Monitoring Access to Care in New Hampshire's Medicaid Program

Review of Key Indicators – February 2013

A Report Prepared by the Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services

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1. Introduction

This report describes the New Hampshire Medicaid program's overall system of healthcare-access measuring, monitoring, and intervention. It is the fourth edition of the report reflecting paid services data through September 2013.[*] The report provides data measuring the adequacy of the Medicaid provider network and level of provider availability, utilization of healthcare by Medicaid beneficiaries over a five year period, as well as consumer perceptions of their ability to access care. New Hampshire engages Medicaid beneficiaries through its consumer hotline as well as through its Medical Care Advisory Committee and stakeholder meetings. Taken together, this data and analysis show that New Hampshire Medicaid beneficiaries have access to healthcare that is similar to that of the general population in New Hampshire. The data and analysis also demonstrate that New Hampshire Medicaid beneficiaries have maintained similar levels of access since the implementation of the 2008 rate changes and the 2011 Disproportionate Share Hospital (DSH) payment changes.

This report focuses on beneficiaries' access to hospital, physician, clinical care, and new in this report, behavioral health services, but not on the full range of New Hampshire Medicaid-covered health care services. For example, data concerning New Hampshire Medicaid beneficiaries' access to long term care services are not addressed in this report and will be the subject of future evaluations. Changes to the reporting format/content in this report include:

- Updates to all quarterly measures.
- Inclusion of an additional 11,000 child members as the result of New Hampshire's transition from its separate CHIP program to a Medicaid expansion program which occurred July 1, 2012. This is noted on relevant member trend charts, necessitated rebasing of member to provider ratio trends, and impacted selected utilization charts due to the relative health of this population.
- An aftermath review of the impact of LRGHealthcare access restrictions on beneficiaries.

New Hampshire Medicaid provides coverage for low-income children, pregnant women, parents with children, elders, and people with disabilities. The New Hampshire Department of Health and Human Services (DHHS) is the single State agency that administers the New Hampshire Medicaid program. New Hampshire Medicaid covered all or part of the health care costs of more than 171,000 people during State Fiscal Year 2011 (July 1, 2010 through June 30, 2011) for a total expenditure of $1.4 Billion.

New Hampshire measures and monitors indicators of healthcare access to ensure sufficient Medicaid beneficiary access to covered services. Pursuant to 42 U.S.C. 1396a(a)(30)(A), New Hampshire's Medicaid program must provide for methods and procedures relative to the utilization of and payment for covered care and services as are necessary to safeguard against unnecessary utilization of care and services and assure that payments are consistent with efficiency, economy, and quality of care. New Hampshire must also ensure that payments are sufficient to enlist enough providers to provide care and

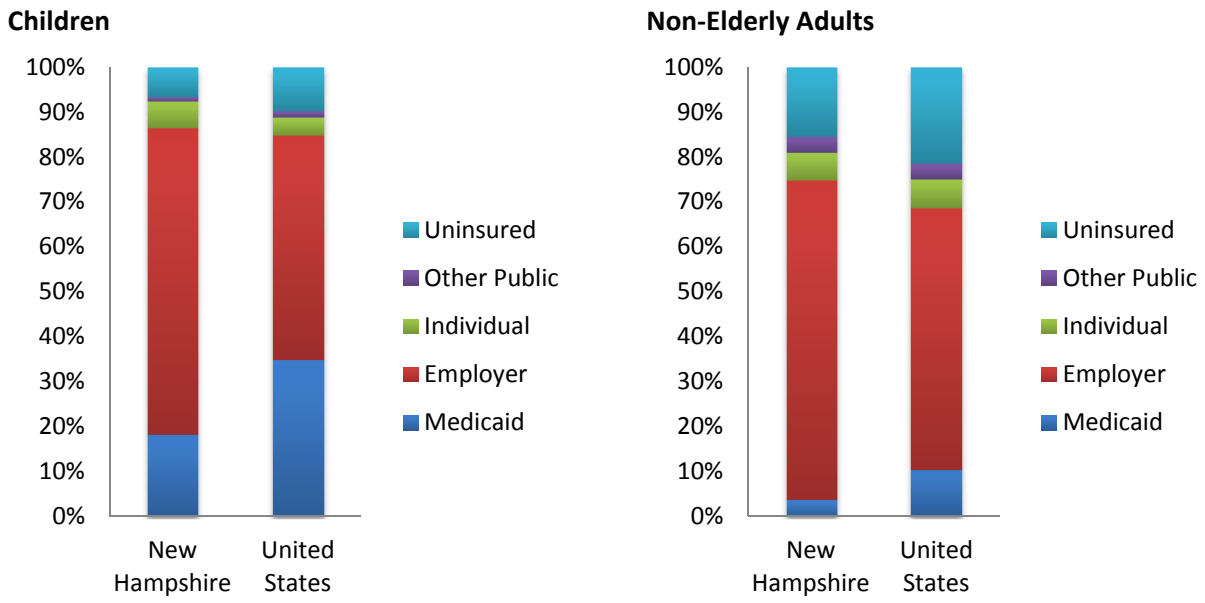
[*] See: http://www.dhhs.nh.gov/ombp/publications.htm#monitoring for prior reports.

services to Medicaid beneficiaries at least to the extent that such care and services are available to the general population in the geographic region. New Hampshire takes these obligations seriously and has developed several mechanisms to assess and monitor beneficiary access.

No common standards exist to demonstrate appropriate healthcare access for Medicaid beneficiaries. The Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC) does provide guidance, however, on the issue of access in its March 2011 Report to the Congress. MACPAC suggests a framework for examining healthcare access for Medicaid and CHIP beneficiaries. The suggested framework has three main elements: beneficiaries and their unique characteristics, provider availability for the Medicaid and CHIP populations, and utilization of available healthcare services. New Hampshire Medicaid's systematic approach to measuring and monitoring healthcare access builds on this MACPAC framework.

New Hampshire has high rates of commercially-covered individuals and low rates of Medicaid-covered and uninsured individuals. Based on Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates, which are based on the Census Bureau's 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements), while the national average for the percentage of a state's population enrolled in Medicaid is 16%, approximately 7% of New Hampshire's population is enrolled in Medicaid. Approximately 18% of New Hampshire's children are covered by Medicaid, compared to 35% nationally, while 68% of New Hampshire children received their coverage through Employer-Sponsored Insurance, compared to 50% nationally. Among the total non-elderly population, New Hampshire has the smallest percent of its population receiving health coverage through Medicaid with a rate of 8% compared to the national average of 18%. New Hampshire also has the highest percent of its population covered by employer-sponsored coverage with a rate of 70% compared to the national average of 56%. The figures below present this information for children and non-elderly adults.

Figure 1. New Hampshire Health Insurance Coverage Compared to the United States, Children and Adults, 2010-2011



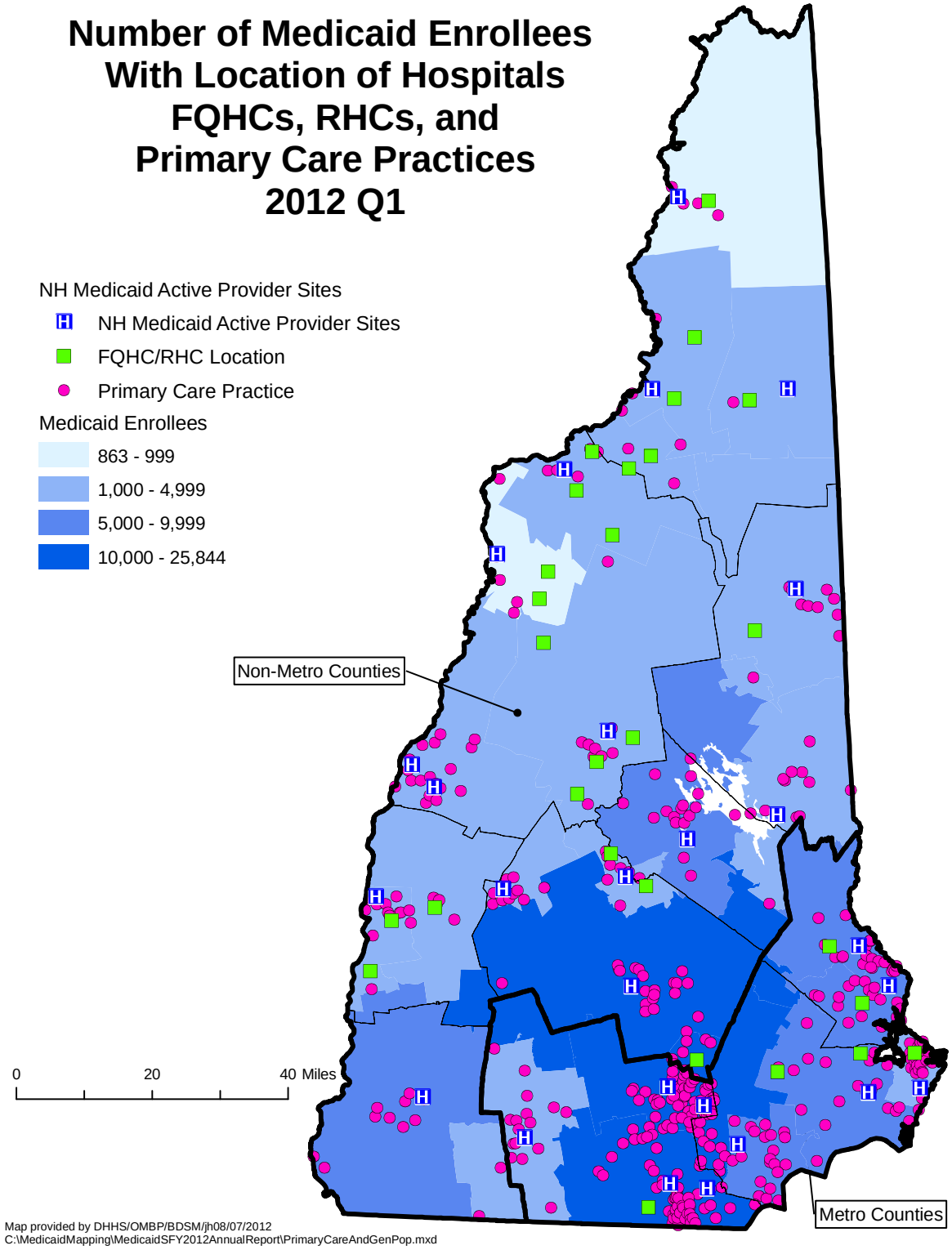
New Hampshire is a small state. It has a total population size of 1.3 Million persons. It is 190 miles long and 70 miles wide. With twenty-six acute care hospitals and affiliated practices, and a strong network of Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) distributed throughout the State, Medicaid beneficiaries have a wide range of options for obtaining healthcare.

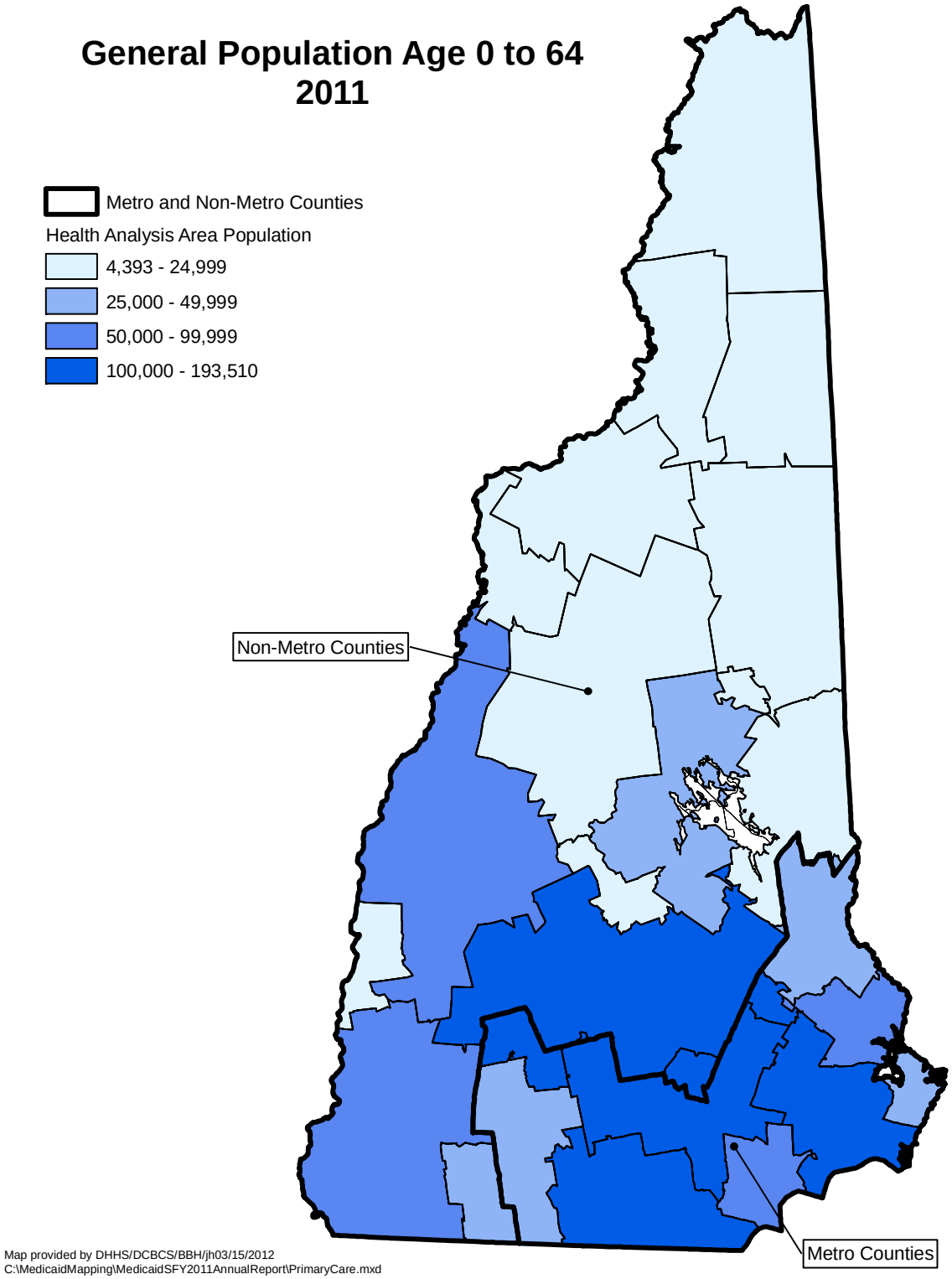
See map of the State of New Hampshire, on the following page, for a depiction of the State, and location of hospitals, FQHCs and RHCs, and hospital affiliate and other primary care practice sites indicated. Sites are marked for providers active in the most recent reporting quarter.

For reference, the second map depicts the distribution of New Hampshire's general population under age 65 (the predominant population where Medicaid is the primary payer for care). As can be seen, the general population (based on Claritas (now Neilson) zip code level population estimates) is distributed very similarly to the Medicaid population.

In this report, New Hampshire Medicaid examines Medicaid beneficiary access to physician and clinic healthcare services by documenting data and trends in three distinct areas: 1) provider and clinic availability, and 2) utilization of healthcare services by Medicaid beneficiaries, and 3) beneficiary needs. The data and analysis set forth in Chapter Three of this report establish the historical and current access levels for these focal areas through analysis of trends from 2007 through 2011 and includes control charts and statistical tests. New Hampshire Medicaid uses this analysis to systematically evaluate and monitor New Hampshire Medicaid beneficiaries' access to health care, as well as to provide for an early warning system for access disruptions. Evidence of ongoing beneficiary engagement is included and evaluated as well. Systematic, data-driven access monitoring plans, based on key indicators chosen to evaluate ac-

cess, as well as planned procedures for corrective action should access problems arise, form the basis of New Hampshire Medicaid's access measuring and monitoring framework.




General Population Age 0 to 64
2011
Metro and Non-Metro Counties
Health Analysis Area Population
4,393 - 24,999
25,000 - 49,999
50,000 - 99,999
100,000 - 193,510
Non-Metro Counties
Metro Counties
Map provided by DHHS/DCBCS/BBH/jh03/15/2012
C:\MedicaidMapping\MedicaidSFY2011AnnualReport\PrimaryCare.mxd

2. Methodology

Information published by MACPAC was used as the primary source of material for developing New Hampshire Medicaid's framework for evaluating healthcare access. New Hampshire Medicaid's analysis of healthcare access follows MACPAC's recommended three-pronged approach: beneficiary characteristics, provider capacity, and service utilization rates. In addition, New Hampshire adds a forth prong: beneficiary assistance and satisfaction.

First, New Hampshire Medicaid evaluated the unique characteristics of New Hampshire Medicaid beneficiaries. Using retrospective data analysis, New Hampshire Medicaid documented the size of the Medicaid population, demographics, enrollment data, trends in enrollment, and geographic dispersion. This was performed to provide a clear picture of the population, their healthcare needs, and the context for evaluating New Hampshire Medicaid's network of providers.

