018, they are still quite low. For example, the cardiology ratio in the non-metropolitan area for Quarter 4 of 2018 is 13 FFS Excluded from Managed Care beneficiaries per active cardiology provider.
- The ratios in the metropolitan area were generally lower than those in the non-metropolitan area for cardiology providers (Figure 11) and home health providers (Figure 14).

**Figure 11. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Cardiology Providers, CY 2014-2018**



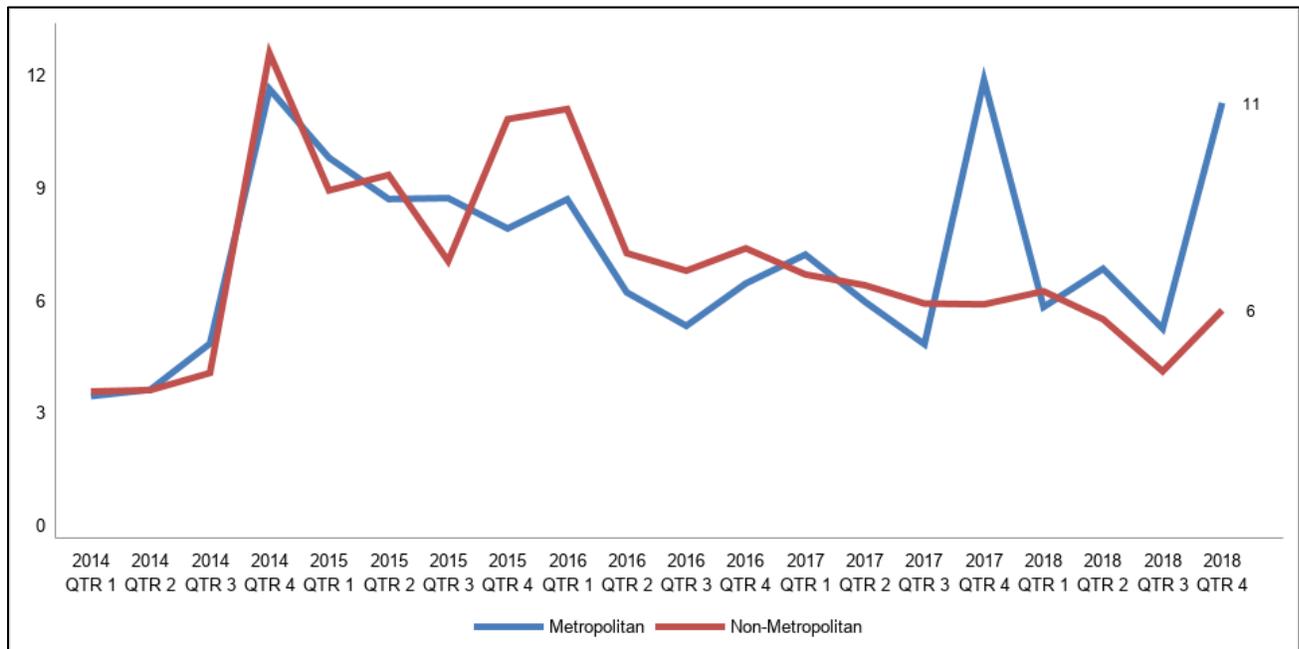
Note: The number of active cardiology providers was less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 active cardiology providers). Please use caution when interpreting results.

**Figure 12. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Radiology Providers, CY 2014-2018**



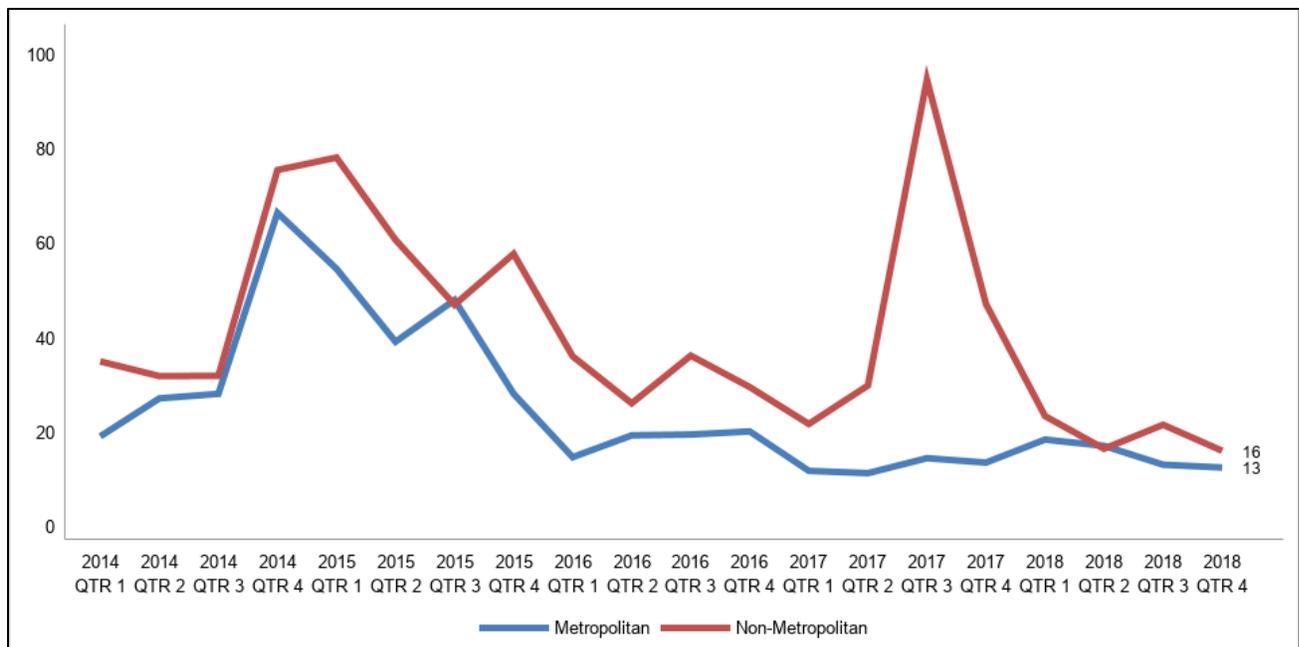
Note: The number of active radiology providers was less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 active radiology providers). Please use caution when interpreting results.

**Figure 13. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Surgery Providers, CY 2014-2018**



Note: The number of active surgery 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.

**Figure 14. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Home Health Providers, CY 2014-2018**



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

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## Utilization of Services

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

Figures in this section show the utilization trends, by quarter, regarding key physician and hospital services used by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries without Medicare and/or other medical insurance as indicated by Medicaid FFS claims data<sup>8</sup>. Rates are the number of FFS visits in the quarter divided by the number of FFS beneficiary months for the quarter multiplied by 1,000. The data in the figures are presented by quarter and are stratified by metropolitan and non-metropolitan areas of the State (to research 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.

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 Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data. Data are presented for the total Medicaid FFS Excluded from Managed Care population, stratified by metropolitan and non-metropolitan areas of the state.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

- For Figures 15 and 16, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the

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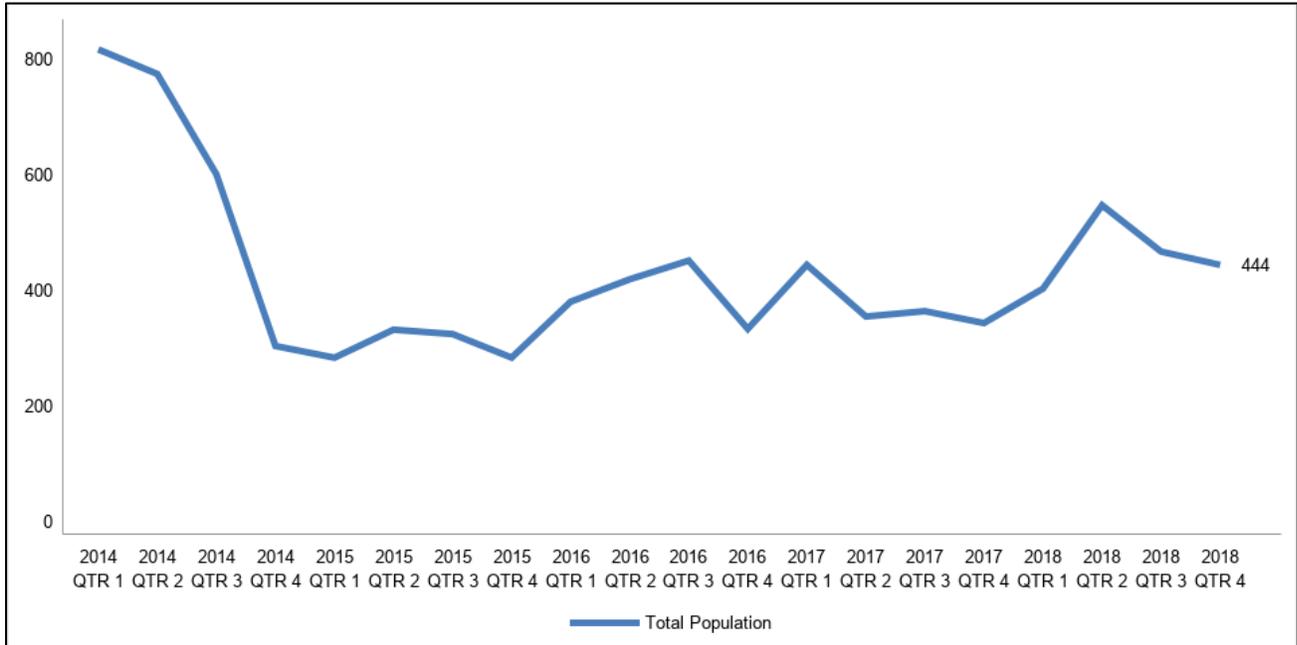
<sup>8</sup>Excluding Medicare dual eligibles and those beneficiaries known to have other medical insurance, as their physician care is nearly always paid for by third parties, not NH Medicaid.

new HIPP<sup>9</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014).

Results Based on 2018 Data

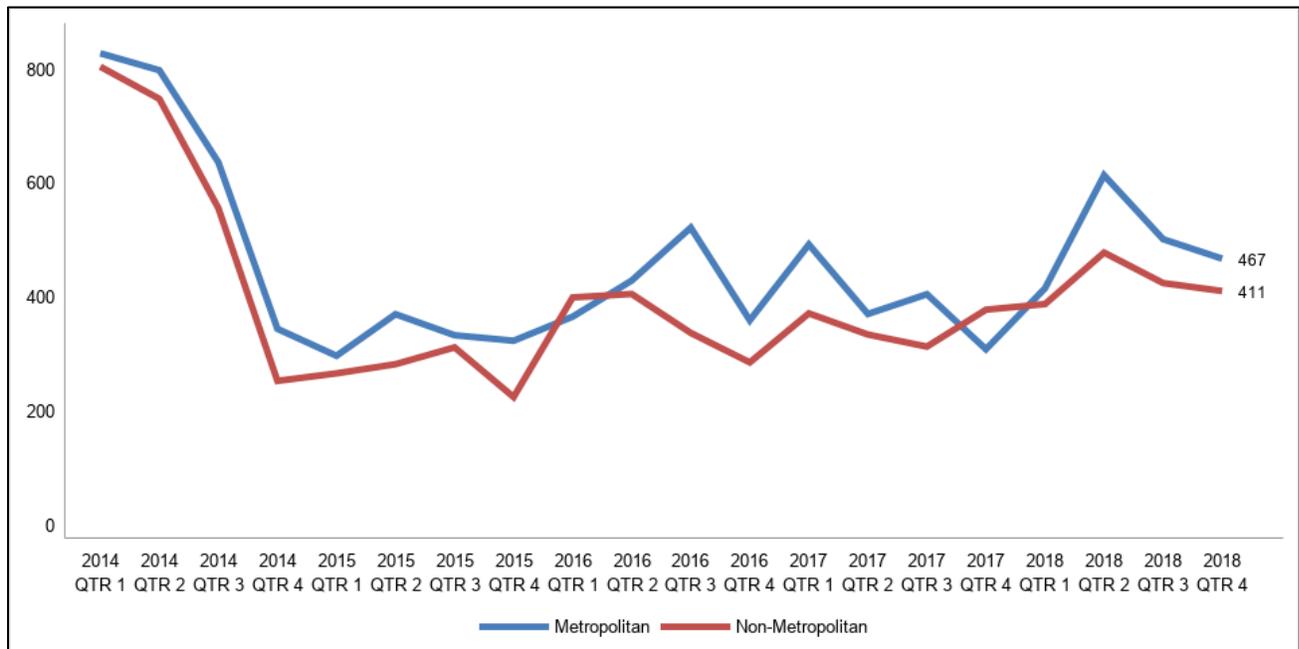
- As shown in Figures 15 and 16, there were slight up and down trends in 2018, as the physician/APRN/clinic visits were the highest in the second quarter among all quarters in 2018.