The second prong of New Hampshire Medicaid analysis focuses on evaluating the adequacy of the New Hampshire Medicaid provider network. Evaluating provider network capacity entails determining whether the number of providers, i.e. physicians, physician groups, clinics, and hospital emergency departments afford sufficient capacity for the Medicaid patient load in New Hampshire. New Hampshire Medicaid used provider enrollment and enrollment trends to evaluate physician and provider adequacy in New Hampshire.

The third prong of New Hampshire's access evaluation framework is an analysis of healthcare service utilization data and trends. Service utilization by Medicaid beneficiaries represents realized access. Realized access refers to how New Hampshire Medicaid beneficiaries are actually using available healthcare services. New Hampshire focuses on utilization statistics by age, geography, and eligibility group. New Hampshire Medicaid examines how patterns of healthcare service use differs among eligibility groups, age groups, and geographic regions; how healthcare service venue has changed; and how healthcare service use trends have changed over time, particularly over the period of time before and after New Hampshire reduced reimbursement rates paid to non-critical care hospitals and made other changes to hospital payment arrangements, including DSH. New Hampshire Medicaid extracted data for the period of 2007 through 2011. Data on healthcare service utilization was interpreted generally by comparing New Hampshire Medicaid utilization over time.

New Hampshire Medicaid compiled eligibility and administrative claims data for five years of Fee for Service (FFS) paid claims reflecting services used by Medicaid beneficiaries. New Hampshire Medicaid compiled service utilization statistics for physicians, APRNs, FQHCs, and RHCs. These provider utilization rates were calculated per 1,000 Medicaid beneficiaries.

Data Sources

Membership, utilization, and active provider reports are based on data extracted from the New Hampshire's Medicaid Management Information System (MMIS), the State's Medicaid claims processing sys-

tem. Inherent in this data are differences in coding practices across providers, which potentially affect results and contribute to observed differences. Client Services Call Center data is based on data extracted from the Call Center's call tracking database.

Population Included in Trend Data

The populations included in the member and utilization trend data are those beneficiaries for whom New Hampshire Medicaid provides the only known sole source of general health care coverage. Beneficiaries with Medicare or other health coverage are excluded because for these groups New Hampshire Medicaid only plays a secondary role in providing general health coverage and as a result does not have complete claims data. Reports on an annual timespan (or in the case of the well-baby visit measure, the first fifteen months of life) only include those beneficiaries continuously enrolled during the period, with no more than a one month gap to allow for consistency with national measure specification standards.

Service Date Periods and Claims Run-out

All utilization reports are based on date of service for time periods, either calendar years or 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 reporting period. Quarterly measures are based on three months of claims run-out (e.g., where the service period being reported covers April - June 2012, the report will include all claims paid through September 30, 2012). While some additional claims will be paid after that service date, by keeping the restriction consistent from period-to-period the trend will not be impacted. Annual measures are based on a longer run-out period of six months to make them more comparable to national benchmarks that are generally based on the same period (six months ensures greater than 99% of claims have been processed).

Geographic Grouping

Beneficiaries are subdivided geographically based on their county of residence. New Hampshire is divided into those counties that are Metropolitan and those that are Non-Metropolitan based on USDA rural/urban continuum codes. Metropolitan counties are Hillsborough, Rockingham, and Strafford and the Non-Metropolitan counties are Belknap, Carroll, Cheshire, Coos, Grafton, Merrimack, and Sullivan. The counties in both groupings are contiguous, with the Metropolitan area counties located in the south-eastern part of the State. As of 2012, the Metropolitan area includes 57% of beneficiaries that have an in-state address. A small number of beneficiaries with out-of-state address are excluded from the geographic groupings, but included in other reporting. Outlines of the two areas are included in the map on page 4.

Age and Eligibility Grouping

Beneficiaries are subdivided based on their age and aid category of assistance during each month of a quarter or for annual data, the last date of the reporting period. Data for most trends is reported using the following groupings (age and aid categories used in parenthesis):

- Children (age less than 19):
  - Blind and Disabled (Aid to Needy Blind and Home Care for Children with Severe Disabilities),
  - Families and Children (TANF and Poverty Level Children), and
  - Foster Care (Foster Care and Adoption Subsidy).

- Adults (age 19 and older):
  - Aged (Old Age Assistance),
  - Blind and Disabled (Aid to Needy Blind, Aid to Permanently and Totally Disabled, Medicaid for Employed Adults with Disabilities), and
  - Families and Children (TANF and Poverty Level Pregnant Women).

Data for well-child visit, preventive or other ambulatory health service, and follow-up visit after behavioral health hospitalization measures use age groupings as specified by the National Committee for Quality Assurance (NCQA).

Control Limits

Control limits are employed in quarterly trend charts to provide a consistent indication of a potential access problem as each new quarter of data is available. Control limits are set as three standard deviations (following conventional practice[*]) from the mean based on Quarter 1 2007 to Quarter 3 2011 data. The control limits are fixed using the prior period because the principal time period analyzed in this report are the final Quarter of 2011 and forward and including these more recent time periods in the control limit calculation could mask an adverse result. Future updates to this report will maintain the same control limits until such time that a rebasing is needed in response to shifts in health care delivery, the health of the population, or changes in available data.

Depending on the measure, a rate for a time period below the lower control limit or above the upper limit is the trigger indicating a potential access problem requiring further investigation. Additionally, a persistent trend above or below the mean line would warrant further research.

Confidence Intervals

For charts based on annual data, control limits are not presented (annual data does not provide enough experience for meaningful limits). Instead, 95% confidence intervals are presented. The confidence interval takes into account random variability in the data to allow for comparison of rates over time. The 95% confidence interval is the range of values that, with 95% certainty includes the underlying rate for the entire population. As the number of beneficiaries represented in the rate increase, the confidence intervals become narrower.

The 95% confidence interval is computed using the following formulas:

Lower limit = $p - [1.96 \times (p*q/B)]$

Upper limit = $p + [1.96 \times (p*q/B)]$

Where b = denominator; p = percent divided by 100; and q = 1- p

If the current period of data deviates to such a degree that its confidence interval does not overlap with the prior period's confidence interval it will indicate a potential access problem requiring further investigation. Additionally, if a slowly declining trend is observed and the current period's confidence interval

[*] E.g., http://www.qualitydigest.com/aug/wheeler.html, http://www.isixsigma.com/dictionary/control-limits/

does not overlap with any of the previous three confidence intervals it will indicate a potential access problem requiring further investigation.

Small Numbers

Because New Hampshire is a small State, it is necessary to take into account the volume of data available for reporting. For some combinations of age and eligibility, the volume of data is too small to allow for meaningful reporting. Rates based on smaller numbers are more volatile due to random variation. To account for this volatility, control limits and confidence intervals must be wider, rendering them less meaningful.

Major Reimbursement Changes

Four New Hampshire Legislative changes in Medicaid payment levels in recent years are relevant to this report's access measures and trend analyses: inpatient and outpatient hospital services rate reductions and Disproportionate Share Hospital (DSH) methodology and payment restructuring. In December 2008, DHHS reduced Medicaid reimbursement rates paid to New Hampshire's 13 non-critical access hospitals for outpatient services by approximately 33%. New Hampshire reduced Medicaid inpatient reimbursement rates for non-critical access hospitals by 10% effective December 1, 2008. New Hampshire Medicaid DSH program methodology was revised in December 2010 to pay higher rates of reimbursement for the uncompensated care costs of critical access hospitals, while still making a DSH payment to all but one psychiatric hospital in the State. In December 2011, DSH qualifying criteria were restructured to make payments available almost exclusively to critical access and "deemed DSH" hospitals, and the total amount of funding for DSH payments statewide was reduced. The potential impacts of these changes are considered in this report from the standpoint of healthcare access and access trend analysis by representing the changes on quarterly utilization trend charts.

Description of Change	Implementation Date
Outpatient Rate Reductions for 13 acute care non-critical access hospitals	December 2008
Inpatient Rate Reductions for 13 acute care non-critical access hospitals	December 2008
Revision of DSH Methodology	December 2010
Reduction in total DSH Funding	December 2011

3. Data and Analysis

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

- New Hampshire Medicaid Beneficiaries,
- Availability of Provider Network,
- Utilization of Services, and
- Beneficiary Assistance and Satisfaction.

Data throughout is presented as five-year trends. Depending on the measure, information is presented quarterly or annually. Annual measures are restricted to those where the national standard definition is annual, typically to account for services that are expected take place a certain number of times over an annual period (e.g., well child visits). To maintain the clarity of the charts, as new periods of data are available, the oldest period of history will be rolled off the reports.

Accompanying the data are indications of the major payment changes impacting the health system being analyzed.

Beyond presenting the data in a visual form, the charts also include analytic tools that provide a defined trigger indicating a potential access problem requiring further research. Quarterly data are presented along with control limits and annual data (where the data is insufficient to support control limits) with confidence intervals. Correlations between the payment changes and the trend data that appear to exist will help inform any further research needed. New to this report are two behavioral health measures based on HEDIS specifications.

The focus of the data presented is general medical physician/APRN/group/clinic, hospital, and behavioral health services.

New Hampshire Medicaid Beneficiaries

Overview of New Hampshire Medicaid Beneficiaries

New Hampshire Medicaid program Beneficiaries are made up of the following mandatory and optional eligibility categories listed below.

Mandatory Eligibility Groups[*]

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

Optional Eligibility Groups[‡]

- Pregnant women up to 185% of the FPL.
- Children up to 300% of the FPL (after the July 1, 2012 conversion of New Hampshire's separate CHIP program to a Medicaid expansion program).
- Individuals determined to be "medically needy" due to large medical expenses[§]
- Home Care for Children with Severe Disabilities (HC-CSD), commonly known as "Katie Beckett"; for severely disabled children up to age 19 whose medical disability qualifies them for institutional care but are cared for at home
- Medicaid for Employed Adults with Disabilities (MEAD) allows Medicaid-eligible disabled individuals between the ages of 18 and 64 who want to save money or work to increase their earnings while maintaining Medicaid coverage (up to 450% FPL)

New Hampshire Medicaid beneficiaries tend to have a higher burden of illness than privately insured individuals. They are twice as likely to have asthma, coronary artery disease, hypertension, depression, and mental health disorders (particularly children); they are three to four times more likely to suffer from a stroke or Chronic Obstructive Pulmonary Disease or to use hospital emergency rooms; and five times as likely to have lung cancer or heart failure (New Hampshire Medicaid Annual Report, 2011).

The two figures below show the distribution of beneficiaries by age, eligibility group, and gender as of June 2011.

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

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

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

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

Children (members 18 years or less) make up 60% of the New Hampshire Medicaid population. As shown below, beneficiaries age 19 to 64 represent 31% of beneficiaries and the remaining 10% are members aged 65 plus.

Females account for over half of Medicaid beneficiaries. Gender differences are observed in all eligibility categories with females predominating low-income adults (84%, due to pregnant women eligibility category and greater likelihood of heading single parent low-income households) and the elderly (74%, due to longer lifespan and likelihood of fewer resources than males). As shown below, the only groups in which males make up a larger proportion of beneficiaries are the low-income child and severely disabled child groups.

Figure 2. NH Medicaid Beneficiaries by Age Categories, June 2011

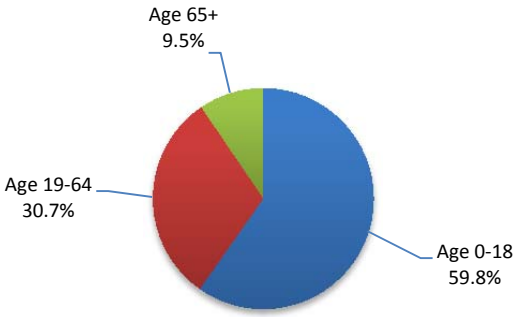
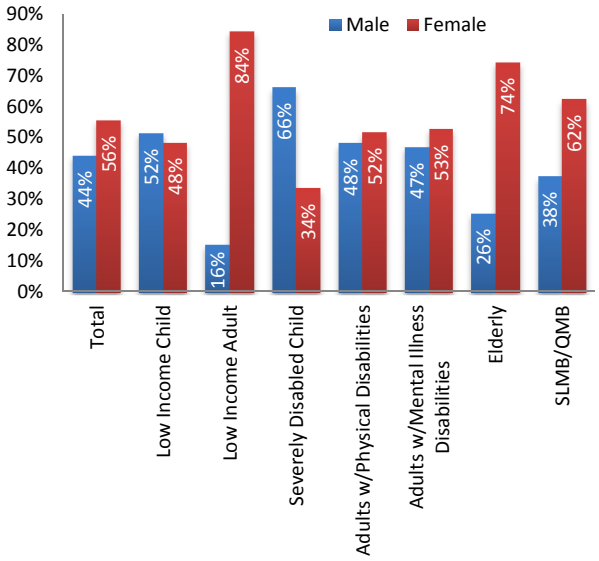


Figure 3. NH Medicaid Beneficiaries by Gender and Eligibility Category, June 2011



The figures above are based on the entire Medicaid beneficiary population. However, the following figures on enrollment, and later figures showing utilization trends, exclude Medicare dually eligibles, and those members known to have other medical insurance. The beneficiaries are excluded because the focus of this report is physician and hospital care, and care for those services is nearly always paid for by third parties, not New Hampshire Medicaid, for these beneficiaries. Approximately 100,000 beneficiaries are the subject of the following reporting.

New Hampshire Medicaid Beneficiary Enrollment Trends

This section reviews trend in average monthly enrollment by quarter of New Hampshire Medicaid beneficiaries. The data in the figures will be updated quarterly. Utilization trends are tracked for these members.

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

The figures show a very gradual rise in enrollment in 2007 and 2008, followed by more rapid increase in 2009 due to the recession, with a slight rise thereafter. In 2011, there was a less than 1% increase in total enrollment.

On July 1, 2012, New Hampshire Medicaid converted its separate CHIP program into a Medicaid expansion program resulting in an additional 9% of enrollment in Quarter 3 compared to Quarter 2. These new beneficiaries were previously being served by a provider network of similar makeup that serves Medicaid beneficiaries; hence the inclusion of this new group did not impact access to care.

Figure 4. NH Medicaid Enrollment, CY 2007-2012, Average Members in Quarter: Total Population
Note: excludes Medicare dually eligibles and members with other medical insurance

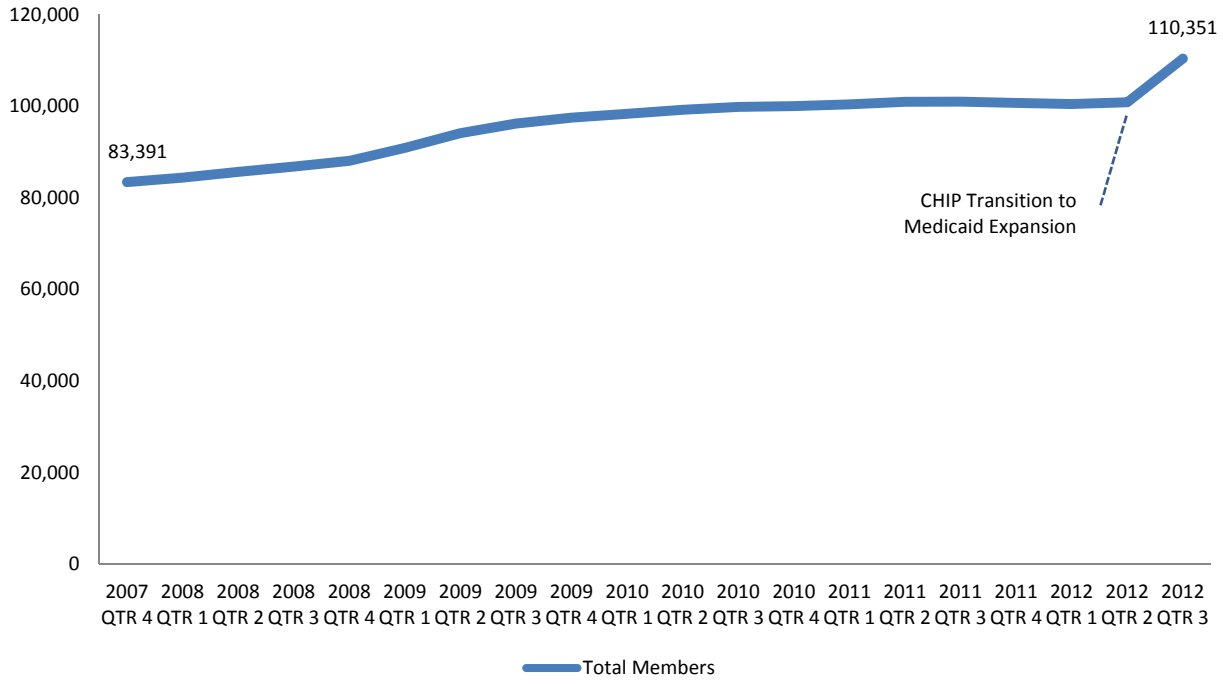


Figure 5. NH Medicaid Enrollment, CY 2007-2012, Average Members in Quarter: Child, Families and Children Eligibility Group

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

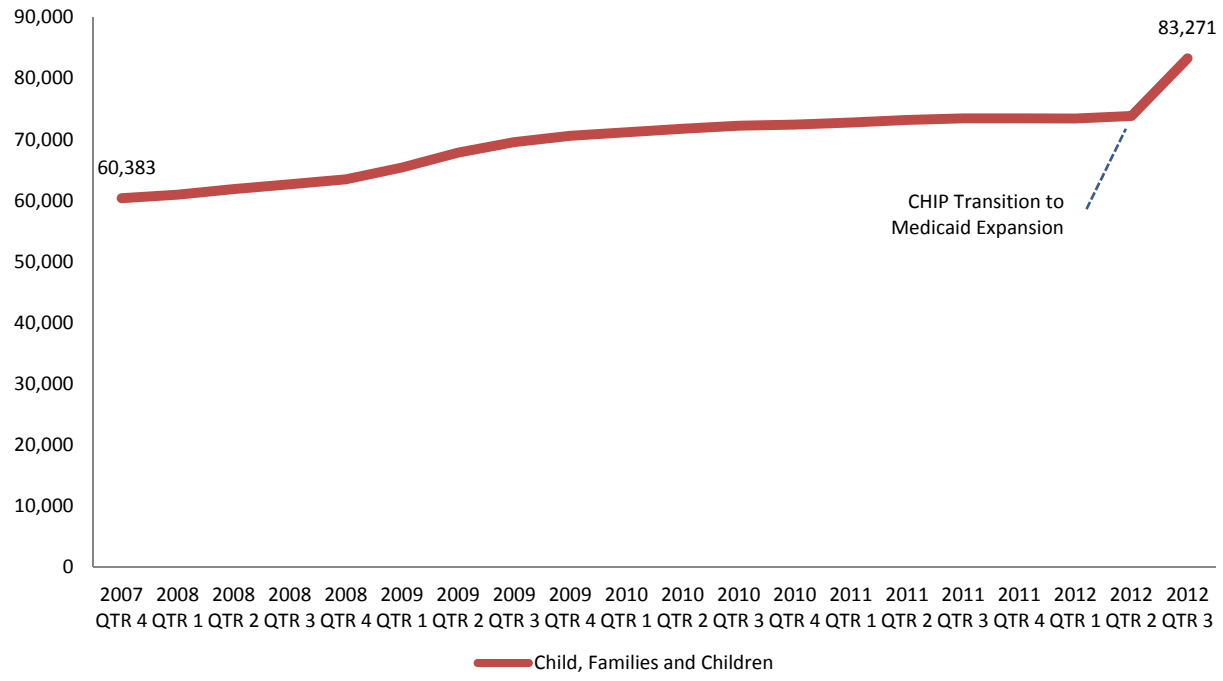


Figure 6. NH Medicaid Enrollment, CY 2007-2012, Average Members in Quarter: Child Foster Care and Child Blind and Disabled Population

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

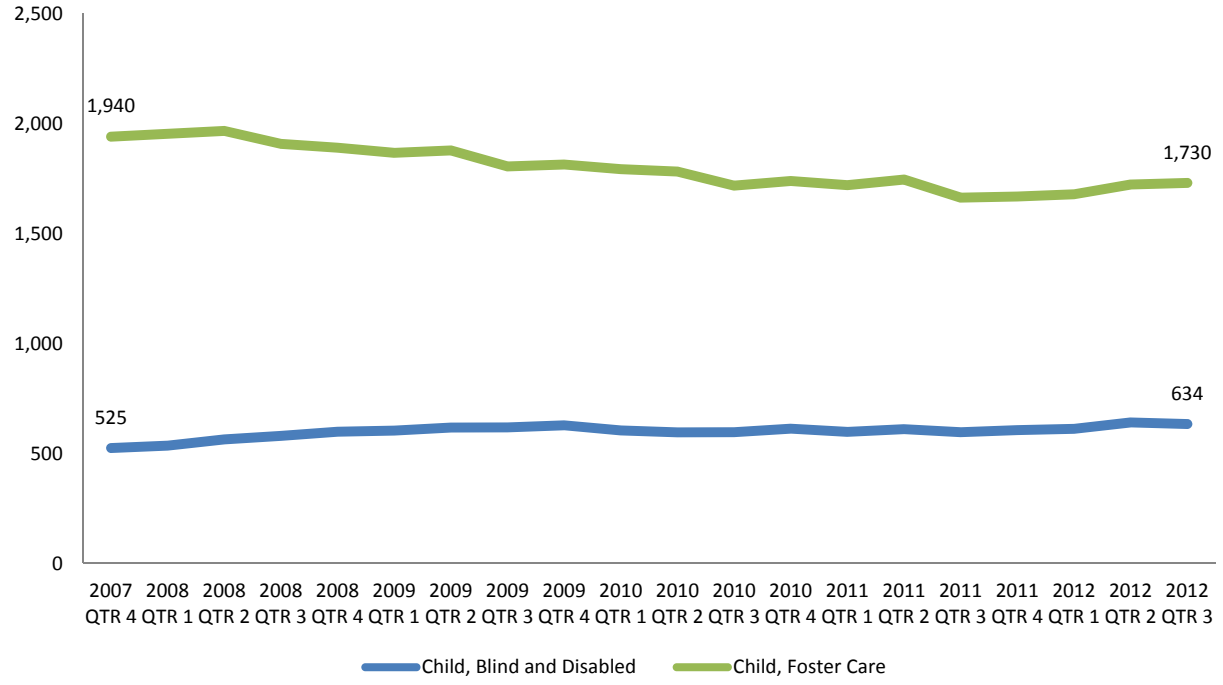


Figure 7. NH Medicaid Enrollment, CY 2007-2012, Average Members in Quarter: Adult Population by Eligibility Group

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

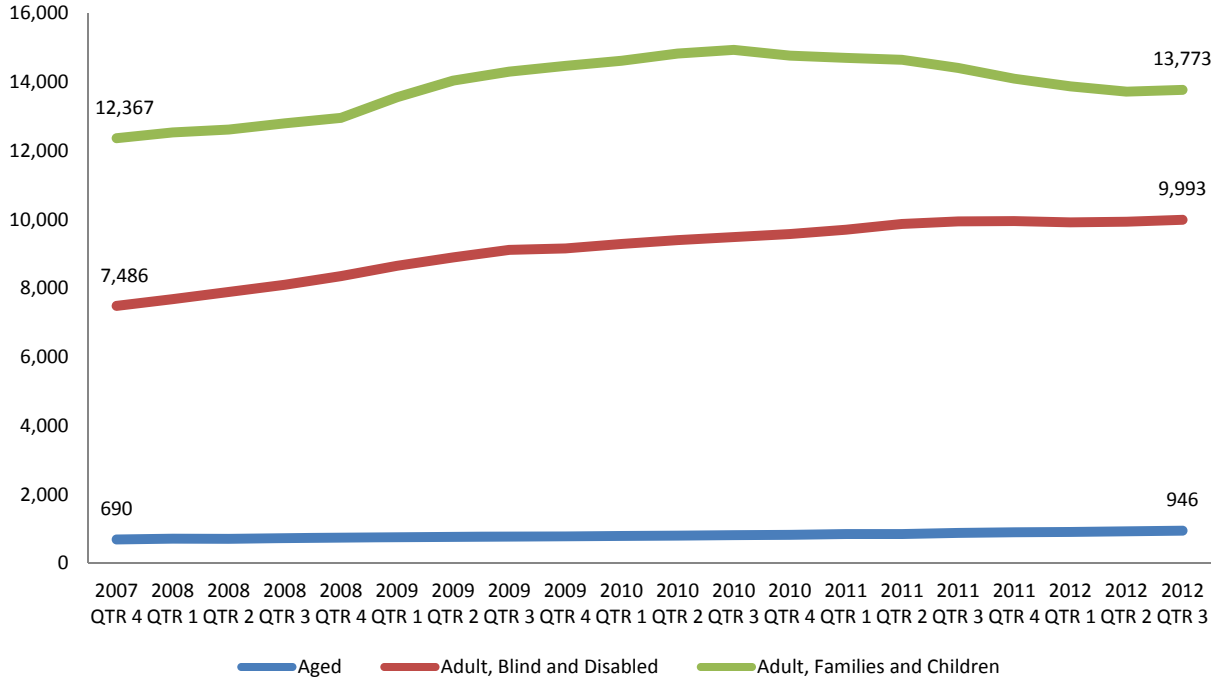
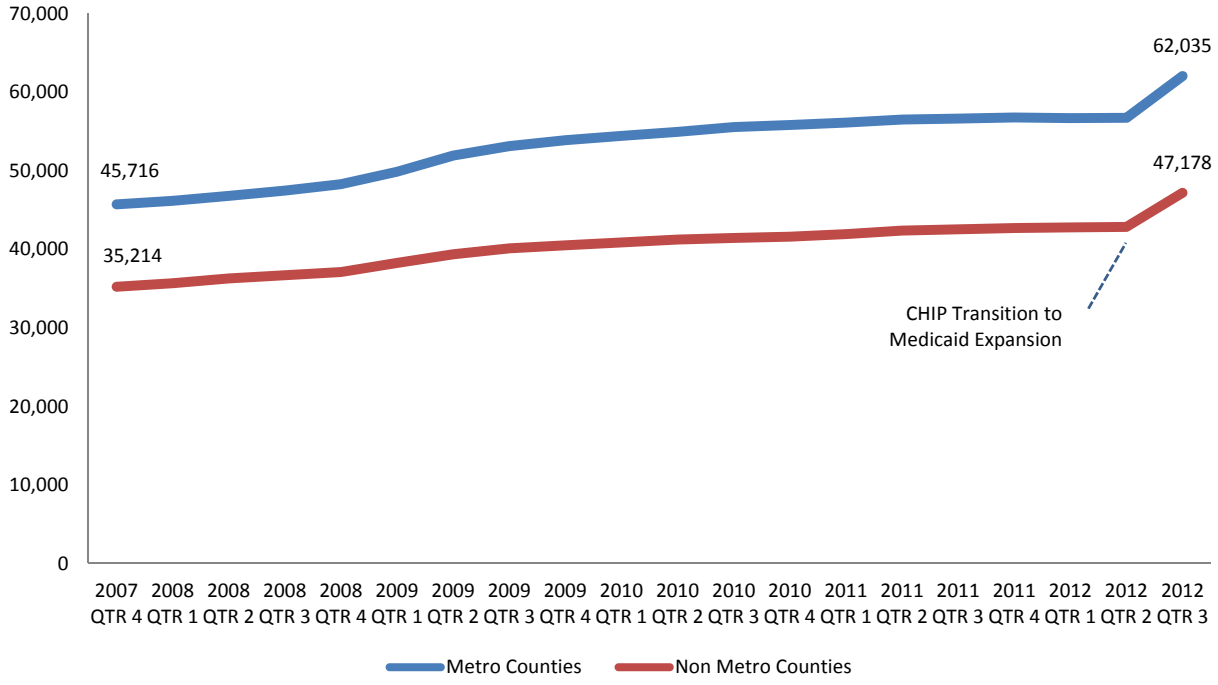


Figure 8. NH Medicaid Enrollment, CY 2007-2012, Average Members in Quarter: Metropolitan and Non-Metropolitan Counties

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



Provider Availability

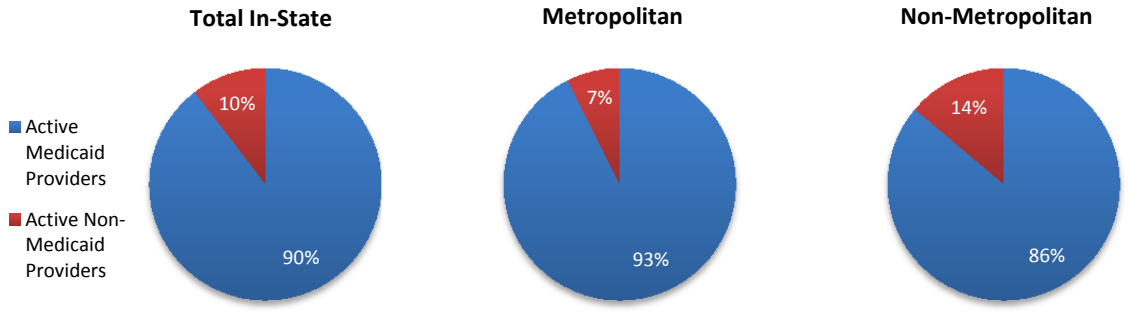
The provider availability section focuses on whether healthcare services are accessible to Medicaid beneficiaries. Measures are included on provider participation in New Hampshire Medicaid and ratios of beneficiaries to active providers. The data in the figures will be updated quarterly.

Physician and Hospital Participation

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

With regard to physicians, Figure 9 provides information on the most recently available data on enrollment by licensed active providers. As can be seen, nearly all (90%) of licensed practicing physicians are also New Hampshire Medicaid providers (data source: NH Board of Medicine). The same is true for both the metropolitan (93%) and non-metropolitan counties (86%).

Figure 9. Active NH Medicaid In-State Physician Providers Compared to Licensed Providers With NH Billing Address, 2012



Because of this broad overlap, ratios of New Hampshire Medicaid beneficiaries to active providers are very high, which also explains why most individual practitioners will likely have small numbers of Medicaid patients in their panel (as compared to more populous or urban states). For example, New Hampshire has 1.3 million people, and a total of 3,913 licensed practicing physicians for a ratio of 336 people per licensed physician, while there are 0.1 million Medicaid beneficiaries and a total of 3,505 active (billing within most recent quarter) physicians for a ratio of 28 people per physician for the New Hampshire Medicaid population. The ratio for metropolitan counties in the State is 392 people per physician for the general population and 29 for New Hampshire Medicaid. The ratio for non-metropolitan counties in the State is 272 people per physician for the general population and 27 for New Hampshire Medicaid (note: Figure 9 will be updated to factor in the new child expansion population in the next report after enough claims experience has been obtained to develop new rates).

Active Primary Care Providers, Pediatricians, and Obstetricians/Gynecologists

The following nine figures show the trend in the ratio of beneficiaries to active providers (those with one claim in the quarter). Three charts each are presented for Primary Care Providers, Pediatricians, and Obstetricians/Gynecologists. For each group of charts the statewide data is presented first followed by two charts subdividing the data by metropolitan and non-metropolitan areas.

For all charts major New Hampshire Medicaid payment changes are indicated and control limits at the third standard deviation of the historical data are included to provide a trigger indicating a potential access problem requiring further investigation. For the ratios presented, exceeding the upper control limit would indicate a potential problem.

Except for Figure 18, the rates shown in the figures do not cross the upper control limit, and therefore do not indicate a potential access problem at this time, nor is there evidence of an impending access problem based on current data. The primary care trend has shown consistent improvements during the past several quarters. In Quarter 3 of 2012, the trend in the ratio of members to obstetricians/gynecologists in non-metropolitan areas (Figure 18) did cross the upper control limit. While DHHS has not had any indication of an access problem from either increased beneficiary requests to the call center or through reports of provider disenrollment, and the metropolitan area ratio is comparable to the non-metropolitan ratio, DHHS does plans to research the reasons why the measure has exceeded the control limit and will report on its findings in the next quarterly report.

Metropolitan and non-metropolitan areas when compared show similar trends, an outcome of the trends being driven by increases in member enrollment correlating to the NH unemployment rate. Ratios are similar between the two regions, with ratios slightly lower (better) for metropolitan areas for pediatricians and primary care.

New in this report is the inclusion of 11,000 beneficiaries who used to be part of New Hampshire's separate CHIP program. As noted previously, on July 1, 2012, New Hampshire transitioned this population to a Medicaid expansion. Because this population was almost entirely served by the same provider network as the Medicaid population, the primary care and pediatrician trends below have been recalculated to include historical enrollment data from the separate CHIP program.