**Figure 15. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



<sup>9</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

**Figure 16. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



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

Figures 17 through 18 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 Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the State where supported by sufficient data needed to produce reliable results.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

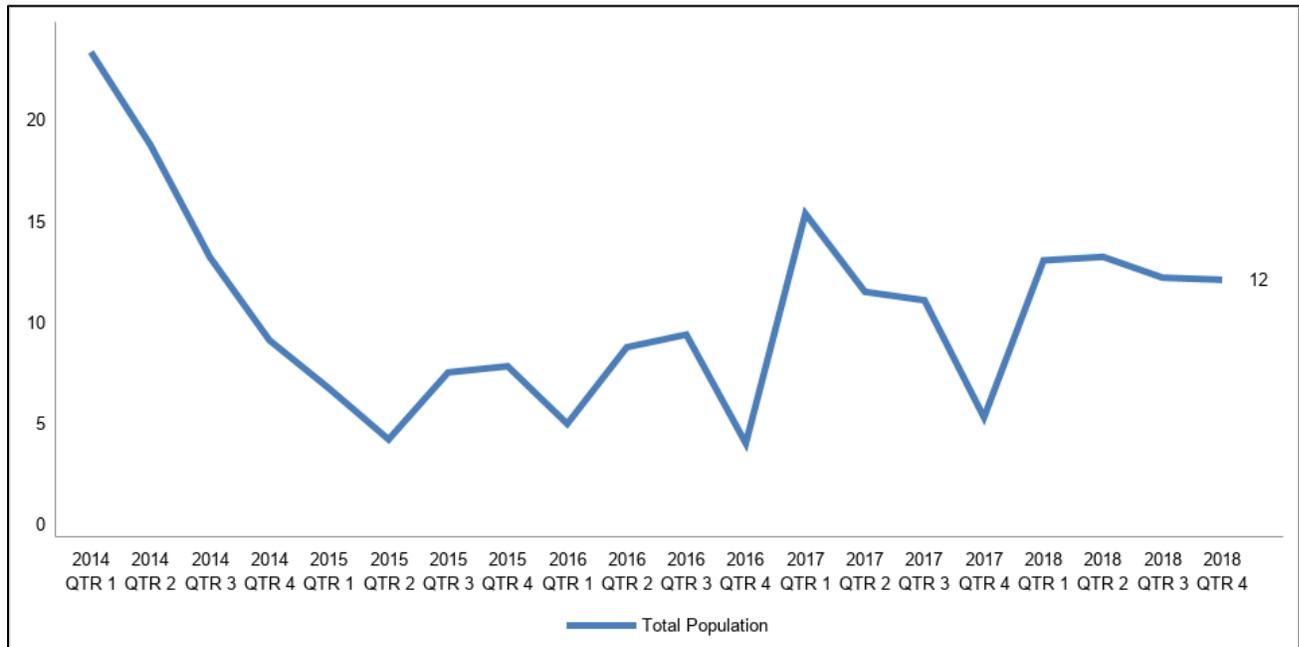
- For Figures 17 and 18, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the new HIPP<sup>10</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014.)

<sup>10</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

Results Based on 2018 Data

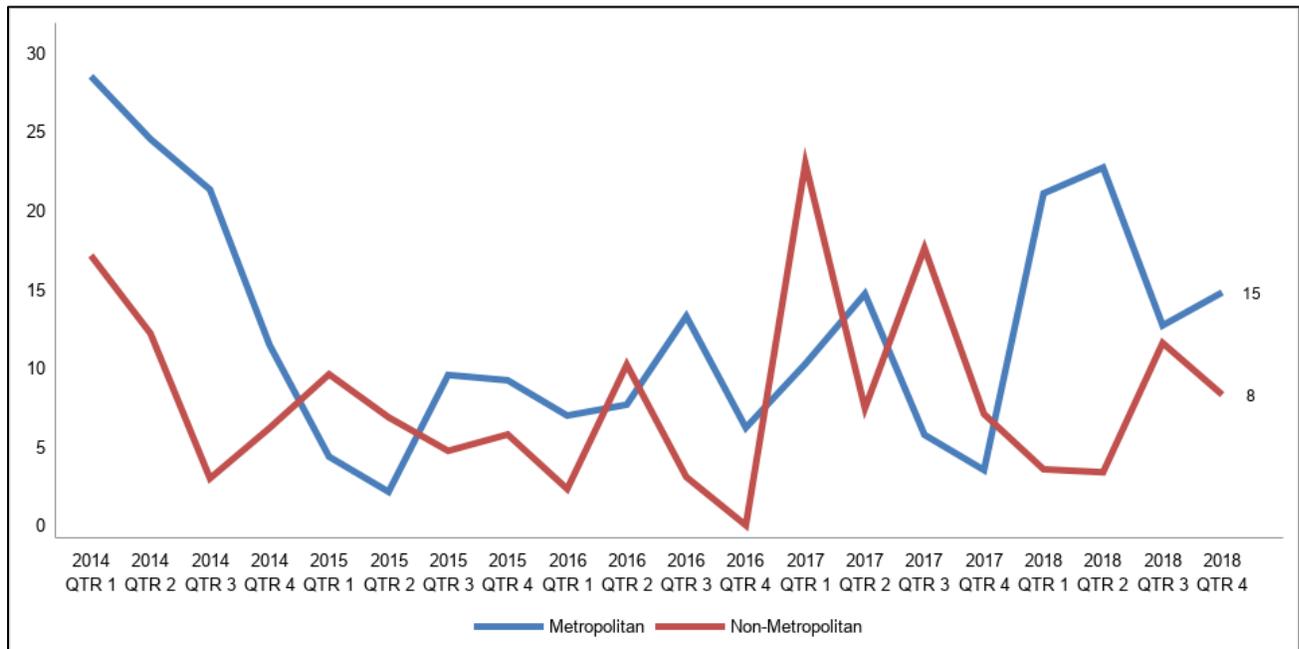
- The number of emergency department visits for conditions potentially treatable in primary care in Figures 17 and 18 is less than 10 for each quarter of 2018. Please use caution when interpreting the up and down trend in 2018.

**Figure 17. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



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

**Figure 18. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



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

### Total Emergency Department Utilization

Figures 19 through 20 demonstrate the trends in quarterly use of hospital emergency departments by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data. Data are presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the State.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

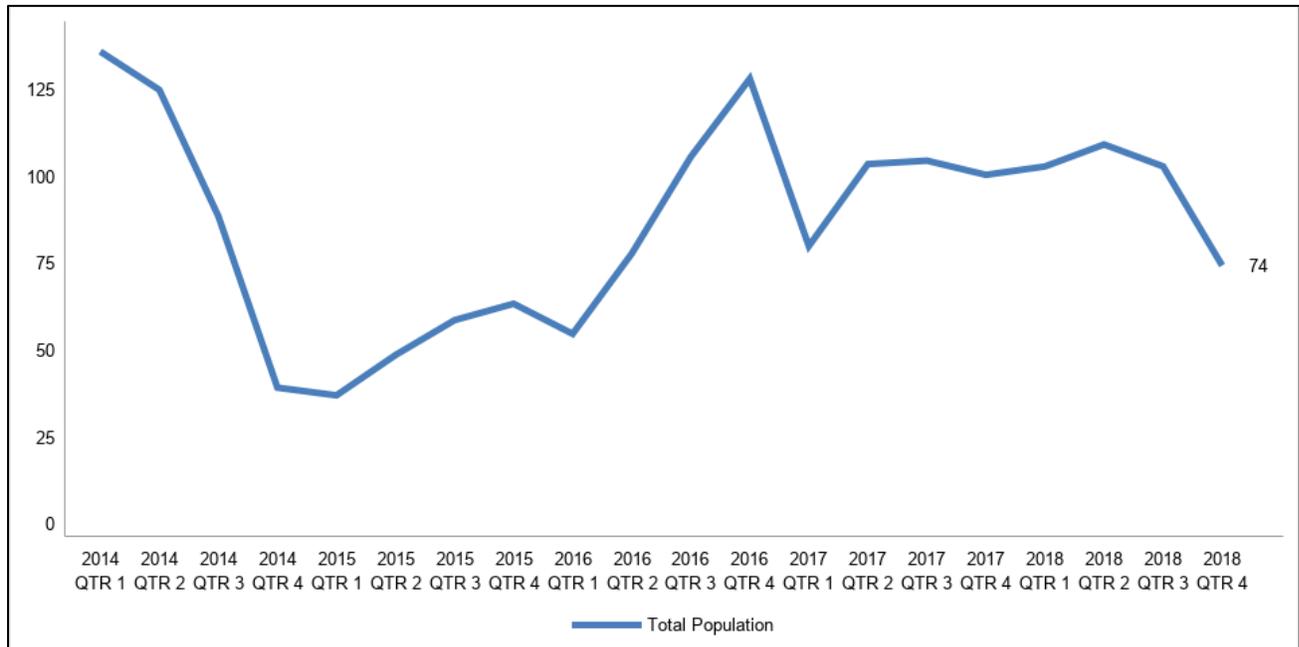
- For Figures 19 and 20, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the new HIPP<sup>11</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014).

<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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

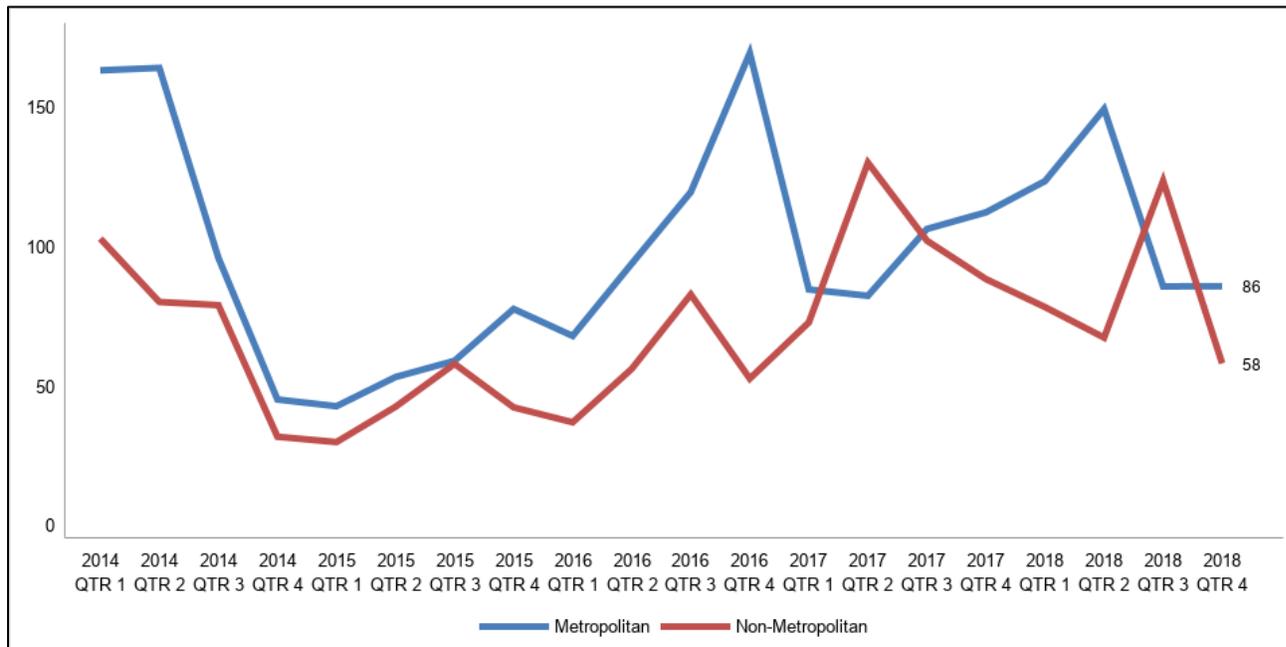
Results Based on 2018 Data

- The utilization rates in Figure 19 decreased in Quarter 4 of 2018. While lower emergency department utilization is generally the goal for this measure, DHHS will continue monitoring these trends in future access reports to ensure the results indicate that beneficiaries are obtaining appropriate care outside of the emergency department and are not indicative of a concern with beneficiaries' access to emergency department care.