Figure 10. Ratio of NH Medicaid/CHIP Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians), CY 2007-2012

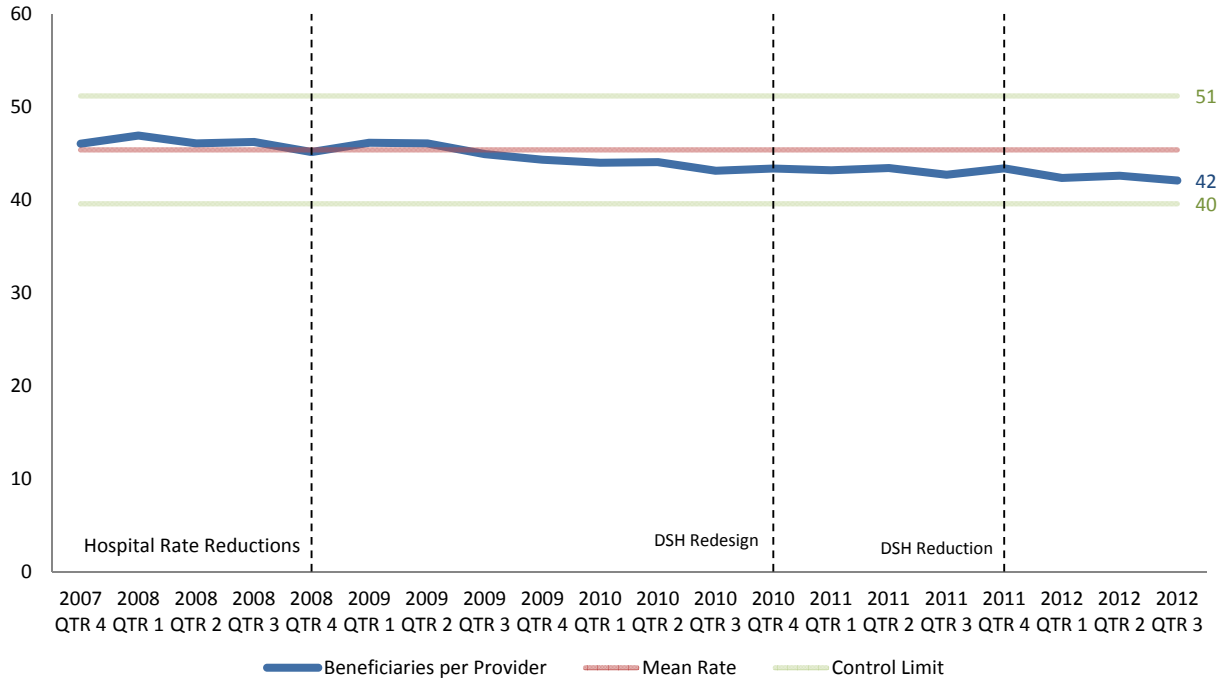


Figure 11. Ratio of NH Medicaid/CHIP Beneficiaries to Active In-State Primary Care Providers, CY 2007-2012: Metropolitan Areas

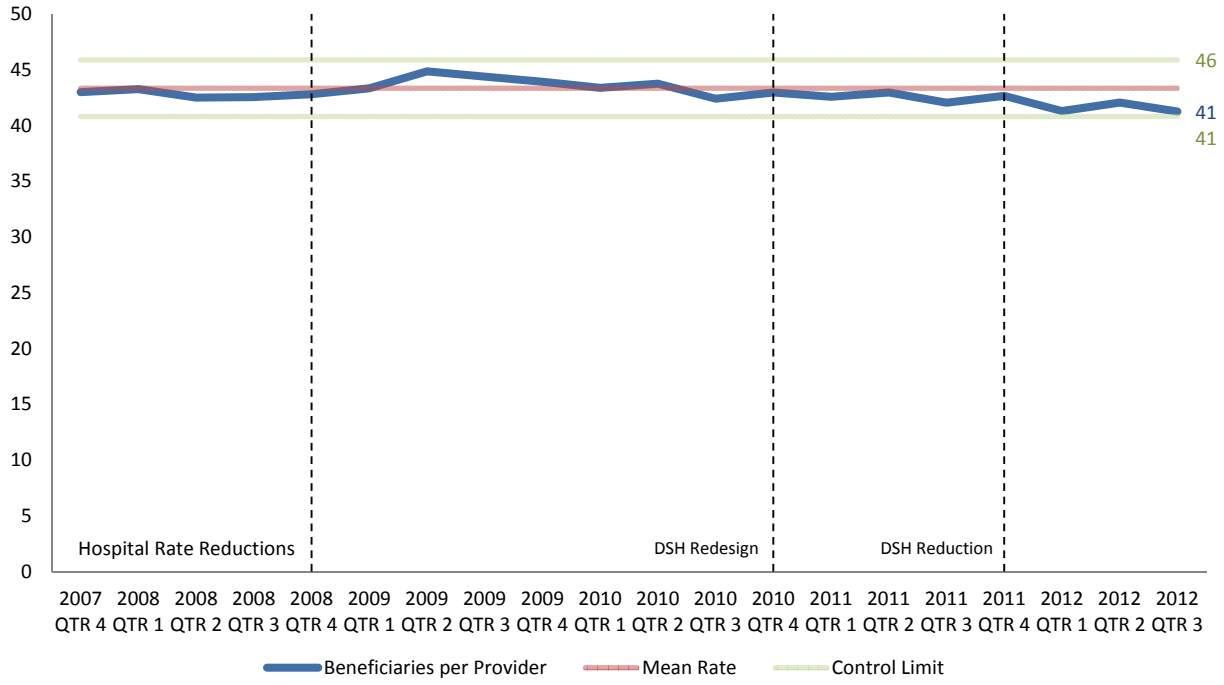


Figure 12. Ratio of NH Medicaid/CHIP Beneficiaries to Active In-State Primary Care Providers, CY 2007-2012: Non-Metropolitan Areas

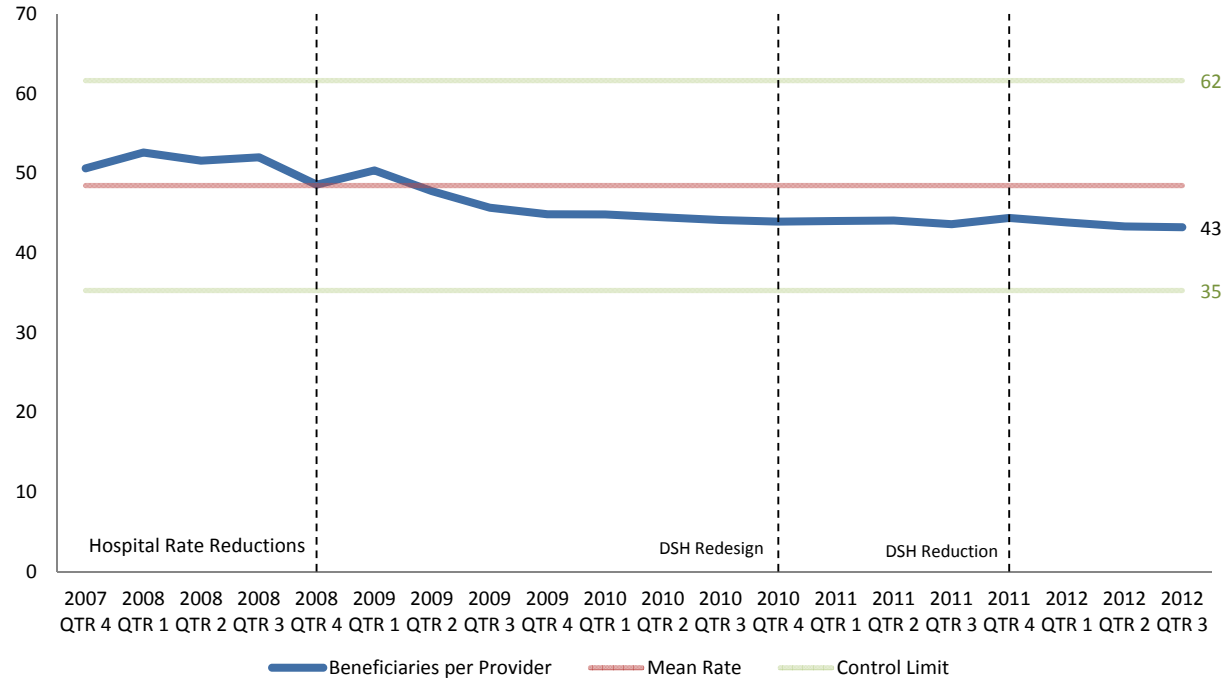


Figure 13. Ratio of NH Medicaid/CHIP Child Beneficiaries to Active In-State Pediatricians, CY 2007-2012

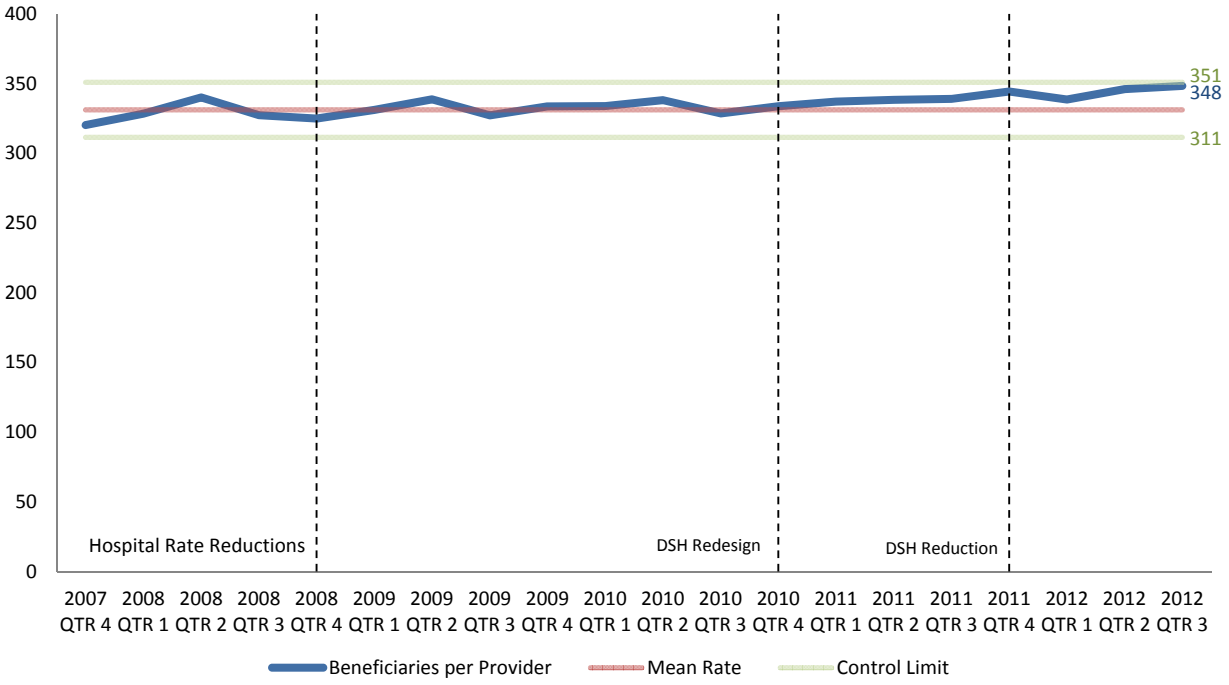


Figure 14. Ratio of NH Medicaid/CHIP Child Beneficiaries to Active In-State Pediatricians, CY 2007-2012: Metropolitan Areas

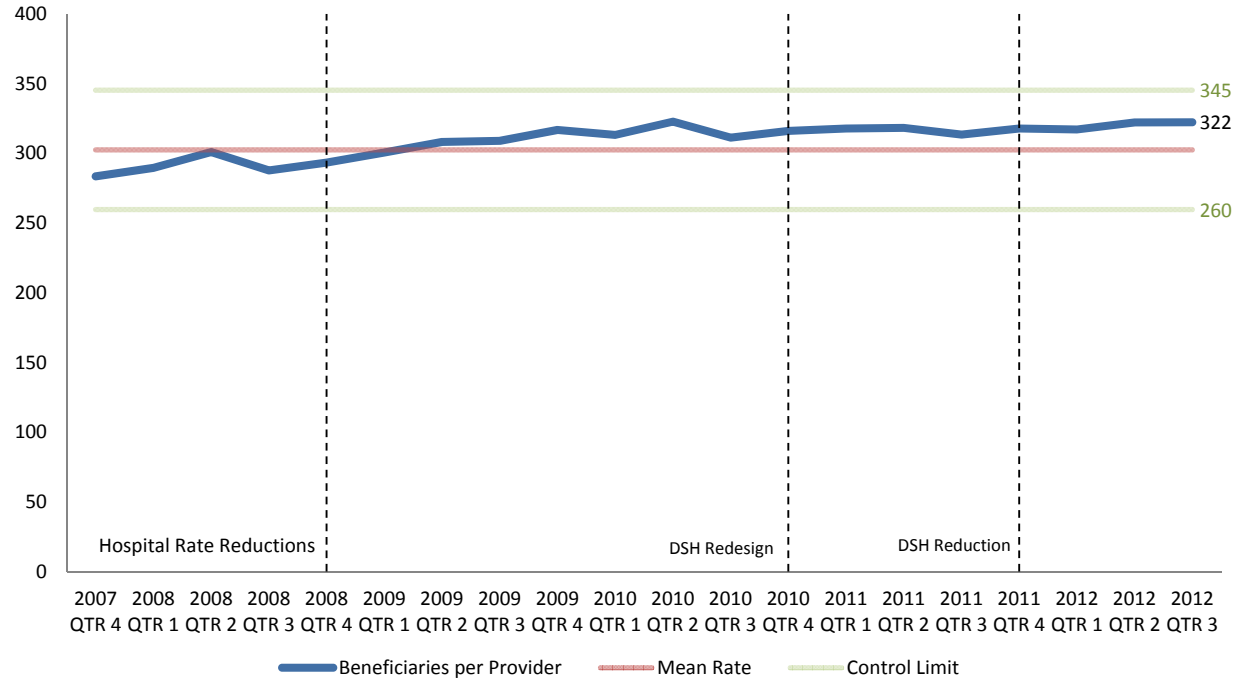


Figure 15. Ratio of NH Medicaid/CHIP Child Beneficiaries to Active In-State Pediatricians, CY 2007-2012: Non-Metropolitan Areas

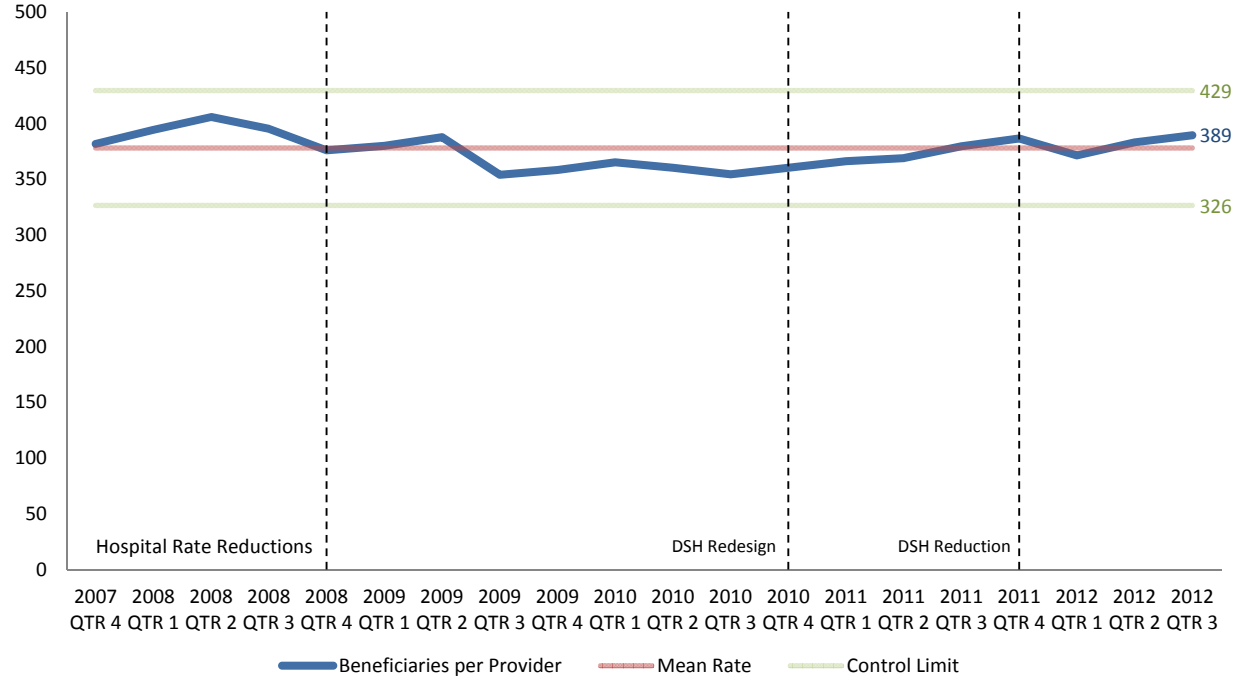


Figure 16. Ratio of NH Medicaid Adult Female Beneficiaries Age 19 to 64 to Active In-State Obstetricians/Gynecologists, CY 2007-2012