**Figure 19. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



**Figure 20. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



Note: The visit counts 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.

### Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions

Figure 21 to 22 demonstrate the trend in quarterly use of inpatient hospitals for ambulatory care sensitive conditions (ACSC) by New Hampshire Medicaid FFS Excluded from Managed Care 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 disproportionately 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 presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the state.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of the Medicaid managed care program, new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

<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)

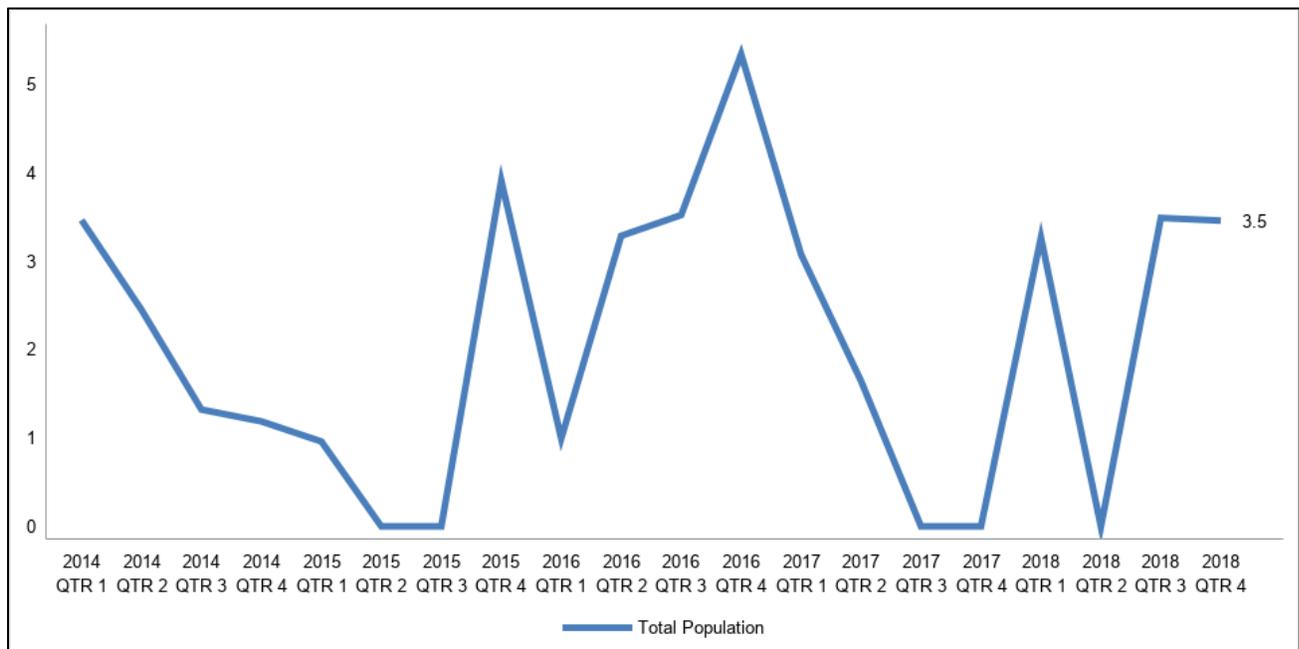
Results Based on Prior Data

- As shown in Appendix B for Figures 21 and 22, the visit counts were less than six for all quarters before 2018. Please use caution when interpreting the trend prior 2018.

Results Based on 2018 Data

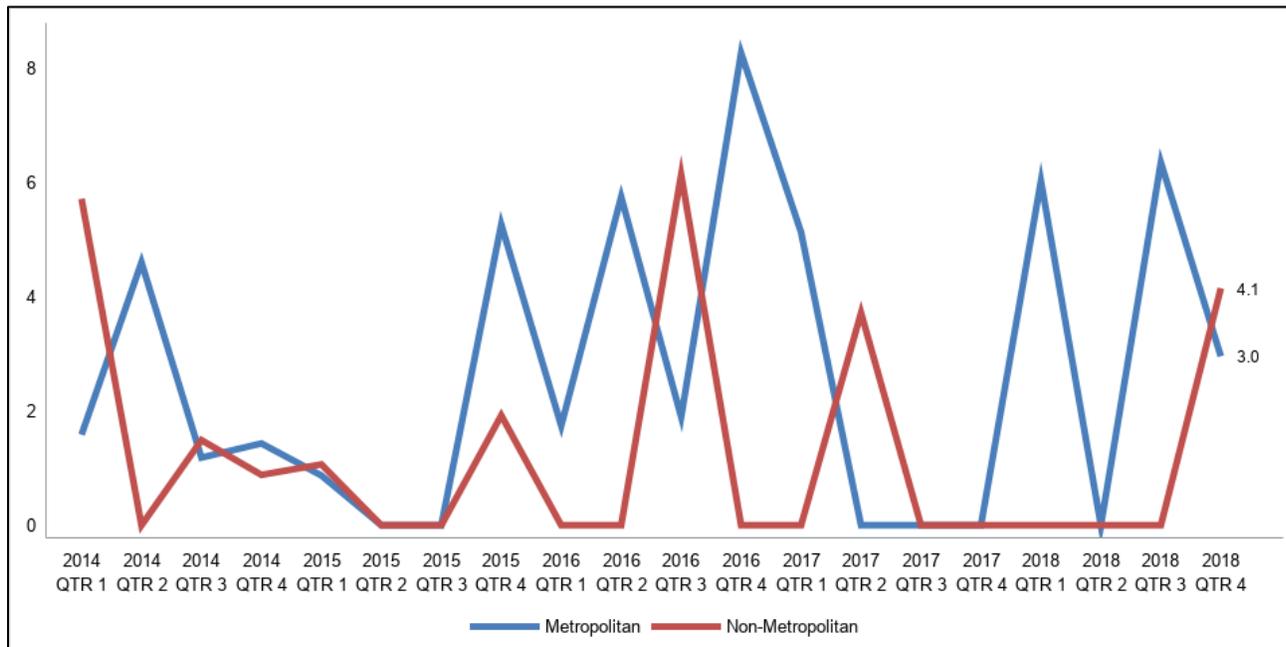
- For the total population (Figure 21), the visit counts were two or zero for all quarters in 2018. Please use caution when interpreting the trend in 2018.

**Figure 21. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



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

**Figure 22. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



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

### Total Inpatient Hospital Utilization

Figure 23 to 24 demonstrate a trend in quarterly use of general inpatient hospitals by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data.

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.

Data are presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the state.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

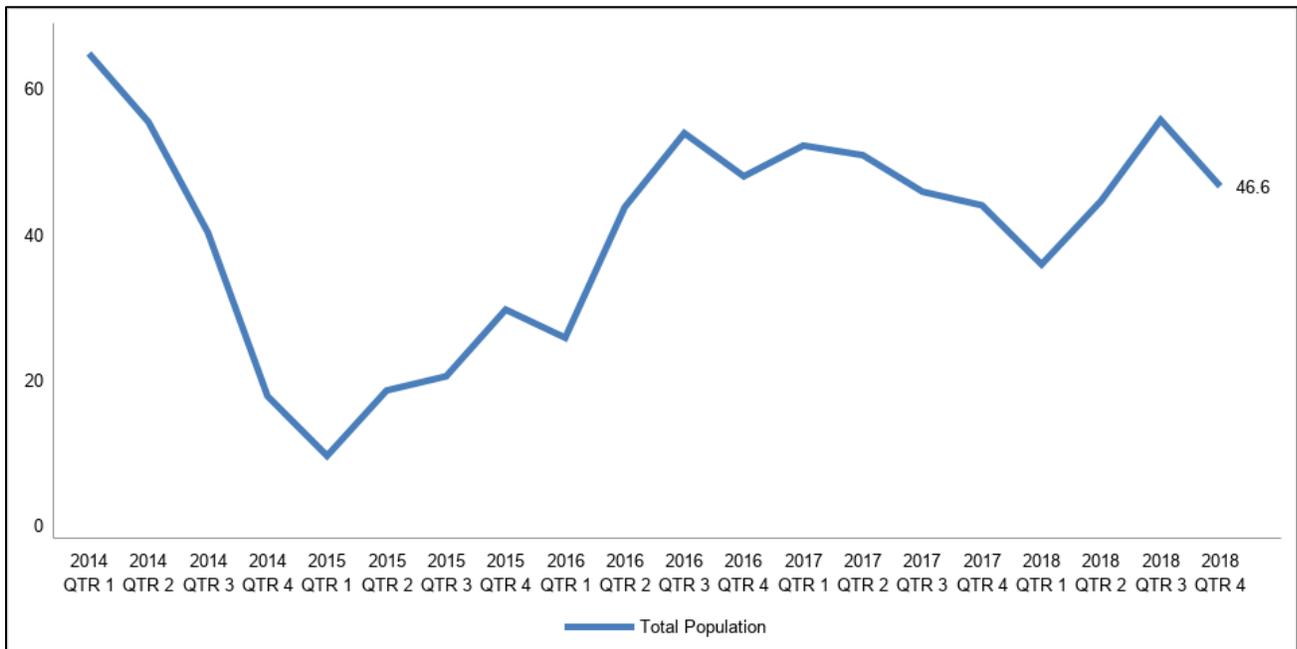
- For Figures 23 and 24, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the

new HIPP<sup>13</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014.)

Results Based on 2018 Data

- The utilization rates went up from Quarter 1 to Quarter 3 of 2018 and then dropped in Quarter 4 of 2018 (Figures 23 and 24). However, since the visit counts in each quarter of 2018 were less than 33, please interpret the results with caution. While lower utilization is generally the goal for this measure, DHHS will continue monitoring these trends in future access reports to ensure the results indicate that beneficiaries are obtaining appropriate care outside of the inpatient hospital setting and are not indicative of a concern with beneficiaries’ access to inpatient hospital services.

**Figure 23. Inpatient Hospital Utilization<sup>14</sup> per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

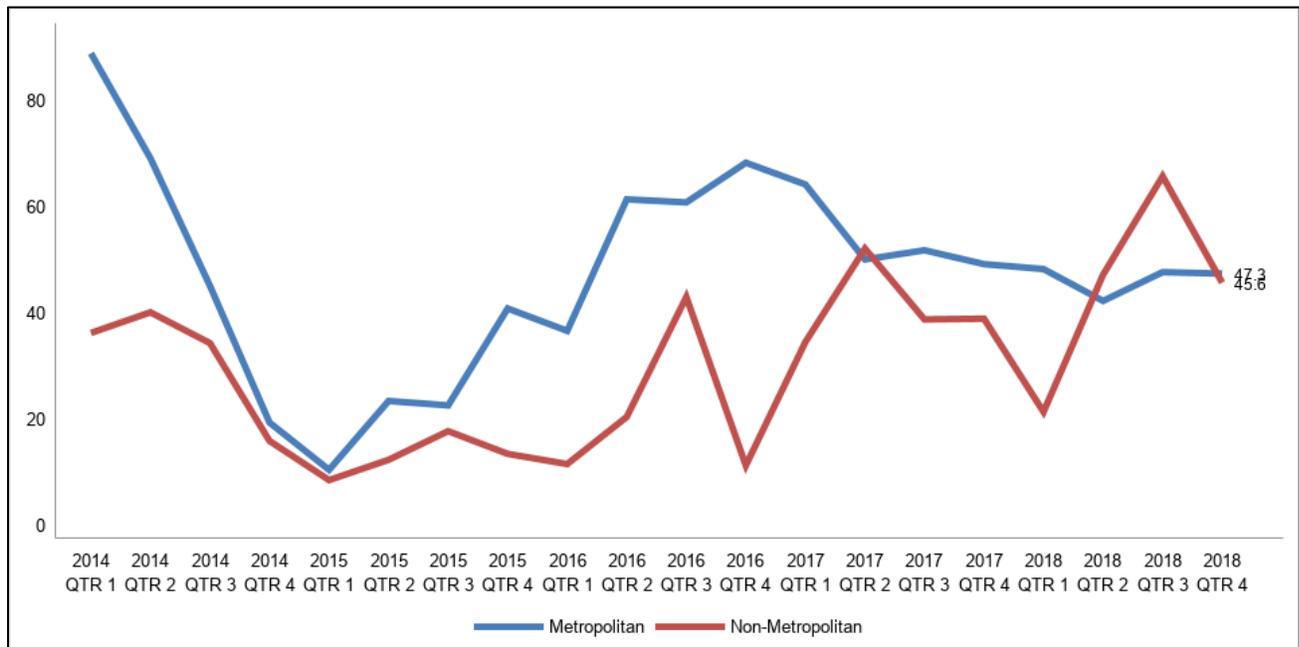


Note: The visit counts were less than 30 for some of the quarters (e.g., refer to Appendix B for the list of quarters with less than 30 visits). Please use caution when interpreting results.