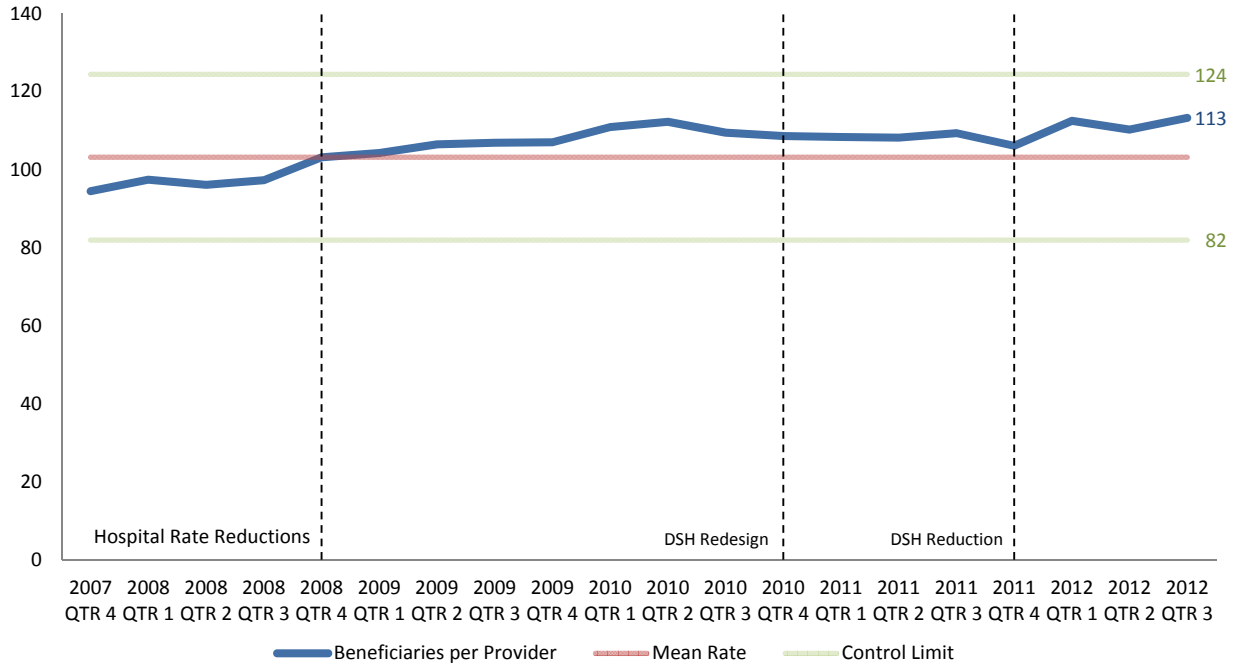


Figure 17. Ratio of NH Medicaid Adult Female Beneficiaries Age 19 to 64 to Active In-State Obstetricians/Gynecologists, CY 2007-2012: Metropolitan Areas

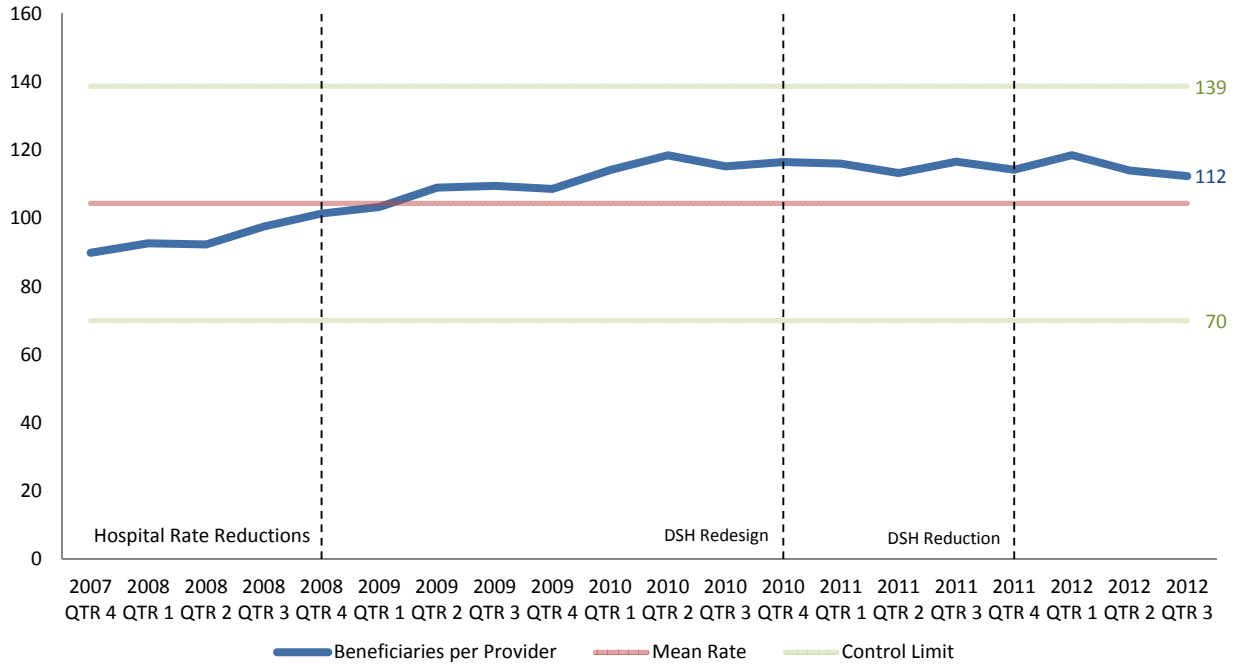
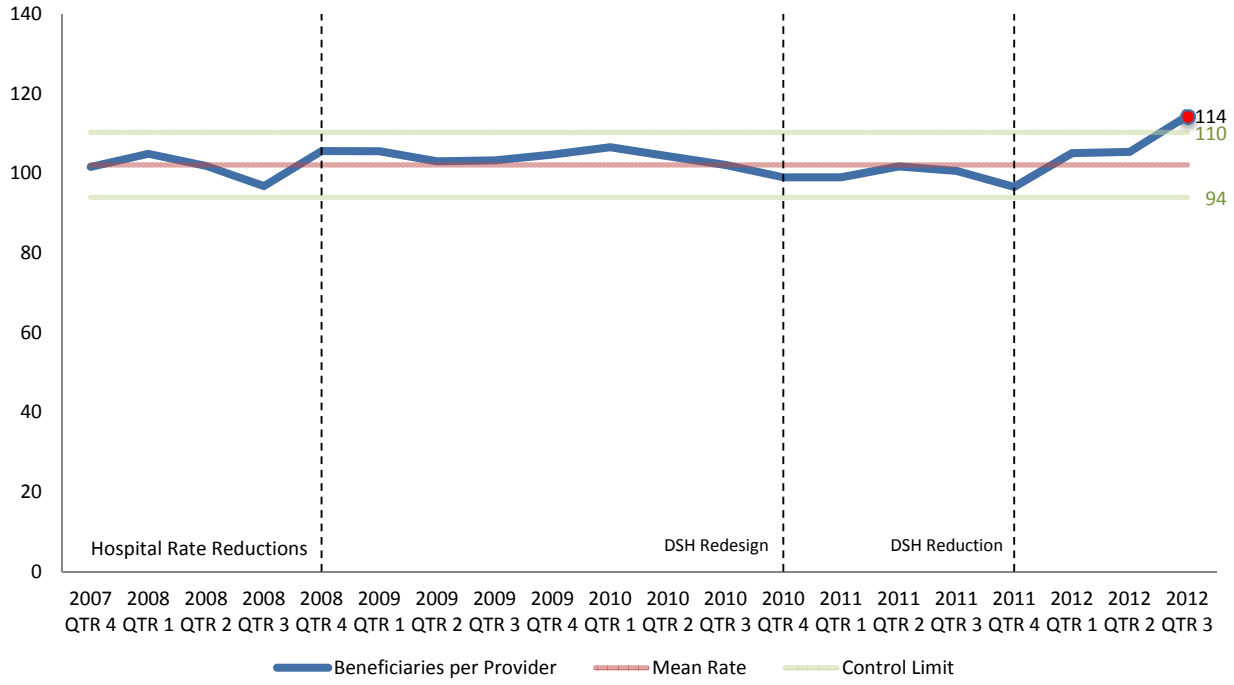


Figure 18. Ratio of NH Medicaid Adult Female Beneficiaries Age 19 to 64 to Active In-State Obstetricians/Gynecologists, CY 2007-2012: Non-Metropolitan Areas



Availability of Capacity at Health Centers

In addition to ongoing assessment of provider participation, New Hampshire Medicaid has begun to undertake periodic assessment of the available capacity of providers to accept new patients on their panels. The first of these assessments was performed for Federally Qualified Health Centers (FQHC), FQHC Look-a-Likes, and Non-FQHC Community Health Centers. The majority of the centers that responded to inquiries reported having available capacity to take on hundreds of new patients each. The complete result of this assessment is provided in the Appendix A.

Utilization of Services

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

Quarterly key physician and hospital utilization trends with control limits and annual utilization of preventive and office/clinic health services trends are presented. Data is broken out by age and eligibility groupings, and broken out for metropolitan and non-metropolitan areas of the State (to take a special look at areas with a greater sensitivity to access problems). The data in the figures will be updated quarterly or annually as appropriate.

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

Quarterly Beneficiary Utilization Analysis

Figures in this section show the trend in quarterly use of key physician and hospital services by New Hampshire Medicaid beneficiaries as indicated by Medicaid claims data*. The data in the figures will be updated quarterly.

Rates are the number of visits in the quarter divided by the number of beneficiary months for the quarter times 1,000.

Major New Hampshire Medicaid payment changes are indicated and control limits at the third standard deviation of the historical data are included to provide a trigger indicating a potential access problem requiring further investigation.

Detail is presented below on:

- 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, and
- Total Inpatient Hospital Utilization.

Many of the utilization control charts show a rise from norms in the fourth quarter of 2009 followed by a decline. The period of this rise is coincident with the peak of H1N1 influenza pandemic in the United States (*MMWR Update: Influenza Activity --- United States, 2009--10 Season*). In order to demonstrate that the peak observed in the control charts was primarily due to H1N1; New Hampshire Medicaid looked in detail at diagnoses in its physician/APRN/clinic utilization claims data for the fourth quarters of CY 2007 to CY 2011. Examining the data by diagnosis code revealed that several diagnosis code groupings directly (diagnosis of influenza) or indirectly related to influenza (asthma) accounted for the majority of the increase observed. The Q4 2009 rate of visits for those diagnosis codes sensitive to influenza was 93.3 per 1,000 compared to an average of 72.1 for the other quarters, or 29% higher. The rate of visits for other diagnosis codes in Q4 2009 was just 4% above the average. Because of this a note has been added to the Physician/APRN/Clinic Utilization and Emergency Department for the total, child eligibility groups, and geographic charts to help guide interpretation (not added to the adult eligibility charts as this population was impacted less by H1N1 and no effect is observed in the charts).

In all cases, no control chart indicates a potential access issue requiring further research. However, as noted in each section below, some charts exhibit persistent trends that will be researched and reported on in the next issue of this report.

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

Seasonally Adjusted 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 beneficiaries as indicated by Medicaid claims data.

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

The data presented has been adjusted to remove seasonality that in New Hampshire reliably results in higher than average rates in the first calendar quarter and lower than average rates in the third calendar quarter (due to seasonality of respiratory infections).

For the physician, APRN, FQHC, and RHC utilization measure, a rate below the lower control limit is the trigger indicating a potential access problem requiring further investigation.

The rates shown in all figures never cross the lower control limit, and therefore do not indicate a potential access problem.

Figure 19. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

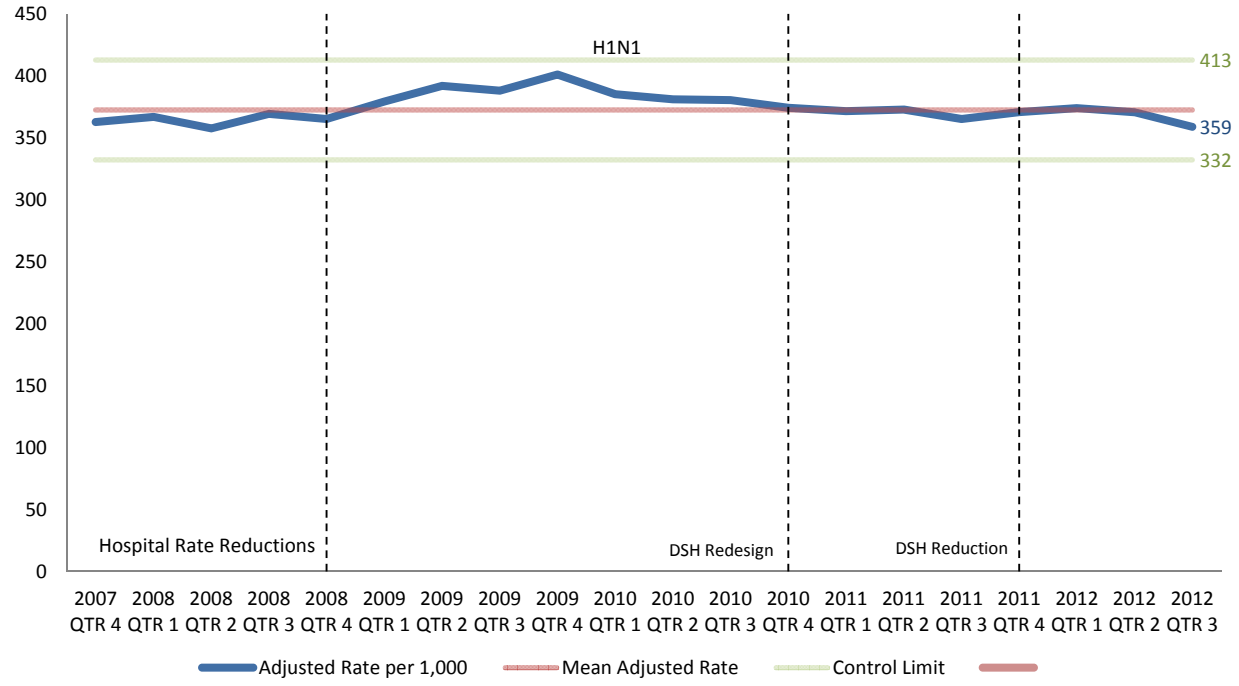


Figure 20. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Blind and Disabled Aid Categories

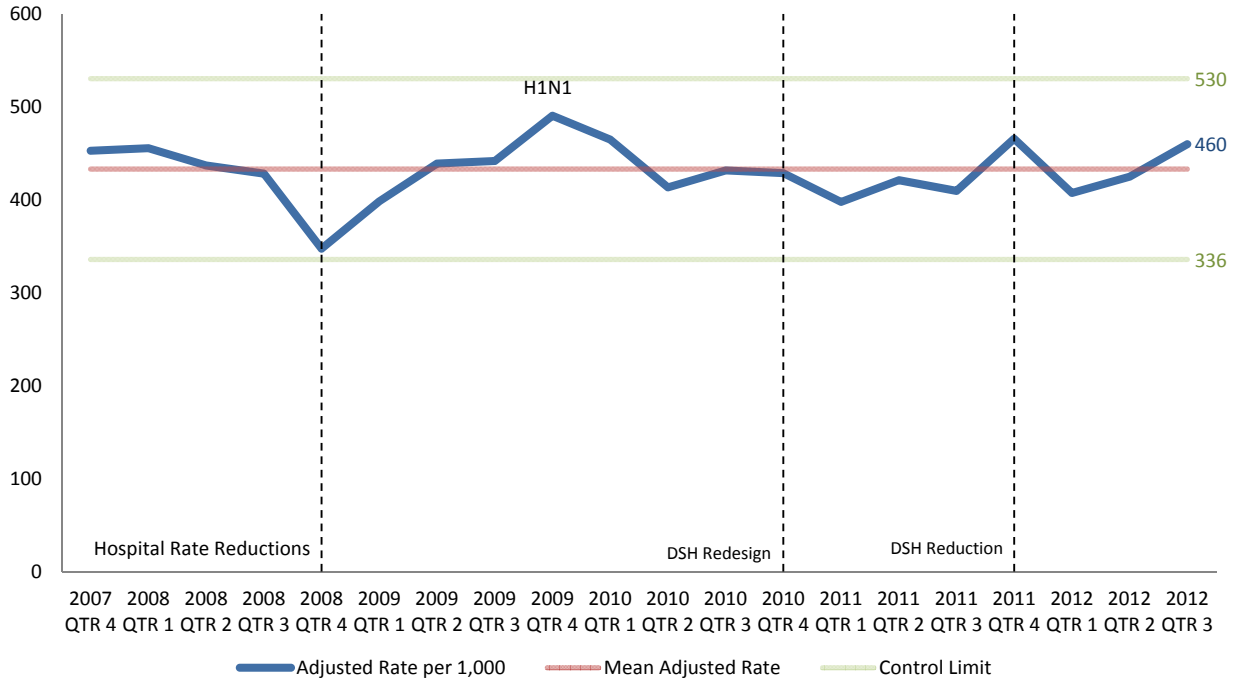


Figure 21. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Children and Families Aid Categories