<sup>13</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

<sup>14</sup> Excludes maternity

**Figure 24. Inpatient Hospital Utilization<sup>15</sup> per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



Note: The visit counts were less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 visits). Please use caution when interpreting results.

### Utilization of Cardiology Providers

Figures 25 through 26 demonstrate the trends in quarterly use of services from cardiology providers by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the state.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

- For Figures 25 and 26, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the new HIPP<sup>16</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014.)

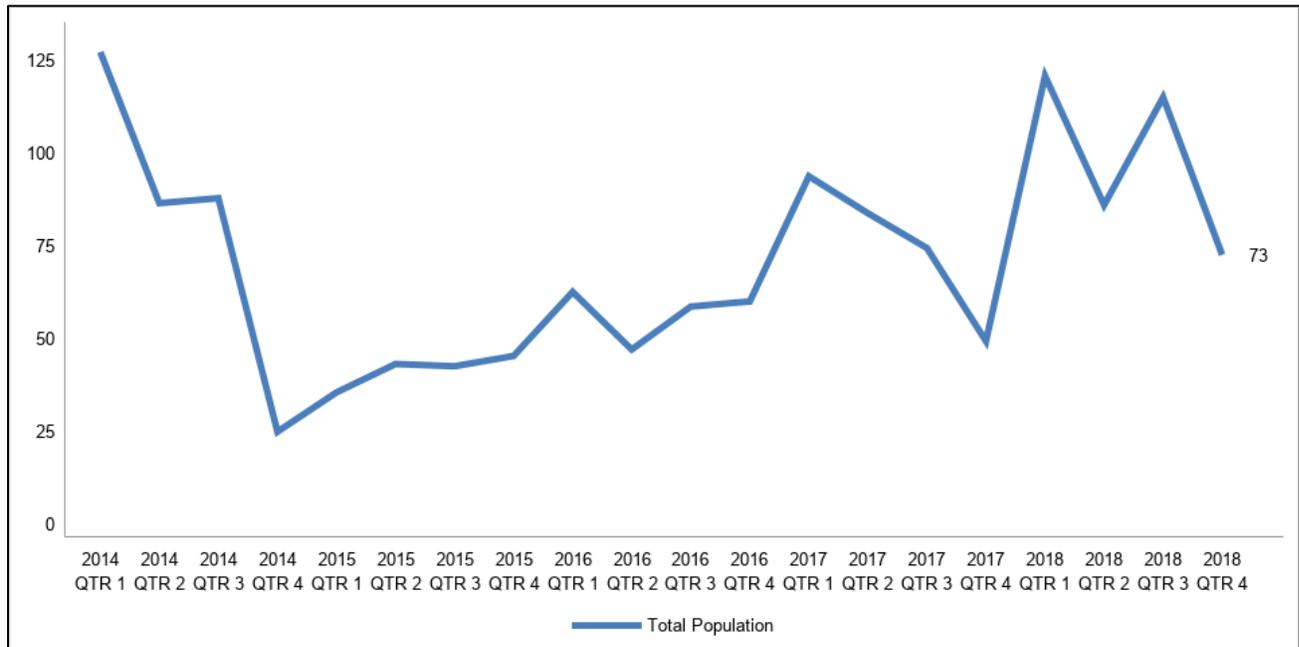
<sup>15</sup> Excludes maternity

<sup>16</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

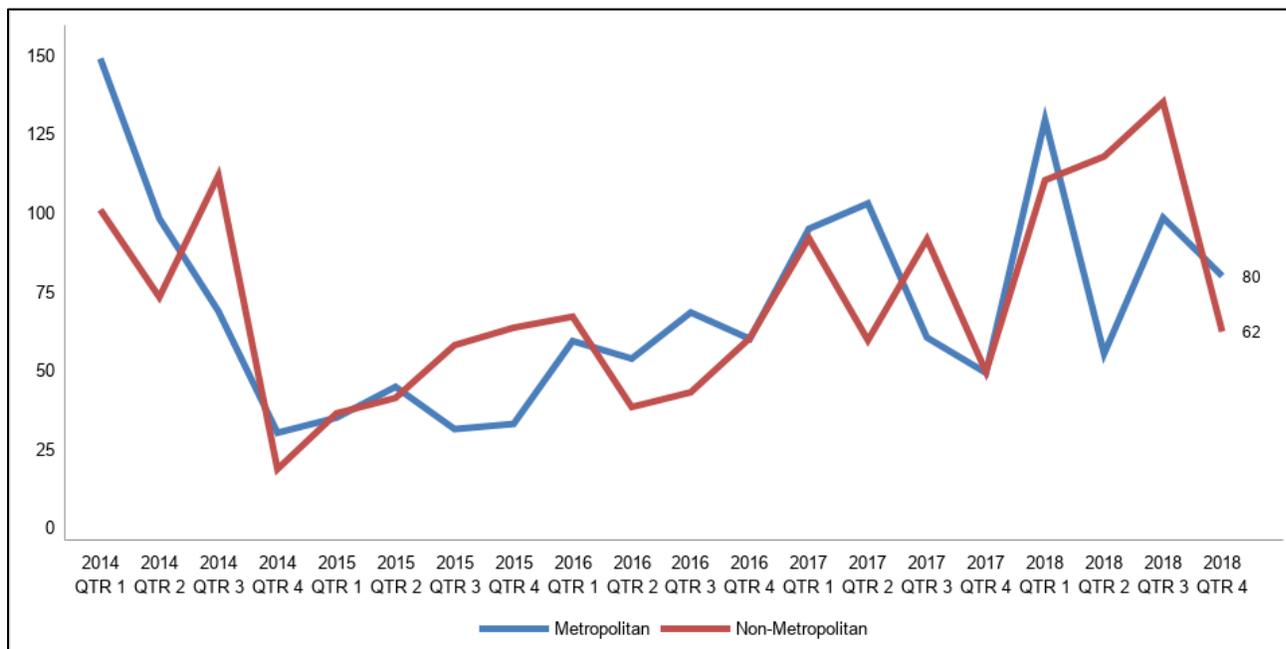
Results Based on 2018 Data

- The beneficiary months had generally decreased in 2018 (Figure 25), but the visit counts varied by quarter throughout 2018. DHHS will continue to monitor this measure to see whether the downward trend continues in future quarters.

**Figure 25. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



**Figure 26. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



Note: The visit counts were less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 visits). Please use caution when interpreting results.

### Utilization of Radiology Providers

Figures 27 through 28 demonstrate the trends in quarterly use of services from radiology providers by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the state.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

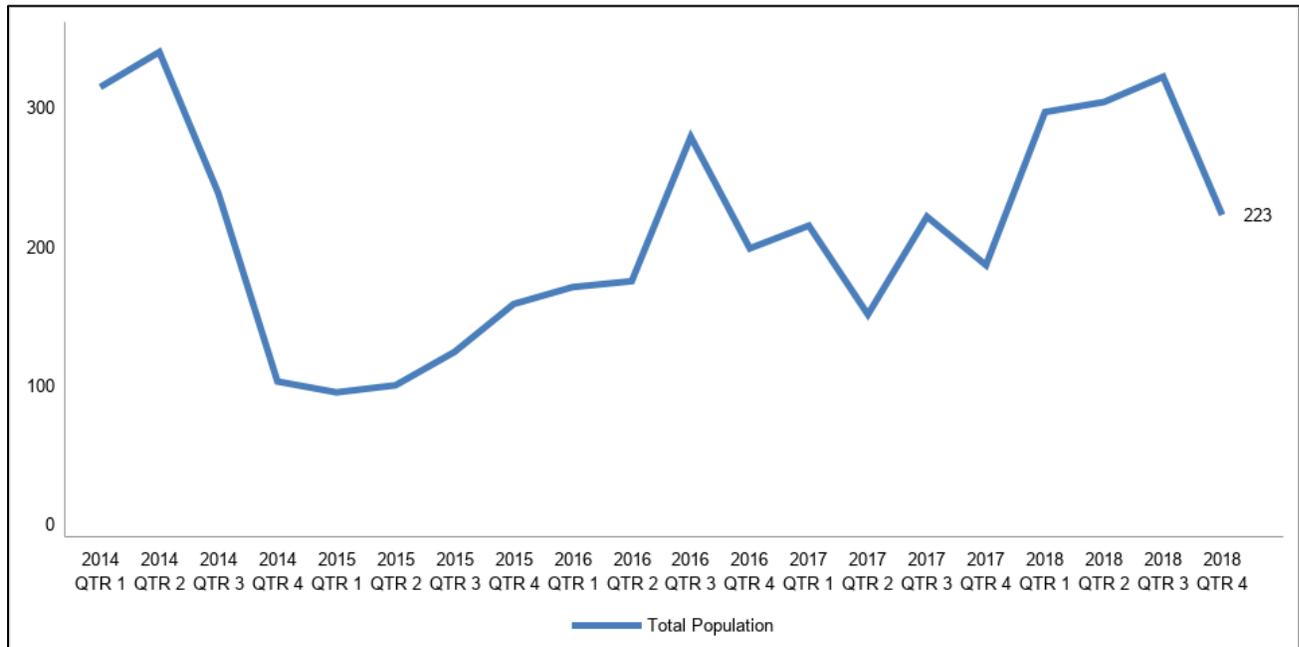
- For Figures 27 and 28, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the new HIPP<sup>17</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014).

<sup>17</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

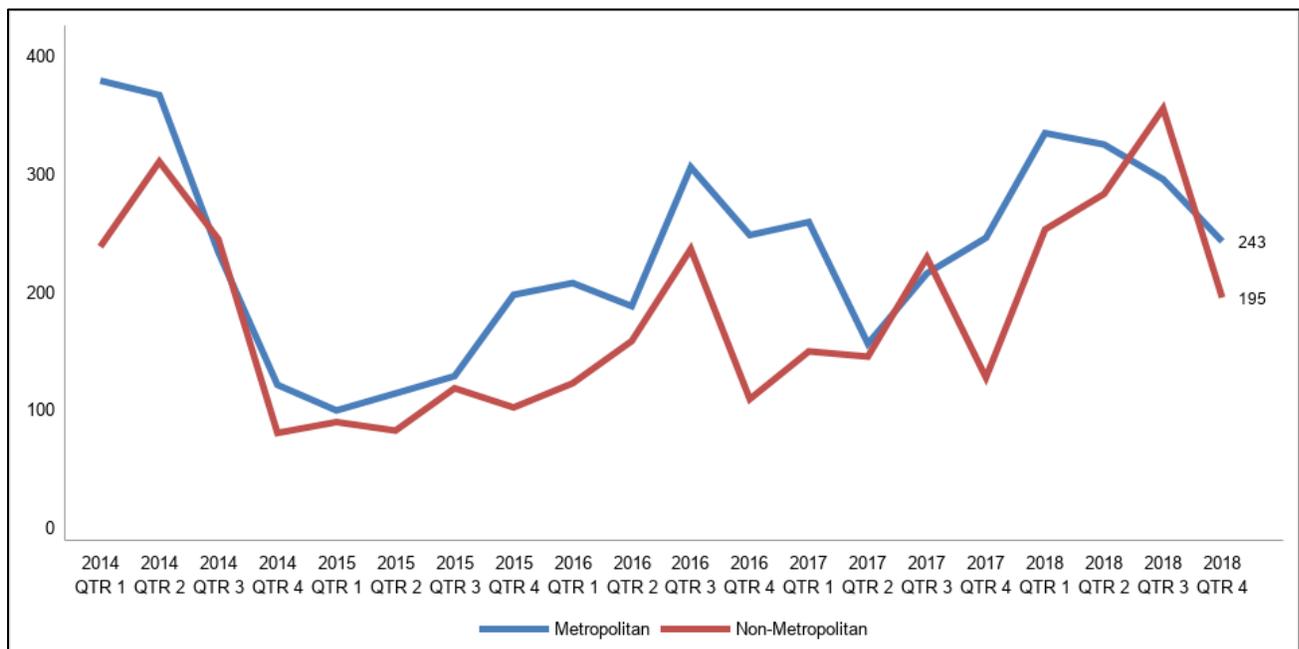
Results Based on 2018 Data

- The beneficiary months had generally decreased in 2018 (Figure 27), but the visit counts showed some variability but ended on a downward trend during Quarter 4 of 2018. DHHS will continue to monitor this measure to see whether the downward trend continues in future quarters.

**Figure 27. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



**Figure 28. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



Note: The visit count in non-metropolitan area was less than 30 for Quarter 4 of 2016. Please use caution when interpreting results.

## Utilization of Surgery Providers

Figures 29 through 30 demonstrate the trends in quarterly use of services from surgery providers by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the state.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of the Medicaid managed care program, new control limits will be developed for all charts as the FFS population stabilizes and sufficient data are collected.

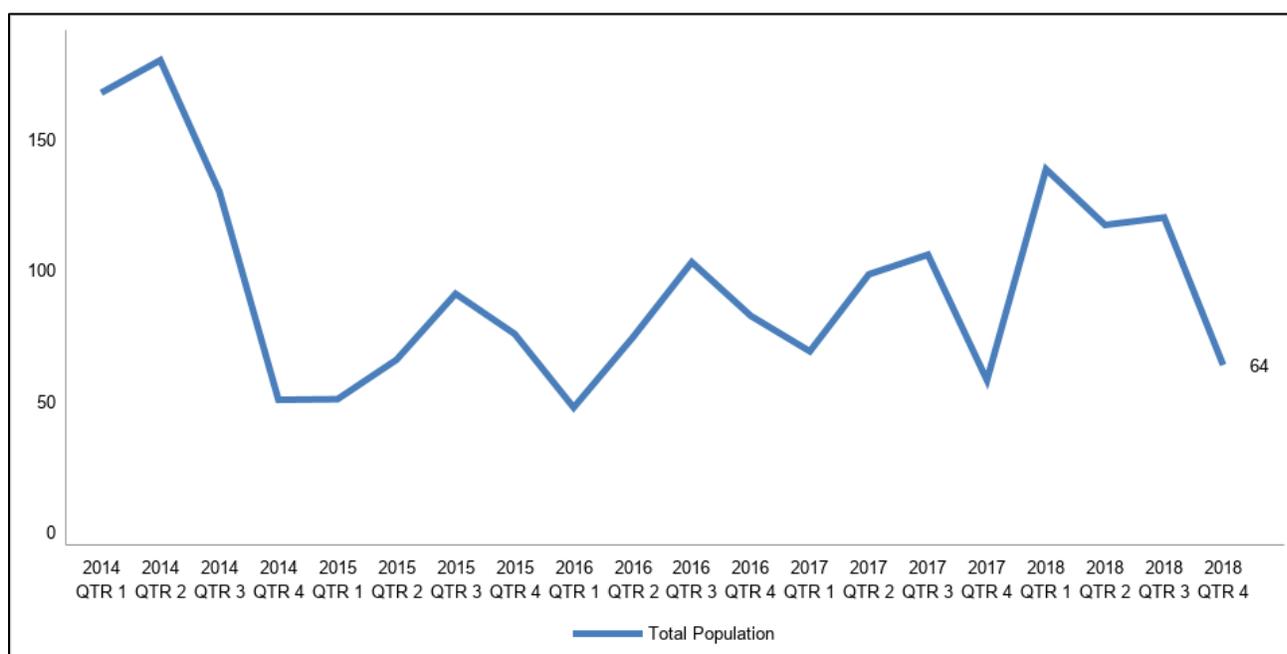
### Results Based on Prior Data

- For Figures 29 and 30, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the new HIPP<sup>18</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014).

### Results Based on 2018 Data

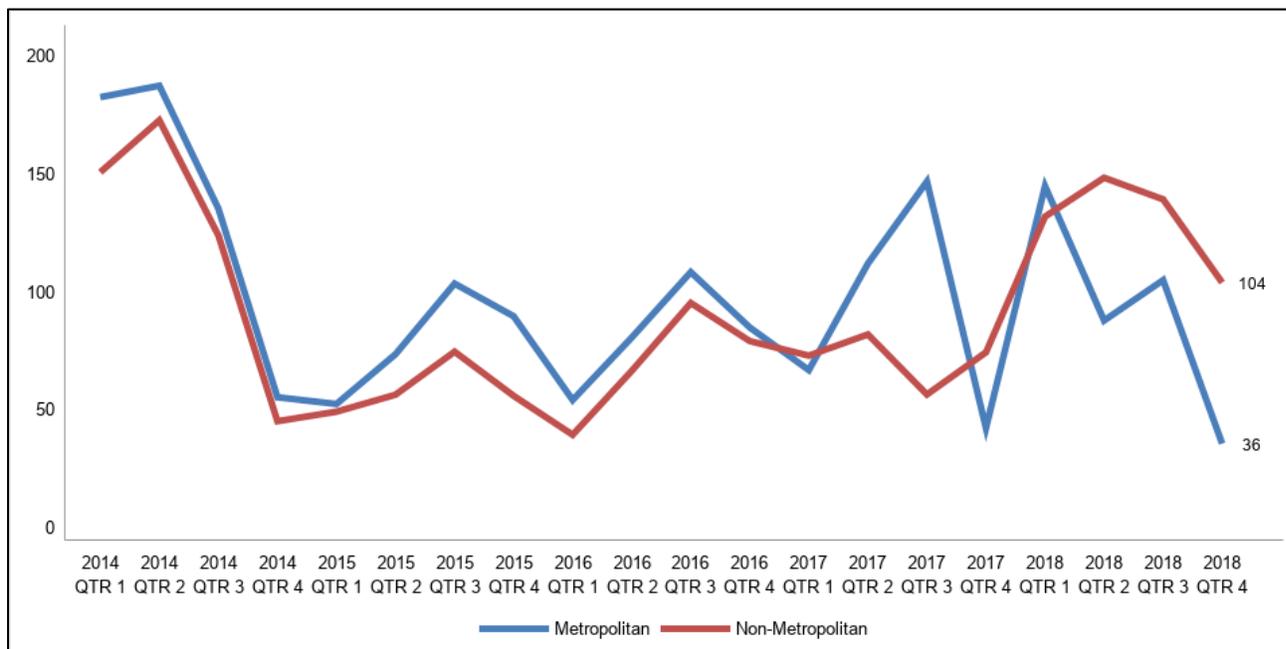
- For the total population (Figure 29), the utilization rates had generally decreased in 2018. DHHS will continue to monitor this measure to see whether the downward trend continues in future quarters.

**Figure 29. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



<sup>18</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

**Figure 30. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



Note: The visit counts were less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 visits). Please use caution when interpreting results.

### Utilization of Home Health Providers

Figures 31 through 32 demonstrate the trends in quarterly use of services from home health providers by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data.

Data are presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan and non-metropolitan areas of the State.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

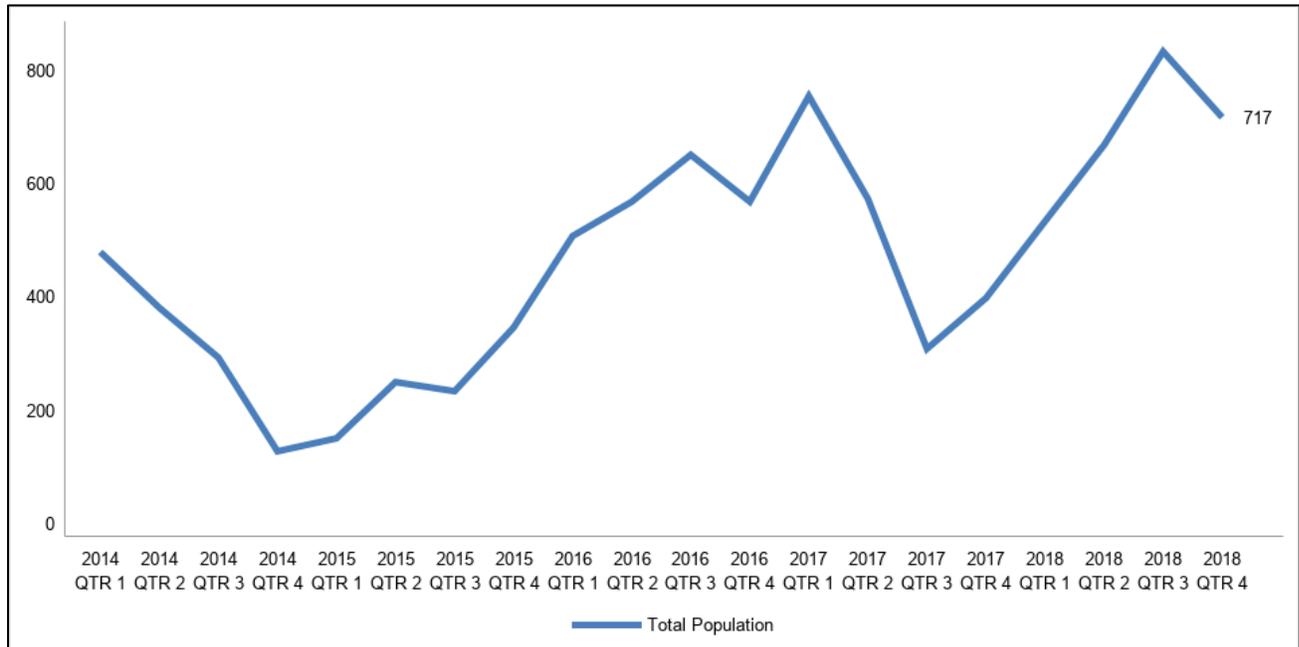
- For Figures 31 and 32, an increase in beneficiary months led to a drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the new HIPP<sup>19</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014).

<sup>19</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

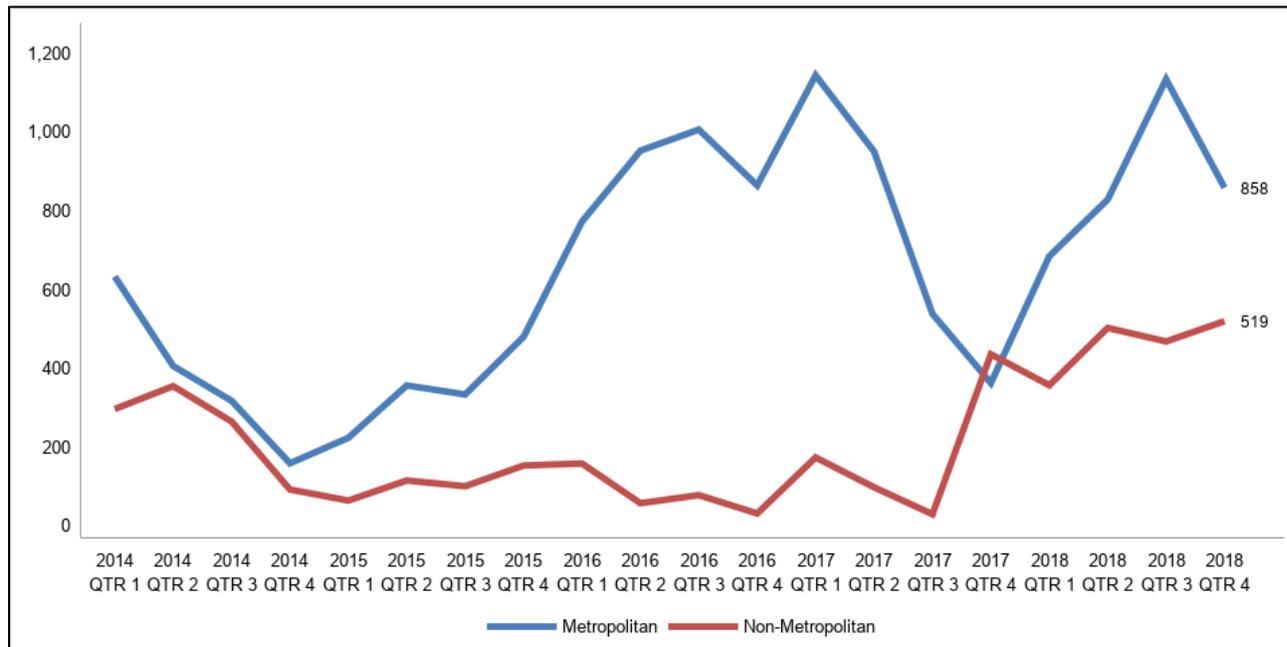
Results Based on 2018 Data

- For the total population (Figure 31), the utilization rates went up from Quarter 1 to Quarter 3 and then went down in Quarter 4 of 2018. DHHS will continue to monitor this measure to see whether the downward trend continues in future quarters.
- Figure 32 shows that the utilization rates for the metropolitan area were higher than those for the non-metropolitan area for all quarters in 2018.