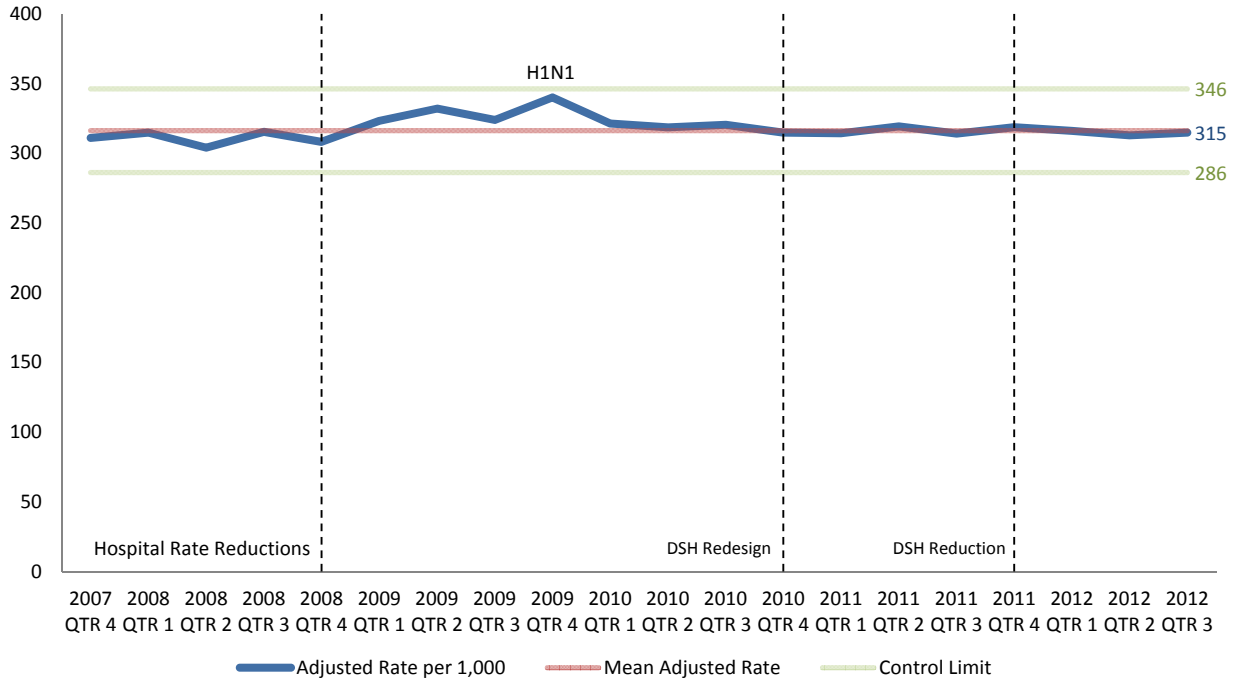


Figure 22. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Foster Care Aid Categories

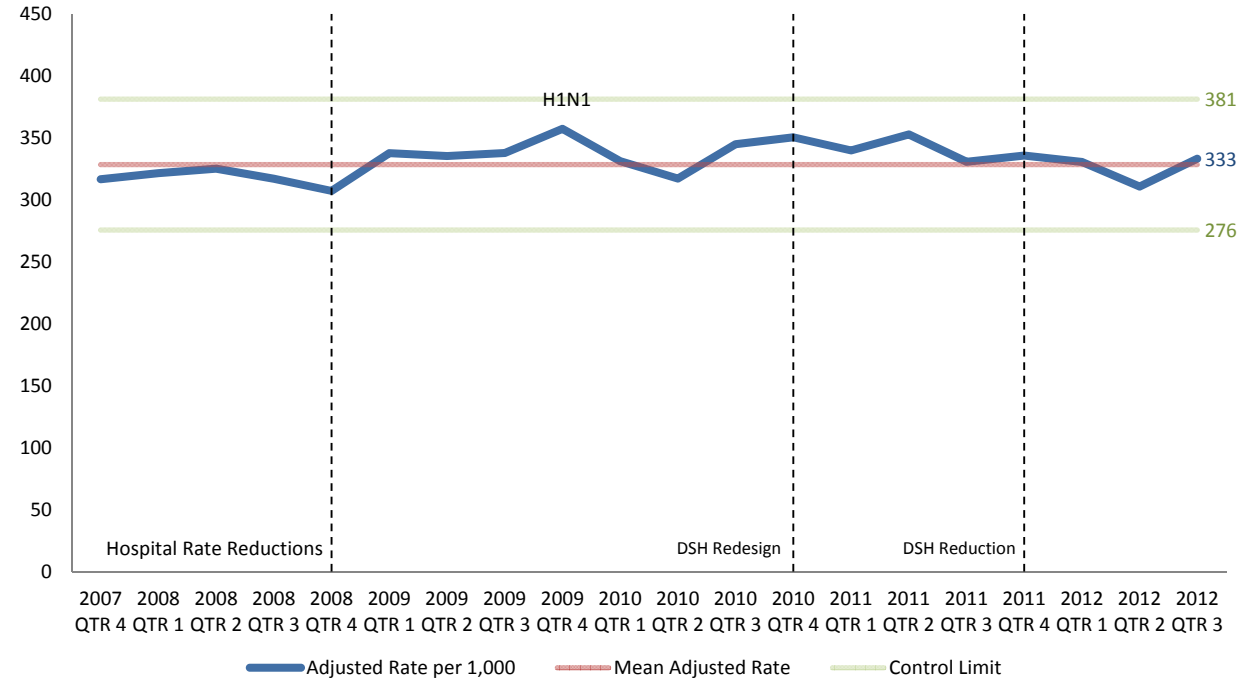


Figure 23. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Aged Aid Categories

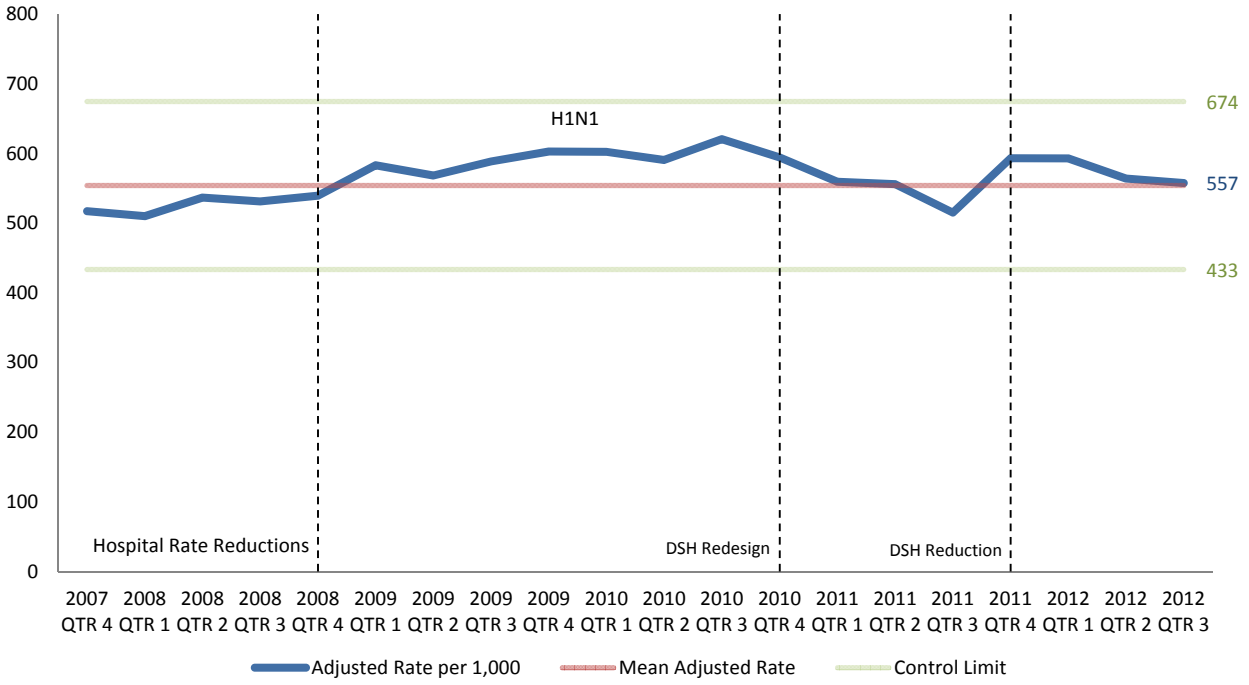


Figure 24. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Blind and Disabled Aid Categories

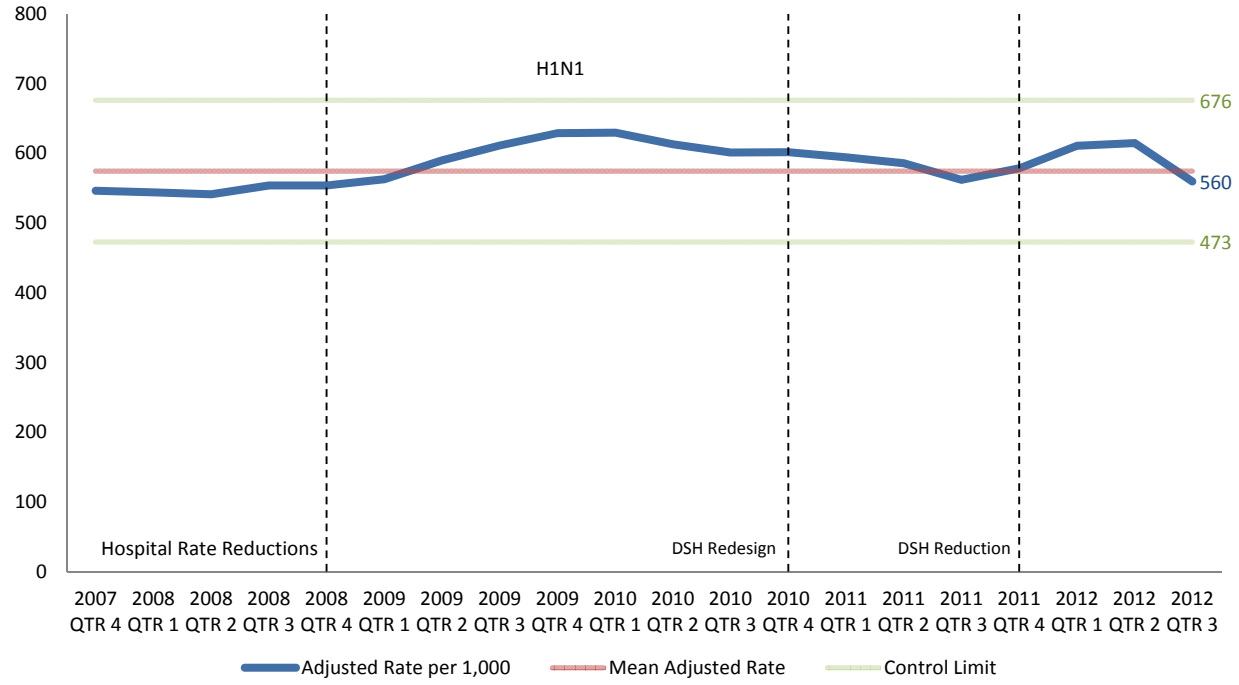


Figure 25. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Families and Children

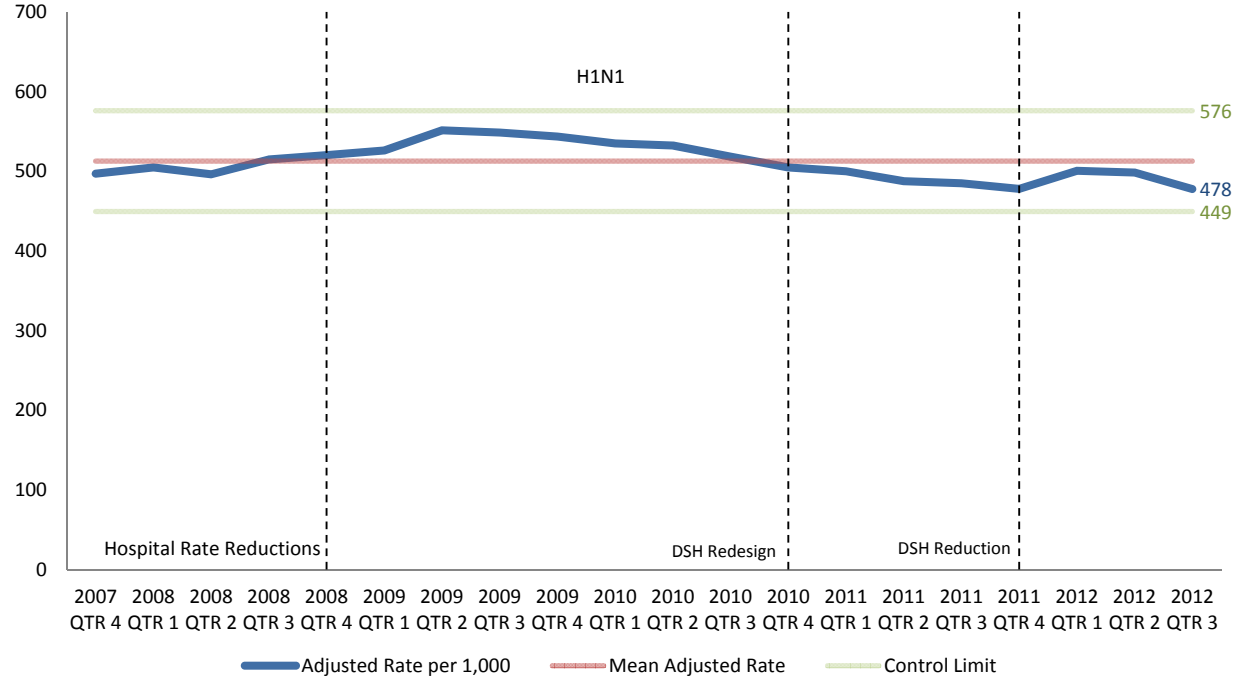


Figure 26. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Areas

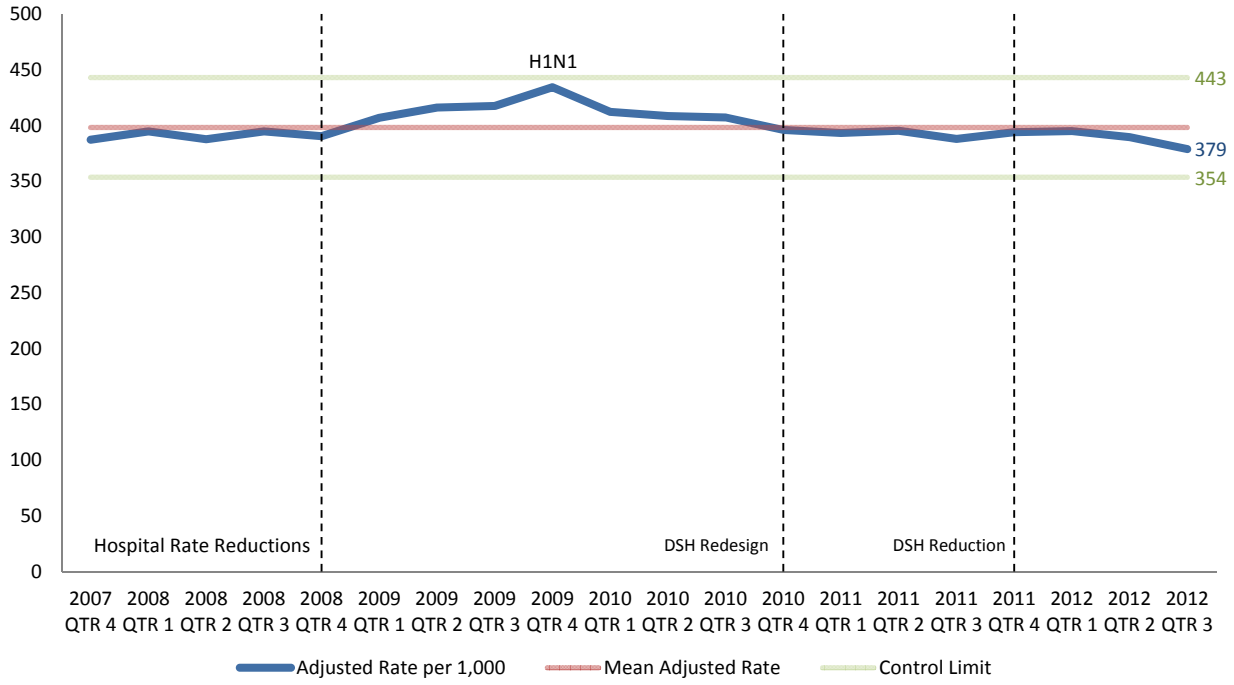
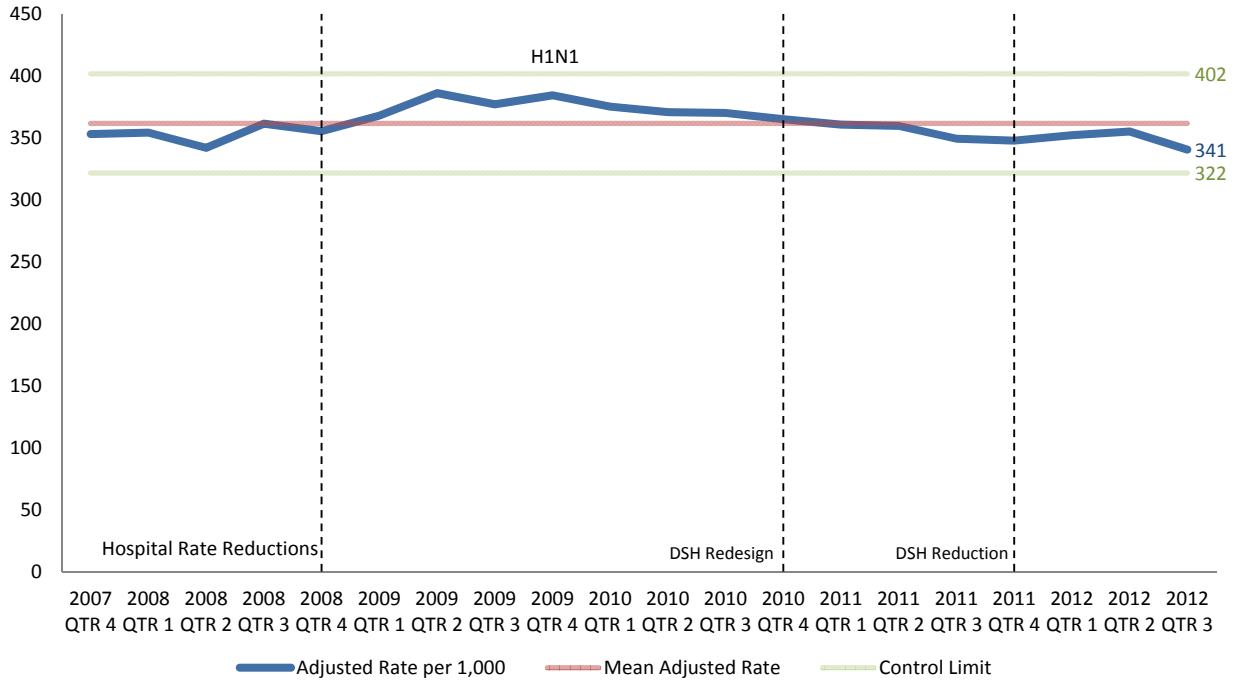


Figure 27. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Areas



Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care

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

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

The data presented has been adjusted to remove seasonality that in New Hampshire reliably results in higher than average rates in the first calendar quarter and lower than average rates in the third calendar quarter (due to seasonality of respiratory infections).