**Figure 31. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



**Figure 32. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



Note: The visit counts for the non-metropolitan area were less than 30 for some quarters (e.g., refer to Appendix B for the list of quarters with less than 30 visits). Please use caution when interpreting results.

### Mental Health Utilization

Figures 33 through 34 demonstrate the trends in quarterly use of mental health services by New Hampshire Medicaid FFS Excluded from Managed Care beneficiaries as indicated by Medicaid FFS claims data. The mental health services were defined based on the National Committee for Quality Assurance (NCQA) measure *Mental Health Utilization* from the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®20</sup>) 2016.

Data are presented for the Medicaid FFS Excluded from Managed Care population stratified by metropolitan versus non-metropolitan areas of the state.

Note: Because the FFS Excluded from Managed Care population has varied over time since the implementation of 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 Based on Prior Data

- For Figures 33 and 34, an increase in beneficiary months led to a sharp drop in utilization rates that occurred during 2014. This may be due to a change in the underlying beneficiary population (e.g., the

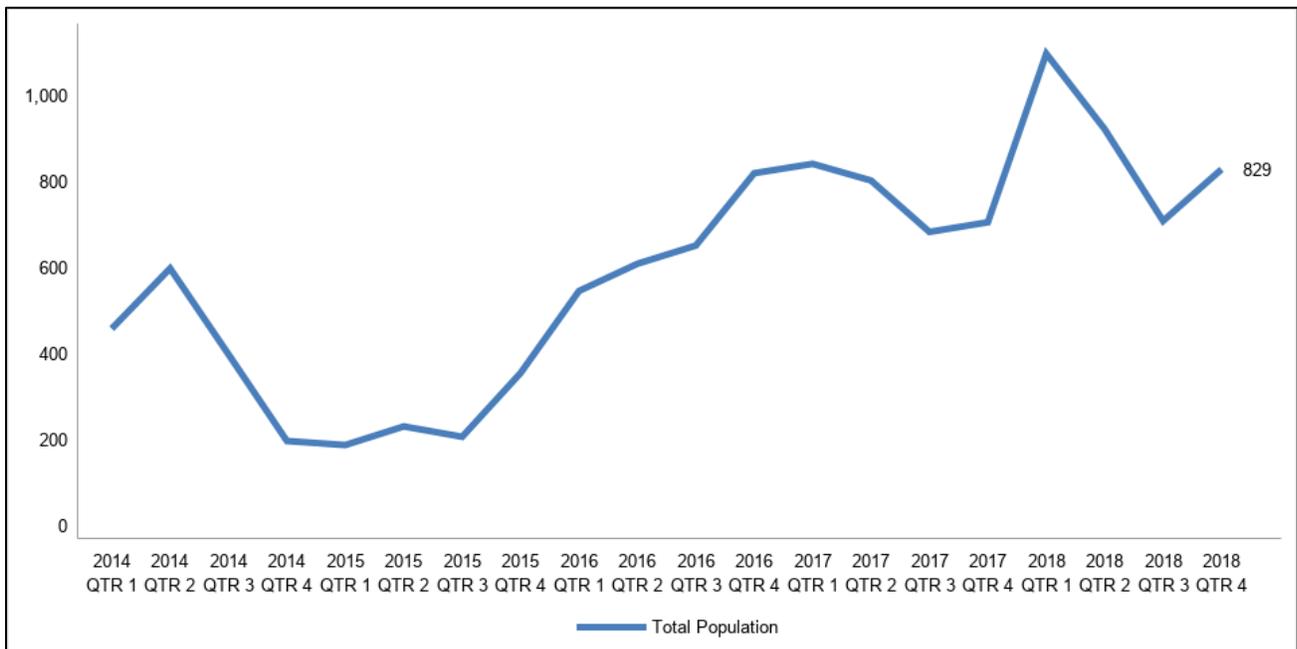
<sup>20</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

new HIPP<sup>21</sup> segment of the NHHPP prior to gaining employer sponsored coverage caused the population increase for the Excluded from Managed Care group from Quarter 3 of 2014 to Quarter 4 of 2014, which contributed to the sudden change in 2014).

Results Based on 2018 Data

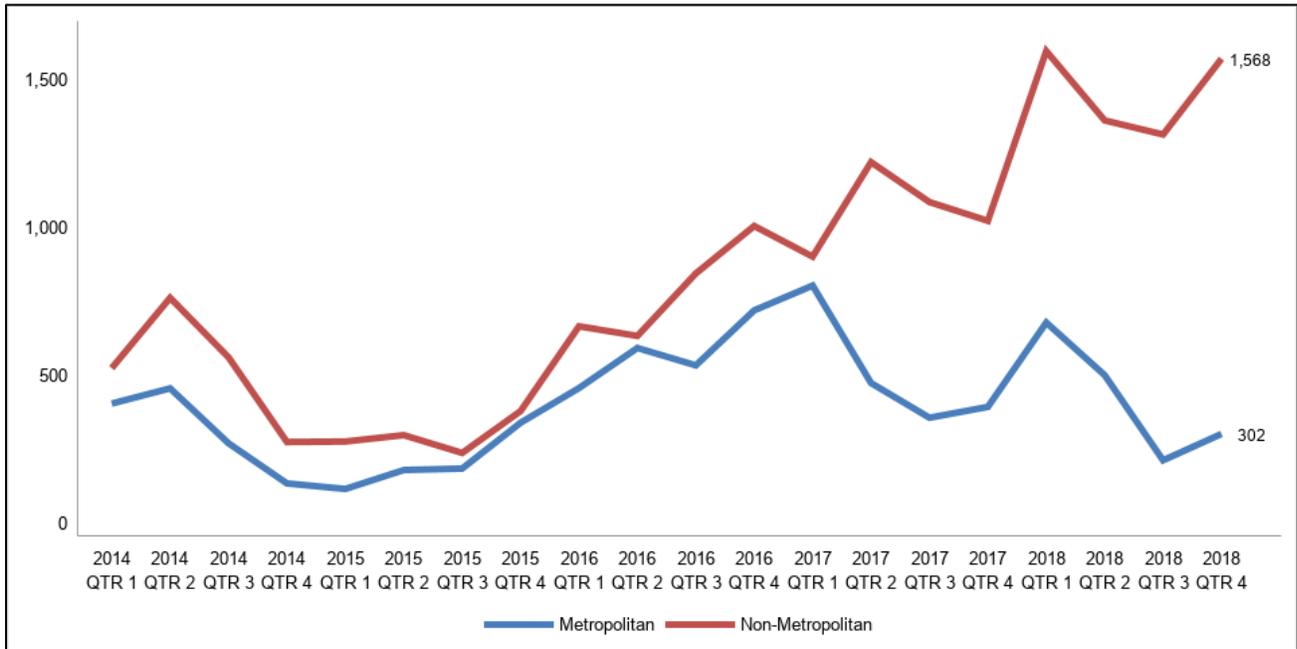
- For the total population (Figure 33), the utilization rates went down from Quarter 1 to Quarter 3 and then went up in Quarter 4 of 2018. DHHS will continue to monitor this measure to see whether the upward trend continues in future quarters.
- Figure 34 shows that the utilization rates for the non-metropolitan area were higher than those for the metropolitan area for all quarters and the difference became more apparent in 2018.

**Figure 33. Utilization from Mental Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**



<sup>21</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 beneficiary was held in FFS. This assessment period has ended and beneficiaries move into employee sponsored health care.

**Figure 34. Utilization from Mental Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**



## 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 assess 2014 to 2018 access levels for physician services, inpatient, and other outpatient services.

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; however, the analysis has shown that the FFS-only population is too small to continue monitoring access with the previous methods.

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.

New Hampshire Medicaid routinely monitors access indicators (i.e., beneficiary enrollment and demographics, member grievances and complaints) 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.

## 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 beneficiaries enrolled transitioned to the Premium Assistance Program.

**Excluded from Managed Care** - Beneficiaries who will never be mandatory for Medicaid Managed Care such as beneficiaries 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 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 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 QHPs 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 FFS Excluded from Managed Care Enrollment: Total Population**

Time Period	Average Beneficiaries
2014 QTR 1	385
2014 QTR 2	409
2014 QTR 3	505
2014 QTR 4	843
2015 QTR 1	695
2015 QTR 2	556
2015 QTR 3	666
2015 QTR 4	427
2016 QTR 1	336
2016 QTR 2	305
2016 QTR 3	284
2016 QTR 4	250
2017 QTR 1	217
2017 QTR 2	203
2017 QTR 3	211
2017 QTR 4	189
2018 QTR 1	204
2018 QTR 2	202
2018 QTR 3	191
2018 QTR 4	193

**Figure 7. NH Medicaid FFS Excluded from Managed Care Enrollment: Metropolitan and Non-Metropolitan Counties**

Time Period	Metropolitan	Non Metropolitan
2014 QTR 1	210	175
2014 QTR 2	217	191
2014 QTR 3	281	224
2014 QTR 4	465	378
2015 QTR 1	382	313
2015 QTR 2	313	243
2015 QTR 3	384	282
2015 QTR 4	253	173
2016 QTR 1	191	144
2016 QTR 2	174	131
2016 QTR 3	176	109
2016 QTR 4	161	89
2017 QTR 1	130	87
2017 QTR 2	113	90
2017 QTR 3	116	95
2017 QTR 4	95	94
2018 QTR 1	111	94
2018 QTR 2	103	99
2018 QTR 3	105	86
2018 QTR 4	113	80

**Figure 8. Active NH Medicaid In-State Physician Providers Compared to Licensed Providers With NH Billing Address, 2018**

Geographic Area	Active Medicaid Providers	Active Non-Medicaid Providers
Total In-State	3,462	866
Metropolitan	1,859	434
Non-Metropolitan	1,603	432

**Figure 9. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians), CY 2014-2018**

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Average Beneficiaries	Ratio	Providers	Average Beneficiaries	Ratio
2014 QTR 1	309	210	0.7	236	175	0.7
2014 QTR 2	317	217	0.7	255	191	0.8
2014 QTR 3	294	281	1.0	227	224	1.0
2014 QTR 4	278	465	1.7	169	378	2.2
2015 QTR 1	213	382	1.8	155	313	2.0
2015 QTR 2	239	313	1.3	134	243	1.8
2015 QTR 3	261	384	1.5	151	282	1.9
2015 QTR 4	182	253	1.4	101	173	1.7
2016 QTR 1	189	191	1.0	86	144	1.7
2016 QTR 2	194	174	0.9	114	131	1.1
2016 QTR 3	233	176	0.8	87	109	1.2
2016 QTR 4	166	161	1.0	72	89	1.2
2017 QTR 1	154	130	0.8	72	87	1.2
2017 QTR 2	124	113	0.9	82	90	1.1
2017 QTR 3	120	116	1.0	99	95	1.0
2017 QTR 4	77	95	1.2	93	94	1.0
2018 QTR 1	137	111	0.8	76	94	1.2
2018 QTR 2	153	103	0.7	92	99	1.1
2018 QTR 3	146	105	0.7	96	86	0.9
2018 QTR 4	136	113	0.8	66	80	1.2

**Figure 10. Ratio of NH Medicaid FFS Excluded from Managed Care Child Beneficiaries to Active In-State Pediatricians, CY 2014-2018**

Time Period	Metropolitan			Non-Metropolitan		
	Providers	0 to 18 Beneficiaries	Ratio	Providers	0 to 18 Beneficiaries	Ratio
2014 QTR 1	2	1	0.5	2	2	1.0
2014 QTR 2	0	0	—	4	3	0.7
2014 QTR 3	0	0	—	1	3	3.3
2014 QTR 4	1	3	2.7	0	5	0.0
2015 QTR 1	2	4	2.2	3	7	2.3
2015 QTR 2	3	10	3.4	2	11	5.3
2015 QTR 3	15	24	1.6	3	12	4.1
2015 QTR 4	23	28	1.2	7	16	2.2
2016 QTR 1	31	33	1.1	5	29	5.7
2016 QTR 2	16	35	2.2	12	27	2.2
2016 QTR 3	27	39	1.4	7	24	3.5
2016 QTR 4	17	30	1.8	6	20	3.3

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Beneficiaries	Ratio	Providers	Beneficiaries	Ratio
2017 QTR 1	20	18	0.9	4	16	4.0
2017 QTR 2	10	17	1.7	6	13	2.2
2017 QTR 3	13	19	1.5	7	11	1.5
2017 QTR 4	6	13	2.1	5	10	2.1
2018 QTR 1	22	18	0.8	4	13	3.2
2018 QTR 2	13	12	0.9	2	9	4.7
2018 QTR 3	10	13	1.3	5	6	1.2
2018 QTR 4	23	18	0.8	1	4	4.0

**Figure 11. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Cardiology Providers, CY 2014-2018**

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Average Beneficiaries	Ratio	Providers	Average Beneficiaries	Ratio
2014 QTR 1	26	210	8	20	175	9
2014 QTR 2	23	217	9	20	191	10
2014 QTR 3	30	281	9	21	224	11
2014 QTR 4	25	465	19	12	378	31
2015 QTR 1	25	382	15	10	313	31
2015 QTR 2	27	313	12	10	243	24
2015 QTR 3	24	384	16	14	282	20
2015 QTR 4	20	253	13	6	173	29
2016 QTR 1	19	191	10	11	144	13
2016 QTR 2	20	174	9	6	131	22
2016 QTR 3	23	176	8	9	109	12
2016 QTR 4	17	161	9	7	89	13
2017 QTR 1	23	130	6	12	87	7
2017 QTR 2	18	113	6	8	90	11
2017 QTR 3	15	116	8	16	95	6
2017 QTR 4	15	95	6	6	94	16
2018 QTR 1	18	111	6	15	94	6
2018 QTR 2	13	103	8	12	99	8
2018 QTR 3	18	105	6	17	86	5
2018 QTR 4	18	113	6	6	80	13

**Figure 12. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Radiology Providers, CY 2014-2018**

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Average Beneficiaries	Ratio	Providers	Average Beneficiaries	Ratio
2014 QTR 1	52	210	4	52	175	3
2014 QTR 2	53	217	4	55	191	3
2014 QTR 3	53	281	5	47	224	5
2014 QTR 4	49	465	9	38	378	10
2015 QTR 1	47	382	8	37	313	8
2015 QTR 2	37	313	8	36	243	7
2015 QTR 3	45	384	9	39	282	7

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Average Beneficiaries	Ratio	Providers	Average Beneficiaries	Ratio
2015 QTR 4	36	253	7	35	173	5
2016 QTR 1	43	191	4	30	144	5
2016 QTR 2	35	174	5	34	131	4
2016 QTR 3	42	176	4	33	109	3
2016 QTR 4	41	161	4	27	89	3
2017 QTR 1	42	130	3	22	87	4
2017 QTR 2	25	113	5	22	90	4
2017 QTR 3	35	116	3	36	95	3
2017 QTR 4	32	95	3	27	94	3
2018 QTR 1	38	111	3	35	94	3
2018 QTR 2	35	103	3	37	99	3
2018 QTR 3	38	105	3	44	86	2
2018 QTR 4	36	113	3	28	80	3

**Figure 13. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Surgery Providers, CY 2014-2018**

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Average Beneficiaries	Ratio	Providers	Average Beneficiaries	Ratio
2014 QTR 1	61	210	3	49	175	4
2014 QTR 2	60	217	4	53	191	4
2014 QTR 3	58	281	5	55	224	4
2014 QTR 4	40	465	12	30	378	13
2015 QTR 1	39	382	10	35	313	9
2015 QTR 2	36	313	9	26	243	9
2015 QTR 3	44	384	9	40	282	7
2015 QTR 4	32	253	8	16	173	11
2016 QTR 1	22	191	9	13	144	11
2016 QTR 2	28	174	6	18	131	7
2016 QTR 3	33	176	5	16	109	7
2016 QTR 4	25	161	6	12	89	7
2017 QTR 1	18	130	7	13	87	7
2017 QTR 2	19	113	6	14	90	6
2017 QTR 3	24	116	5	16	95	6
2017 QTR 4	8	95	12	16	94	6
2018 QTR 1	19	111	6	15	94	6
2018 QTR 2	15	103	7	18	99	6
2018 QTR 3	20	105	5	21	86	4
2018 QTR 4	10	113	11	14	80	6

**Figure 14. Ratio of NH Medicaid FFS Excluded from Managed Care Beneficiaries to Active In-State Home Health Providers, CY 2014-2018**

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Average Beneficiaries	Ratio	Providers	Average Beneficiaries	Ratio
2014 QTR 1	11	210	19	5	175	35
2014 QTR 2	8	217	27	6	191	32
2014 QTR 3	10	281	28	7	224	32

Time Period	Metropolitan			Non-Metropolitan		
	Providers	Average Beneficiaries	Ratio	Providers	Average Beneficiaries	Ratio
2014 QTR 4	7	465	66	5	378	76
2015 QTR 1	7	382	55	4	313	78
2015 QTR 2	8	313	39	4	243	61
2015 QTR 3	8	384	48	6	282	47
2015 QTR 4	9	253	28	3	173	58
2016 QTR 1	13	191	15	4	144	36
2016 QTR 2	9	174	19	5	131	26
2016 QTR 3	9	176	20	3	109	36
2016 QTR 4	8	161	20	3	89	30
2017 QTR 1	11	130	12	4	87	22
2017 QTR 2	10	113	11	3	90	30
2017 QTR 3	8	116	15	1	95	95
2017 QTR 4	7	95	14	2	94	47
2018 QTR 1	6	111	18	4	94	23
2018 QTR 2	6	103	17	6	99	17
2018 QTR 3	8	105	13	4	86	22
2018 QTR 4	9	113	13	5	80	16

**Figure 15. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	944	1,156	817
2014 QTR 2	949	1,226	774
2014 QTR 3	910	1,515	601
2014 QTR 4	768	2,529	304
2015 QTR 1	591	2,085	283
2015 QTR 2	554	1,669	332
2015 QTR 3	648	1,998	324
2015 QTR 4	363	1,280	284
2016 QTR 1	383	1,007	380
2016 QTR 2	383	914	419
2016 QTR 3	385	853	451
2016 QTR 4	250	750	333
2017 QTR 1	289	651	444
2017 QTR 2	216	609	355
2017 QTR 3	230	632	364
2017 QTR 4	195	568	343
2018 QTR 1	247	613	403
2018 QTR 2	331	605	547
2018 QTR 3	268	574	467
2018 QTR 4	257	579	444

**Figure 16. Physician/APRN/Clinic Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	522	631	827	422	525	804
2014 QTR 2	520	652	798	429	574	747

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 3	537	844	636	373	671	556
2014 QTR 4	481	1,396	345	287	1,133	253
2015 QTR 1	341	1,147	297	250	938	267
2015 QTR 2	348	940	370	206	729	283
2015 QTR 3	384	1,152	333	264	846	312
2015 QTR 4	246	760	324	117	520	225
2016 QTR 1	210	574	366	173	433	400
2016 QTR 2	224	522	429	159	392	406
2016 QTR 3	275	527	522	110	326	337
2016 QTR 4	174	484	360	76	266	286
2017 QTR 1	192	390	492	97	261	372
2017 QTR 2	126	340	371	90	269	335
2017 QTR 3	141	348	405	89	284	313
2017 QTR 4	88	285	309	107	283	378
2018 QTR 1	138	332	416	109	281	388
2018 QTR 2	189	308	614	142	297	478
2018 QTR 3	158	315	502	110	259	425
2018 QTR 4	158	338	467	99	241	411

**Figure 17. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	27	1,156	23
2014 QTR 2	23	1,226	19
2014 QTR 3	20	1,515	13
2014 QTR 4	23	2,529	9
2015 QTR 1	14	2,085	7
2015 QTR 2	7	1,669	4
2015 QTR 3	15	1,998	8
2015 QTR 4	10	1,280	8
2016 QTR 1	5	1,007	5
2016 QTR 2	8	914	9
2016 QTR 3	8	853	9
2016 QTR 4	3	750	4
2017 QTR 1	10	651	15
2017 QTR 2	7	609	11
2017 QTR 3	7	632	11
2017 QTR 4	3	568	5
2018 QTR 1	8	613	13
2018 QTR 2	8	605	13
2018 QTR 3	7	574	12
2018 QTR 4	7	579	12

**Figure 18. Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	18	631	29	9	525	17

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 2	16	652	25	7	574	12
2014 QTR 3	18	844	21	2	671	3
2014 QTR 4	16	1,396	11	7	1,133	6
2015 QTR 1	5	1,147	4	9	938	10
2015 QTR 2	2	940	2	5	729	7
2015 QTR 3	11	1,152	10	4	846	5
2015 QTR 4	7	760	9	3	520	6
2016 QTR 1	4	574	7	1	433	2
2016 QTR 2	4	522	8	4	392	10
2016 QTR 3	7	527	13	1	326	3
2016 QTR 4	3	484	6	0	266	0
2017 QTR 1	4	390	10	6	261	23
2017 QTR 2	5	340	15	2	269	7
2017 QTR 3	2	348	6	5	284	18
2017 QTR 4	1	285	4	2	283	7
2018 QTR 1	7	332	21	1	281	4
2018 QTR 2	7	308	23	1	297	3
2018 QTR 3	4	315	13	3	259	12
2018 QTR 4	5	338	15	2	241	8

**Figure 19. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	157	1,156	136
2014 QTR 2	153	1,226	125
2014 QTR 3	134	1,515	88
2014 QTR 4	99	2,529	39
2015 QTR 1	77	2,085	37
2015 QTR 2	81	1,669	49
2015 QTR 3	117	1,998	59
2015 QTR 4	81	1,280	63
2016 QTR 1	55	1,007	55
2016 QTR 2	71	914	78
2016 QTR 3	90	853	106
2016 QTR 4	96	750	128
2017 QTR 1	52	651	80
2017 QTR 2	63	609	103
2017 QTR 3	66	632	104
2017 QTR 4	57	568	100
2018 QTR 1	63	613	103
2018 QTR 2	66	605	109
2018 QTR 3	59	574	103
2018 QTR 4	43	579	74

**Figure 20. Total Emergency Department Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	103	631	163	54	525	103
2014 QTR 2	107	652	164	46	574	80
2014 QTR 3	81	844	96	53	671	79
2014 QTR 4	63	1,396	45	36	1,133	32
2015 QTR 1	49	1,147	43	28	938	30
2015 QTR 2	50	940	53	31	729	43
2015 QTR 3	68	1,152	59	49	846	58
2015 QTR 4	59	760	78	22	520	42
2016 QTR 1	39	574	68	16	433	37
2016 QTR 2	49	522	94	22	392	56
2016 QTR 3	63	527	120	27	326	83
2016 QTR 4	82	484	169	14	266	53
2017 QTR 1	33	390	85	19	261	73
2017 QTR 2	28	340	82	35	269	130
2017 QTR 3	37	348	106	29	284	102
2017 QTR 4	32	285	112	25	283	88
2018 QTR 1	41	332	123	22	281	78
2018 QTR 2	46	308	149	20	297	67
2018 QTR 3	27	315	86	32	259	124
2018 QTR 4	29	338	86	14	241	58

**Figure 21. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	4	1,156	3.5
2014 QTR 2	3	1,226	2.4
2014 QTR 3	2	1,515	1.3
2014 QTR 4	3	2,529	1.2
2015 QTR 1	2	2,085	1.0
2015 QTR 2	0	1,669	0.0
2015 QTR 3	0	1,998	0.0
2015 QTR 4	5	1,280	3.9
2016 QTR 1	1	1,007	1.0
2016 QTR 2	3	914	3.3
2016 QTR 3	3	853	3.5
2016 QTR 4	4	750	5.3
2017 QTR 1	2	651	3.1
2017 QTR 2	1	609	1.6
2017 QTR 3	0	632	0.0
2017 QTR 4	0	568	0.0
2018 QTR 1	2	613	3.3
2018 QTR 2	0	605	0.0
2018 QTR 3	2	574	3.5
2018 QTR 4	2	579	3.5

**Figure 22. Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	1	631	1.6	3	525	5.7
2014 QTR 2	3	652	4.6	0	574	0.0
2014 QTR 3	1	844	1.2	1	671	1.5
2014 QTR 4	2	1,396	1.4	1	1,133	0.9
2015 QTR 1	1	1,147	0.9	1	938	1.1
2015 QTR 2	0	940	0.0	0	729	0.0
2015 QTR 3	0	1,152	0.0	0	846	0.0
2015 QTR 4	4	760	5.3	1	520	1.9
2016 QTR 1	1	574	1.7	0	433	0.0
2016 QTR 2	3	522	5.7	0	392	0.0
2016 QTR 3	1	527	1.9	2	326	6.1
2016 QTR 4	4	484	8.3	0	266	0.0
2017 QTR 1	2	390	5.1	0	261	0.0
2017 QTR 2	0	340	0.0	1	269	3.7
2017 QTR 3	0	348	0.0	0	284	0.0
2017 QTR 4	0	285	0.0	0	283	0.0
2018 QTR 1	2	332	6.0	0	281	0.0
2018 QTR 2	0	308	0.0	0	297	0.0
2018 QTR 3	2	315	6.3	0	259	0.0
2018 QTR 4	1	338	3.0	1	241	4.1