For this measure, a rate above the control limits is the trigger indicating a potential access problem requiring further investigation. Higher rates, in conjunction with lower use of primary care could indicate an access problem.

The rates shown in all figures never cross the upper control limits, and therefore do not indicate a potential access problem.

Figure 28. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

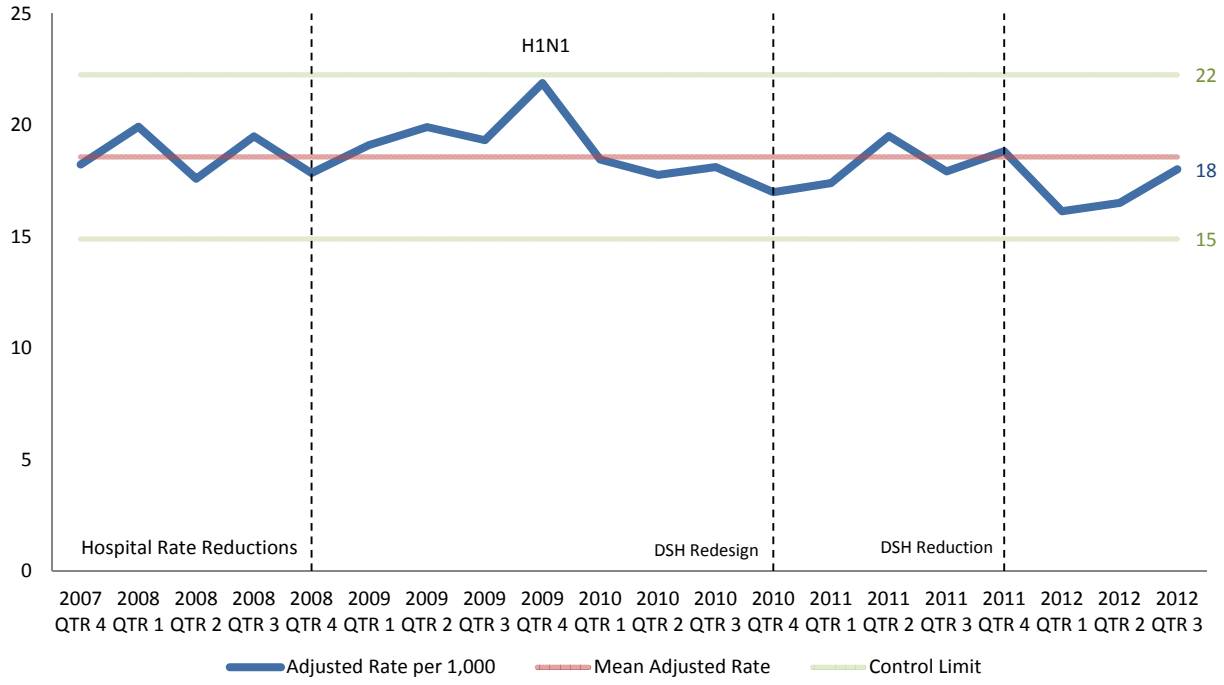


Figure 29. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Children and Families Aid Categories

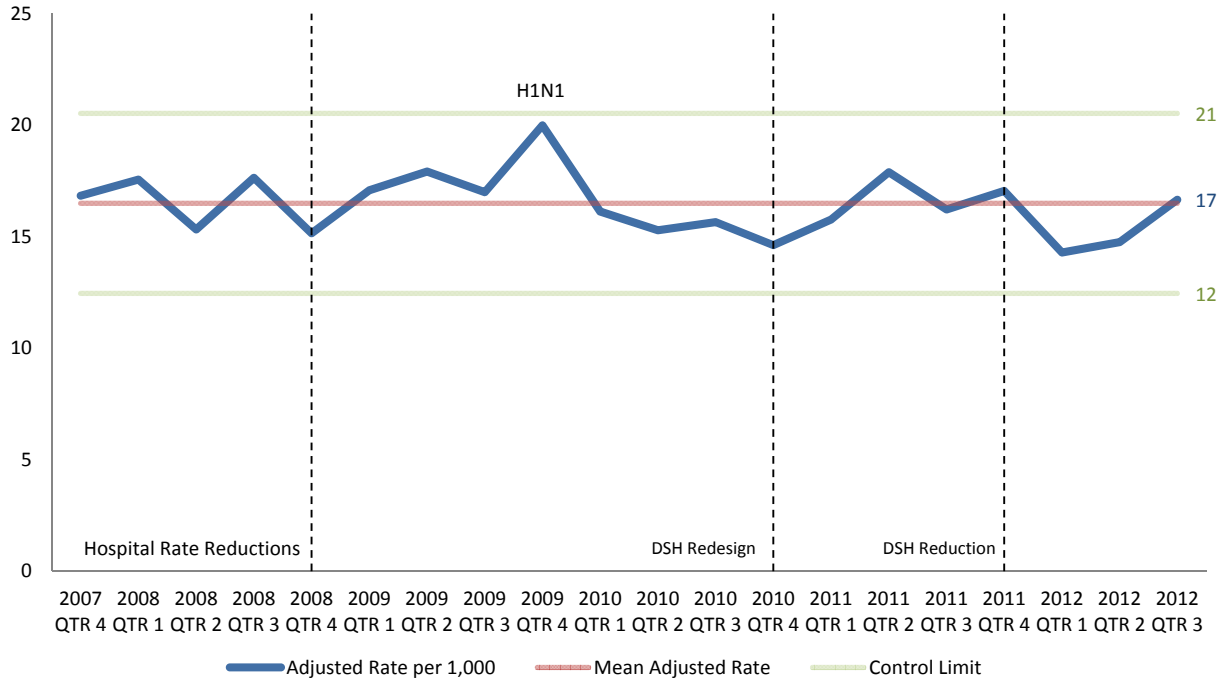


Figure 30. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Blind and Disabled Aid Categories

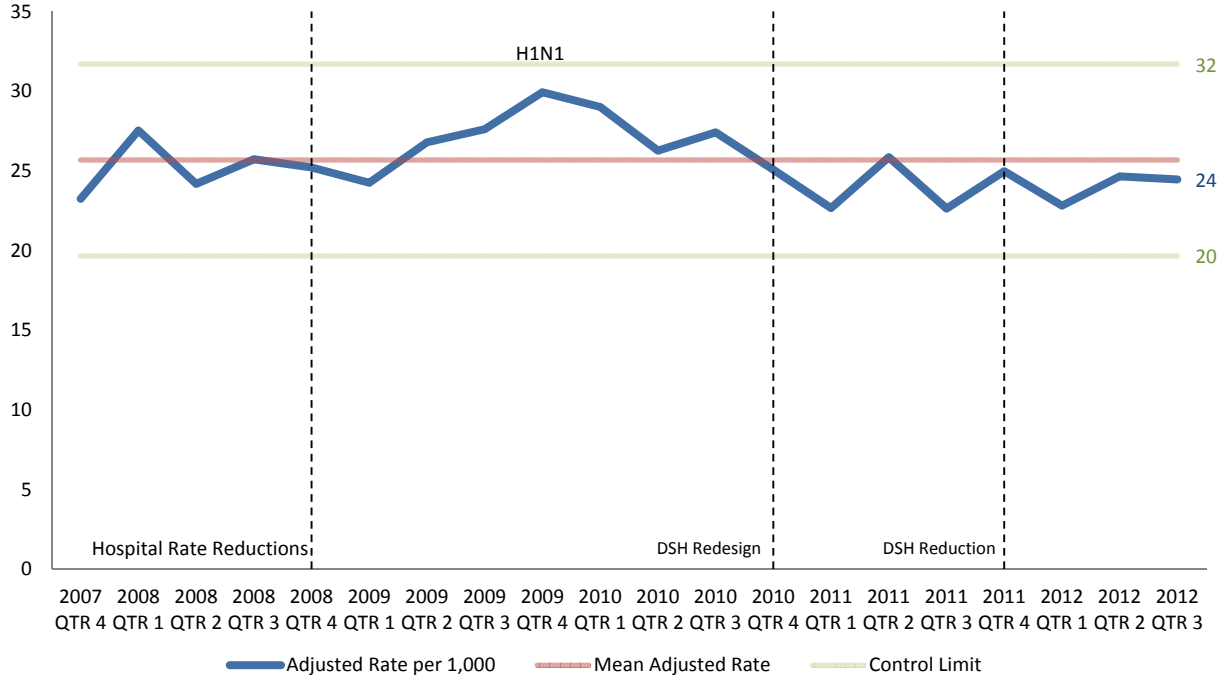


Figure 31. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Children and Families Aid Categories

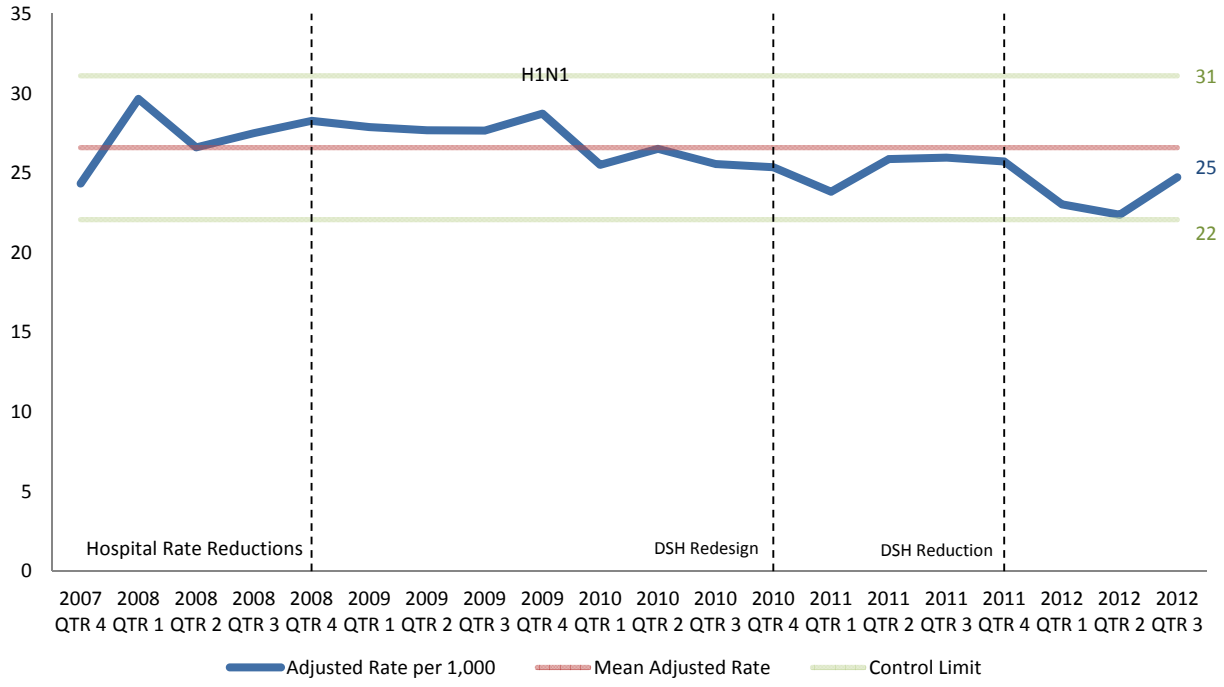


Figure 32. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Areas

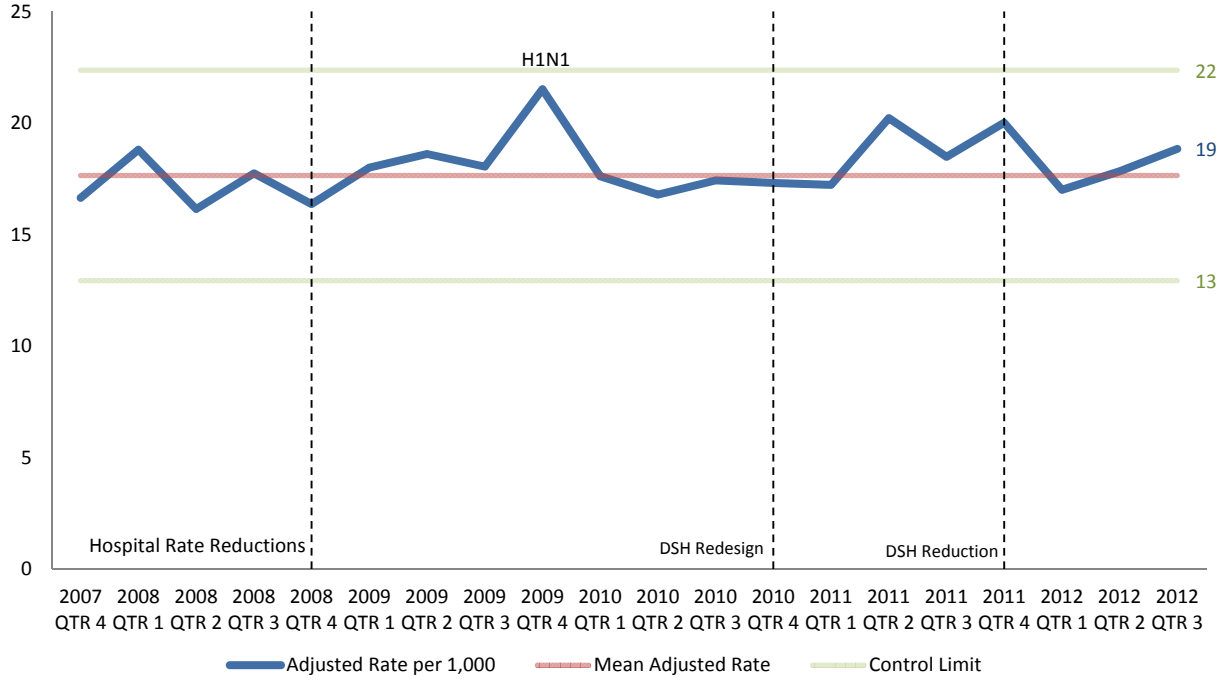
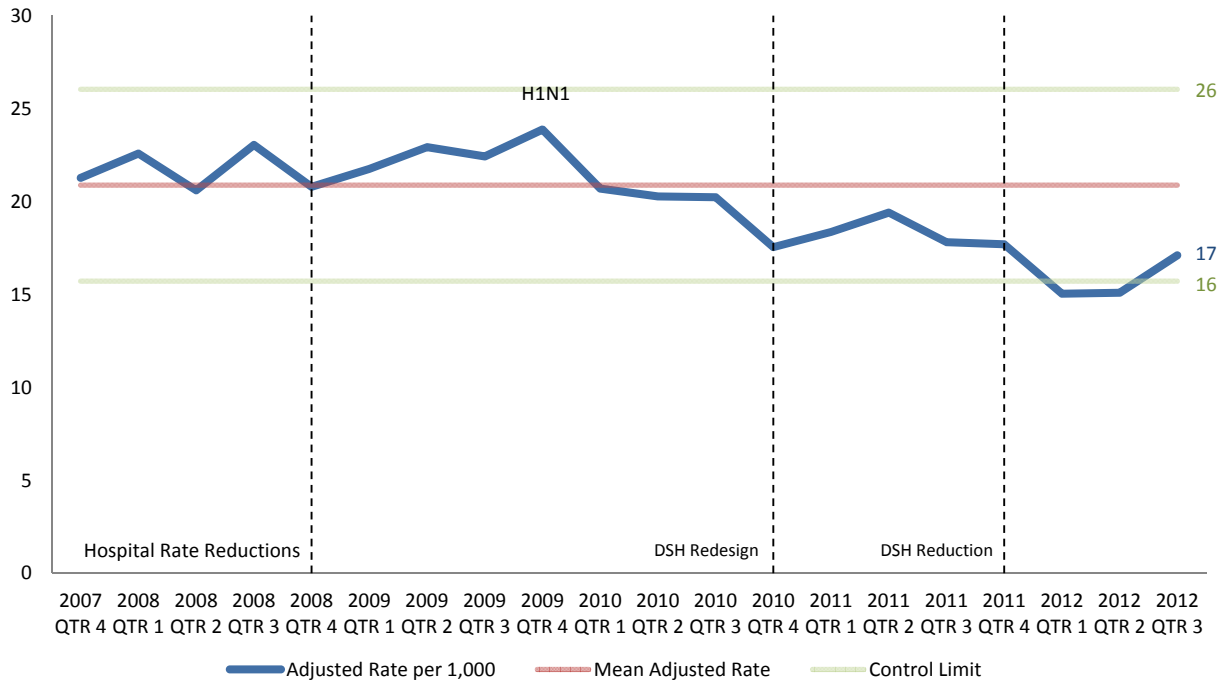


Figure 33. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Areas



Seasonally Adjusted Total Emergency Department Utilization

Figures in this section show the trend in quarterly use of hospital emergency departments by New Hampshire Medicaid beneficiaries as indicated by Medicaid claims data.