**Figure 23. Inpatient Hospital Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	75	1,156	64.9
2014 QTR 2	68	1,226	55.5
2014 QTR 3	61	1,515	40.3
2014 QTR 4	45	2,529	17.8
2015 QTR 1	20	2,085	9.6
2015 QTR 2	31	1,669	18.6
2015 QTR 3	41	1,998	20.5
2015 QTR 4	38	1,280	29.7
2016 QTR 1	26	1,007	25.8
2016 QTR 2	40	914	43.8
2016 QTR 3	46	853	53.9
2016 QTR 4	36	750	48.0
2017 QTR 1	34	651	52.2
2017 QTR 2	31	609	50.9
2017 QTR 3	29	632	45.9
2017 QTR 4	25	568	44.0
2018 QTR 1	22	613	35.9
2018 QTR 2	27	605	44.6
2018 QTR 3	32	574	55.7
2018 QTR 4	27	579	46.6

**Figure 24. Inpatient Hospital Utilization per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	56	631	88.7	19	525	36.2
2014 QTR 2	45	652	69.0	23	574	40.1
2014 QTR 3	38	844	45.0	23	671	34.3
2014 QTR 4	27	1,396	19.3	18	1,133	15.9
2015 QTR 1	12	1,147	10.5	8	938	8.5
2015 QTR 2	22	940	23.4	9	729	12.3
2015 QTR 3	26	1,152	22.6	15	846	17.7
2015 QTR 4	31	760	40.8	7	520	13.5
2016 QTR 1	21	574	36.6	5	433	11.5
2016 QTR 2	32	522	61.3	8	392	20.4
2016 QTR 3	32	527	60.7	14	326	42.9
2016 QTR 4	33	484	68.2	3	266	11.3
2017 QTR 1	25	390	64.1	9	261	34.5
2017 QTR 2	17	340	50.0	14	269	52.0
2017 QTR 3	18	348	51.7	11	284	38.7
2017 QTR 4	14	285	49.1	11	283	38.9
2018 QTR 1	16	332	48.2	6	281	21.4
2018 QTR 2	13	308	42.2	14	297	47.1
2018 QTR 3	15	315	47.6	17	259	65.6
2018 QTR 4	16	338	47.3	11	241	45.6

**Figure 25. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	147	1,156	127
2014 QTR 2	106	1,226	86
2014 QTR 3	133	1,515	88
2014 QTR 4	63	2,529	25
2015 QTR 1	74	2,085	35
2015 QTR 2	72	1,669	43
2015 QTR 3	85	1,998	43
2015 QTR 4	58	1,280	45
2016 QTR 1	63	1,007	63
2016 QTR 2	43	914	47
2016 QTR 3	50	853	59
2016 QTR 4	45	750	60
2017 QTR 1	61	651	94
2017 QTR 2	51	609	84
2017 QTR 3	47	632	74
2017 QTR 4	28	568	49
2018 QTR 1	74	613	121
2018 QTR 2	52	605	86
2018 QTR 3	66	574	115
2018 QTR 4	42	579	73

**Figure 26. Utilization from Cardiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	94	631	149	53	525	101
2014 QTR 2	64	652	98	42	574	73
2014 QTR 3	58	844	69	75	671	112
2014 QTR 4	42	1,396	30	21	1,133	19
2015 QTR 1	40	1,147	35	34	938	36
2015 QTR 2	42	940	45	30	729	41
2015 QTR 3	36	1,152	31	49	846	58
2015 QTR 4	25	760	33	33	520	63
2016 QTR 1	34	574	59	29	433	67
2016 QTR 2	28	522	54	15	392	38
2016 QTR 3	36	527	68	14	326	43
2016 QTR 4	29	484	60	16	266	60
2017 QTR 1	37	390	95	24	261	92
2017 QTR 2	35	340	103	16	269	59
2017 QTR 3	21	348	60	26	284	92
2017 QTR 4	14	285	49	14	283	49
2018 QTR 1	43	332	130	31	281	110
2018 QTR 2	17	308	55	35	297	118
2018 QTR 3	31	315	98	35	259	135
2018 QTR 4	27	338	80	15	241	62

**Figure 27. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	364	1,156	315
2014 QTR 2	417	1,226	340
2014 QTR 3	361	1,515	238
2014 QTR 4	260	2,529	103
2015 QTR 1	198	2,085	95
2015 QTR 2	167	1,669	100
2015 QTR 3	248	1,998	124
2015 QTR 4	203	1,280	159
2016 QTR 1	172	1,007	171
2016 QTR 2	160	914	175
2016 QTR 3	238	853	279
2016 QTR 4	149	750	199
2017 QTR 1	140	651	215
2017 QTR 2	92	609	151
2017 QTR 3	140	632	222
2017 QTR 4	106	568	187
2018 QTR 1	182	613	297
2018 QTR 2	184	605	304
2018 QTR 3	185	574	322
2018 QTR 4	129	579	223

**Figure 28. Utilization from Radiology Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	239	631	379	125	525	238
2014 QTR 2	239	652	367	178	574	310
2014 QTR 3	197	844	233	164	671	244
2014 QTR 4	169	1,396	121	91	1,133	80
2015 QTR 1	114	1,147	99	84	938	90
2015 QTR 2	107	940	114	60	729	82
2015 QTR 3	148	1,152	128	100	846	118
2015 QTR 4	150	760	197	53	520	102
2016 QTR 1	119	574	207	53	433	122
2016 QTR 2	98	522	188	62	392	158
2016 QTR 3	161	527	306	77	326	236
2016 QTR 4	120	484	248	29	266	109
2017 QTR 1	101	390	259	39	261	149
2017 QTR 2	53	340	156	39	269	145
2017 QTR 3	75	348	216	65	284	229
2017 QTR 4	70	285	246	36	283	127
2018 QTR 1	111	332	334	71	281	253
2018 QTR 2	100	308	325	84	297	283
2018 QTR 3	93	315	295	92	259	355
2018 QTR 4	82	338	243	47	241	195

**Figure 29. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	194	1,156	168
2014 QTR 2	221	1,226	180
2014 QTR 3	197	1,515	130
2014 QTR 4	128	2,529	51
2015 QTR 1	106	2,085	51
2015 QTR 2	110	1,669	66
2015 QTR 3	182	1,998	91
2015 QTR 4	97	1,280	76
2016 QTR 1	48	1,007	48
2016 QTR 2	68	914	74
2016 QTR 3	88	853	103
2016 QTR 4	62	750	83
2017 QTR 1	45	651	69
2017 QTR 2	60	609	99
2017 QTR 3	67	632	106
2017 QTR 4	33	568	58
2018 QTR 1	85	613	139
2018 QTR 2	71	605	117
2018 QTR 3	69	574	120
2018 QTR 4	37	579	64

**Figure 30. Utilization from Surgery Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	115	631	182	79	525	150
2014 QTR 2	122	652	187	99	574	172
2014 QTR 3	114	844	135	83	671	124
2014 QTR 4	77	1,396	55	51	1,133	45
2015 QTR 1	60	1,147	52	46	938	49
2015 QTR 2	69	940	73	41	729	56
2015 QTR 3	119	1,152	103	63	846	74
2015 QTR 4	68	760	89	29	520	56
2016 QTR 1	31	574	54	17	433	39
2016 QTR 2	42	522	80	26	392	66
2016 QTR 3	57	527	108	31	326	95
2016 QTR 4	41	484	85	21	266	79
2017 QTR 1	26	390	67	19	261	73
2017 QTR 2	38	340	112	22	269	82
2017 QTR 3	51	348	147	16	284	56
2017 QTR 4	12	285	42	21	283	74
2018 QTR 1	48	332	145	37	281	132
2018 QTR 2	27	308	88	44	297	148
2018 QTR 3	33	315	105	36	259	139
2018 QTR 4	12	338	36	25	241	104

**Figure 31. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	554	1,156	479
2014 QTR 2	467	1,226	381
2014 QTR 3	444	1,515	293
2014 QTR 4	323	2,529	128
2015 QTR 1	314	2,085	151
2015 QTR 2	417	1,669	250
2015 QTR 3	467	1,998	234
2015 QTR 4	443	1,280	346
2016 QTR 1	511	1,007	507
2016 QTR 2	519	914	568
2016 QTR 3	555	853	651
2016 QTR 4	426	750	568
2017 QTR 1	491	651	754
2017 QTR 2	349	609	573
2017 QTR 3	195	632	309
2017 QTR 4	226	568	398
2018 QTR 1	327	613	533
2018 QTR 2	404	605	668
2018 QTR 3	478	574	833
2018 QTR 4	415	579	717

**Figure 32. Utilization from Home Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months, CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	399	631	632	155	525	295
2014 QTR 2	264	652	405	203	574	354
2014 QTR 3	267	844	316	177	671	264
2014 QTR 4	220	1,396	158	103	1,133	91
2015 QTR 1	255	1,147	222	59	938	63
2015 QTR 2	334	940	355	83	729	114
2015 QTR 3	383	1,152	332	84	846	99
2015 QTR 4	364	760	479	79	520	152
2016 QTR 1	443	574	772	68	433	157
2016 QTR 2	497	522	952	22	392	56
2016 QTR 3	530	527	1,006	25	326	77
2016 QTR 4	418	484	864	8	266	30
2017 QTR 1	446	390	1,144	45	261	172
2017 QTR 2	323	340	950	26	269	97
2017 QTR 3	187	348	537	8	284	28
2017 QTR 4	103	285	361	123	283	435
2018 QTR 1	227	332	684	100	281	356
2018 QTR 2	255	308	828	149	297	502
2018 QTR 3	357	315	1,133	121	259	467
2018 QTR 4	290	338	858	125	241	519

**Figure 33. Utilization from Mental Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months , CY 2014-2018**

Time Period	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	530	1,156	458
2014 QTR 2	734	1,226	599
2014 QTR 3	604	1,515	399
2014 QTR 4	499	2,529	197
2015 QTR 1	392	2,085	188
2015 QTR 2	386	1,669	231
2015 QTR 3	414	1,998	207
2015 QTR 4	455	1,280	355
2016 QTR 1	550	1,007	546
2016 QTR 2	557	914	609
2016 QTR 3	556	853	652
2016 QTR 4	615	750	820
2017 QTR 1	548	651	842
2017 QTR 2	489	609	803
2017 QTR 3	432	632	684
2017 QTR 4	401	568	706
2018 QTR 1	673	613	1,098
2018 QTR 2	558	605	922
2018 QTR 3	407	574	709
2018 QTR 4	480	579	829

**Figure 34. Utilization from Mental Health Providers per 1,000 NH Medicaid FFS Excluded from Managed Care Beneficiary Months , CY 2014-2018: Metropolitan Counties and Non-Metropolitan Counties**

Time Period	Metropolitan			Non-Metropolitan		
	Visits	Beneficiary Months	Rate per 1,000	Visits	Beneficiary Months	Rate per 1,000
2014 QTR 1	255	631	404	275	525	524
2014 QTR 2	297	652	456	437	574	761
2014 QTR 3	228	844	270	376	671	560
2014 QTR 4	188	1,396	135	311	1,133	274
2015 QTR 1	133	1,147	116	259	938	276
2015 QTR 2	169	940	180	217	729	298
2015 QTR 3	213	1,152	185	201	846	238
2015 QTR 4	258	760	339	197	520	379
2016 QTR 1	262	574	456	288	433	665
2016 QTR 2	309	522	592	248	392	633
2016 QTR 3	281	527	533	275	326	844
2016 QTR 4	348	484	719	267	266	1,004
2017 QTR 1	313	390	803	235	261	900
2017 QTR 2	161	340	474	328	269	1,219
2017 QTR 3	124	348	356	308	284	1,085
2017 QTR 4	112	285	393	289	283	1,021
2018 QTR 1	225	332	678	448	281	1,594
2018 QTR 2	154	308	500	404	297	1,360
2018 QTR 3	67	315	213	340	259	1,313
2018 QTR 4	102	338	302	378	241	1,568

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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 provided to NH's Medicaid Medical Care Advisory Committee (MCAC) on August 23, 2017. The Department did not receive any correspondence from the general public or MCAC.