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

The data presented has been adjusted to remove seasonality that in New Hampshire reliably results in higher than average rates in the first calendar quarter and lower than average rates in the third calendar quarter (due to seasonality of respiratory infections).

For the total emergency department utilization measure, a rate either above or below the control limits is the trigger indicating a potential access problem requiring further investigation. Higher rates, in conjunction with lower use of primary care could, although it is unlikely, indicate an access problem. Rates below the control limit could indicate more appropriate use of care (a goal of the program), but would still be investigated if provider enrollment data indicates the potential for reduced emergency department access.

As shown below, the data indicates that emergency utilization has not crossed the upper control limits and supports the conclusion that Medicaid beneficiaries in New Hampshire do not have a problem accessing healthcare services. The Emergency Department Utilization in Non-Metropolitan Counties does cross the lower control limit during the third quarter. While low ED use rates are typically not a concern,

DHHS will be investigating this to see if it is tied to a specific provider other factors. There are two likely causes. One possibility is that the introduction of the CHIP population (which is known to have low rates of ED use) may have reduced the rate below the limit. The other possibility is the implementation of the emergency department visit limit of four visits unless services are for the treatment of an emergency medical condition, as requested in SPA 12-004 implemented on March 1, 2012.

Figure 34. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

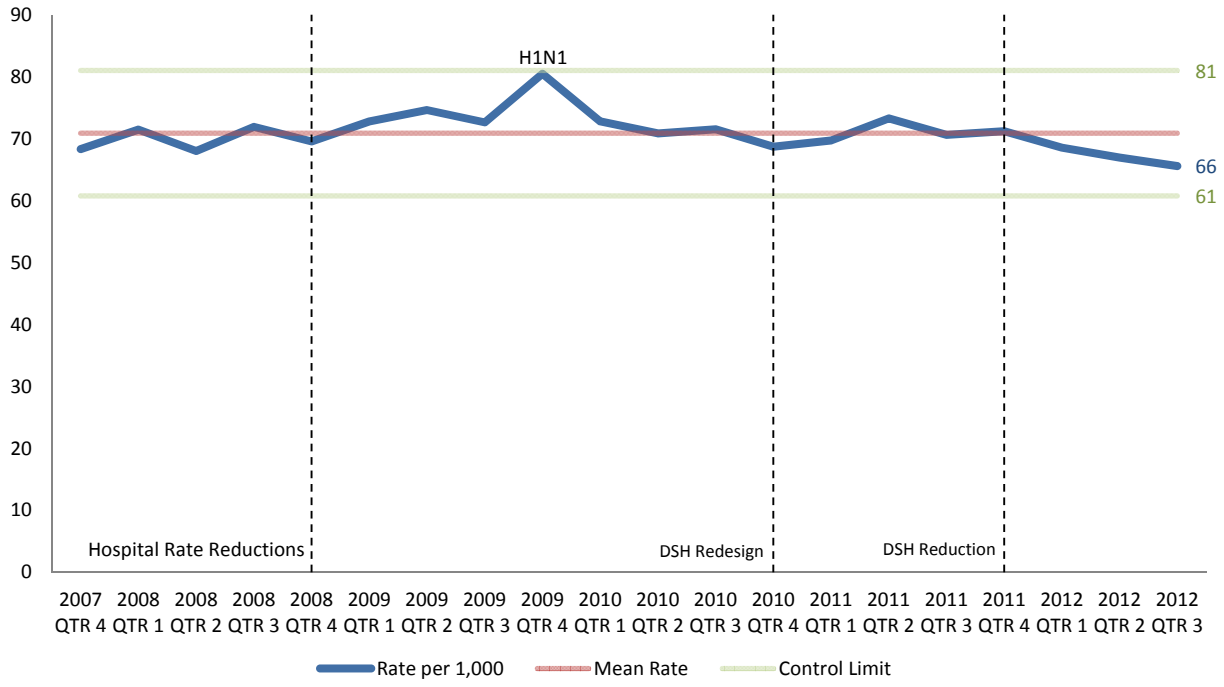


Figure 35. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Blind and Disabled Aid Categories

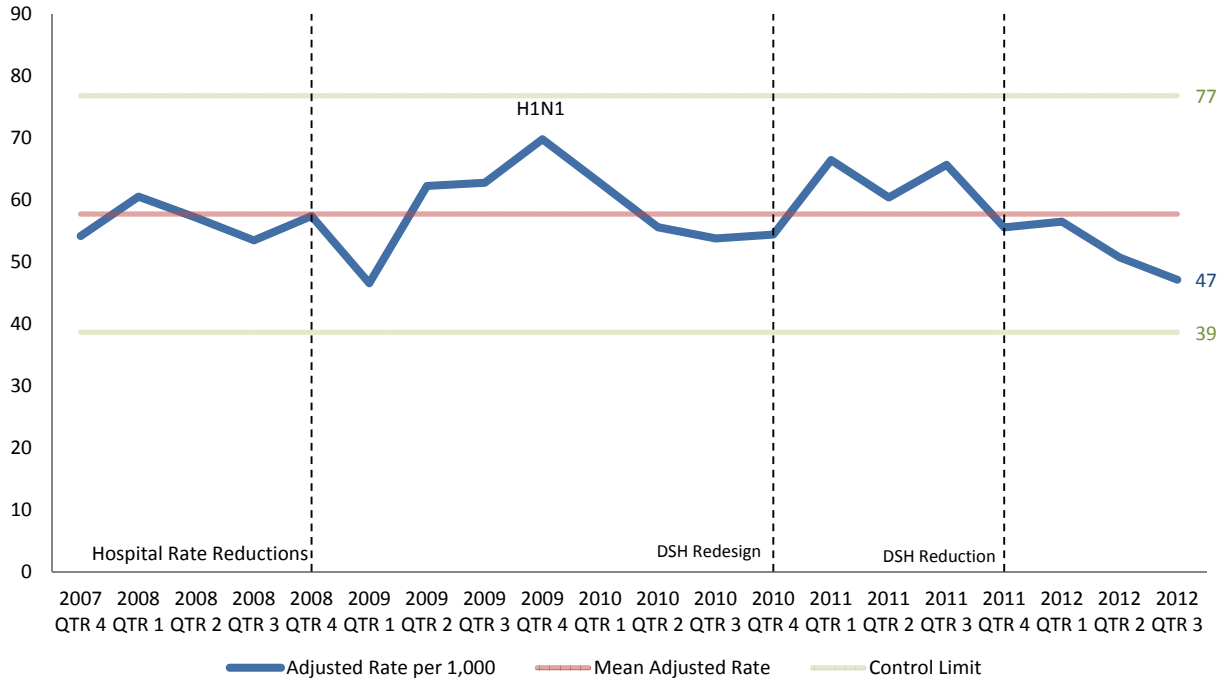


Figure 36. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Children and Families Aid Categories

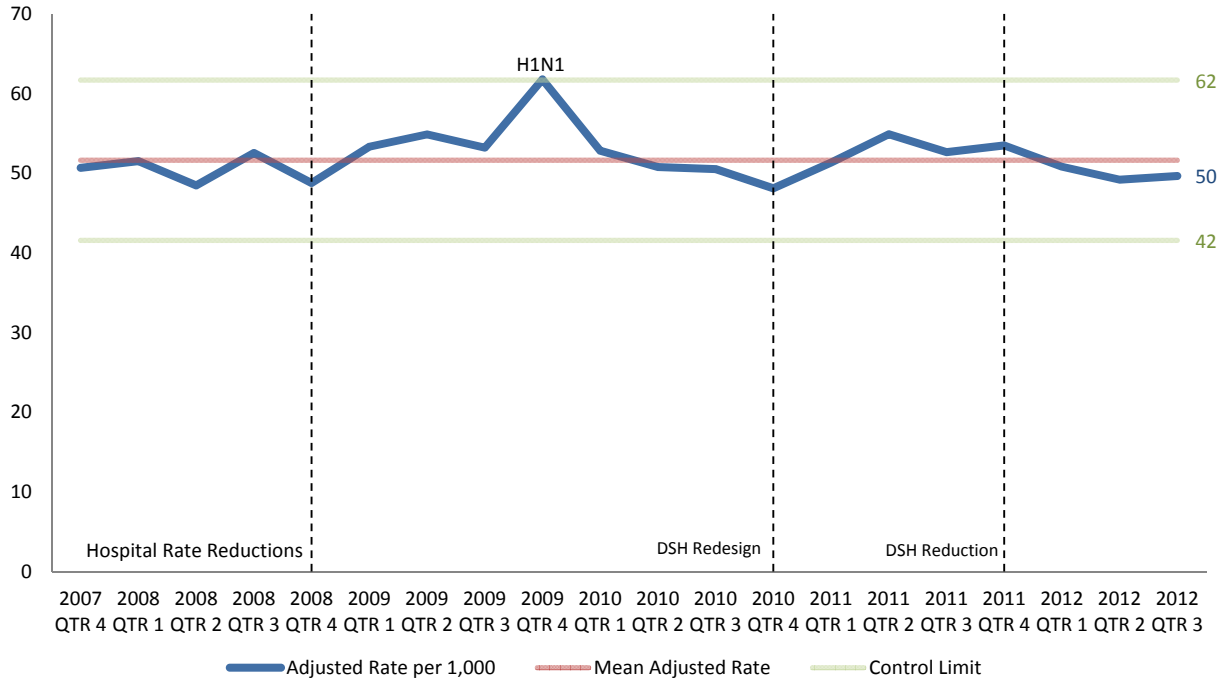


Figure 37. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Foster Care Aid Categories

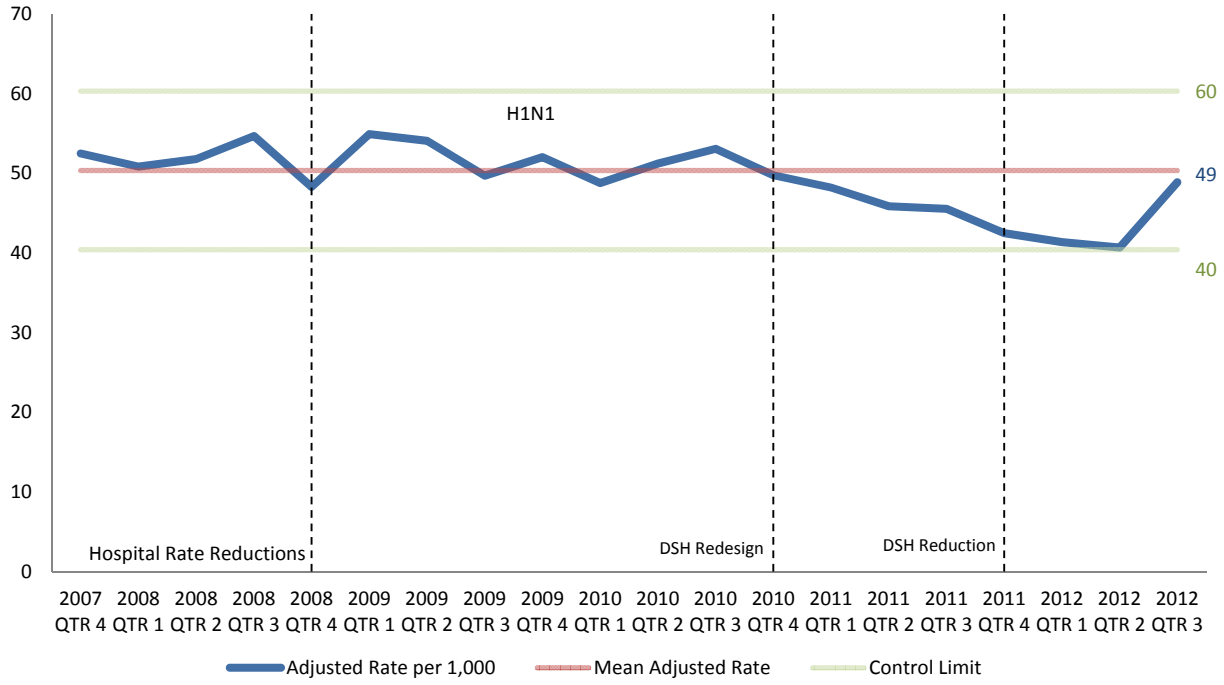


Figure 38. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adult, Aged Aid Categories

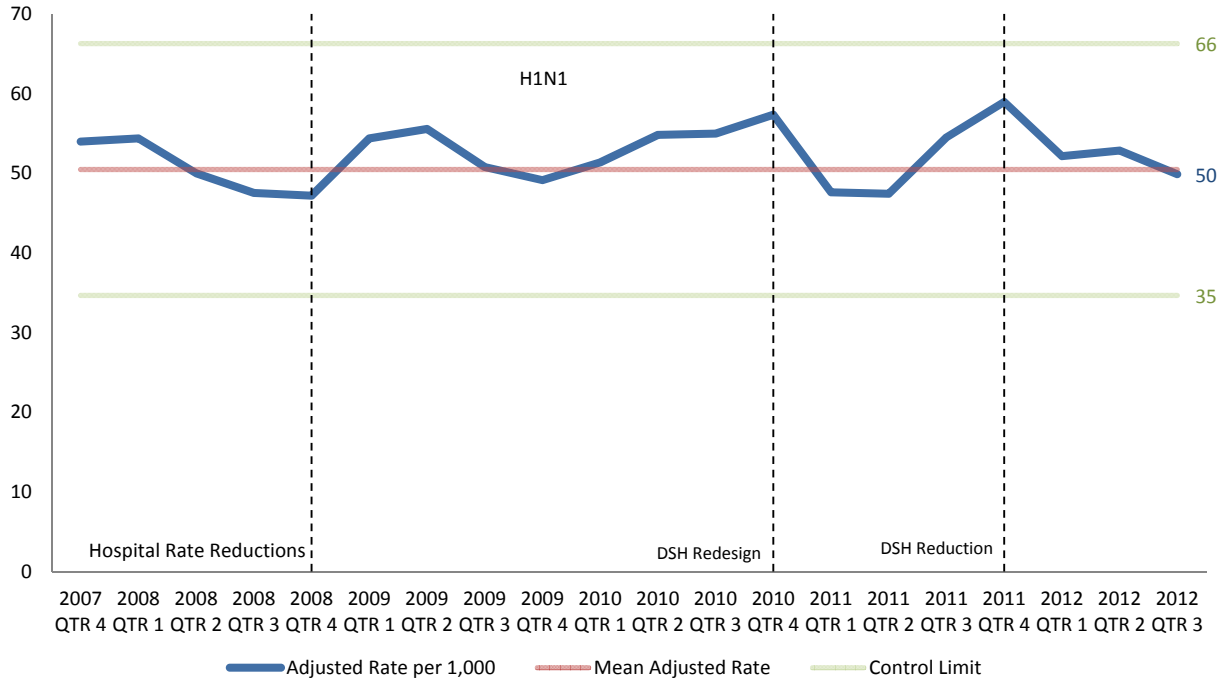


Figure 39. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adult, Blind and Disabled Aid Categories

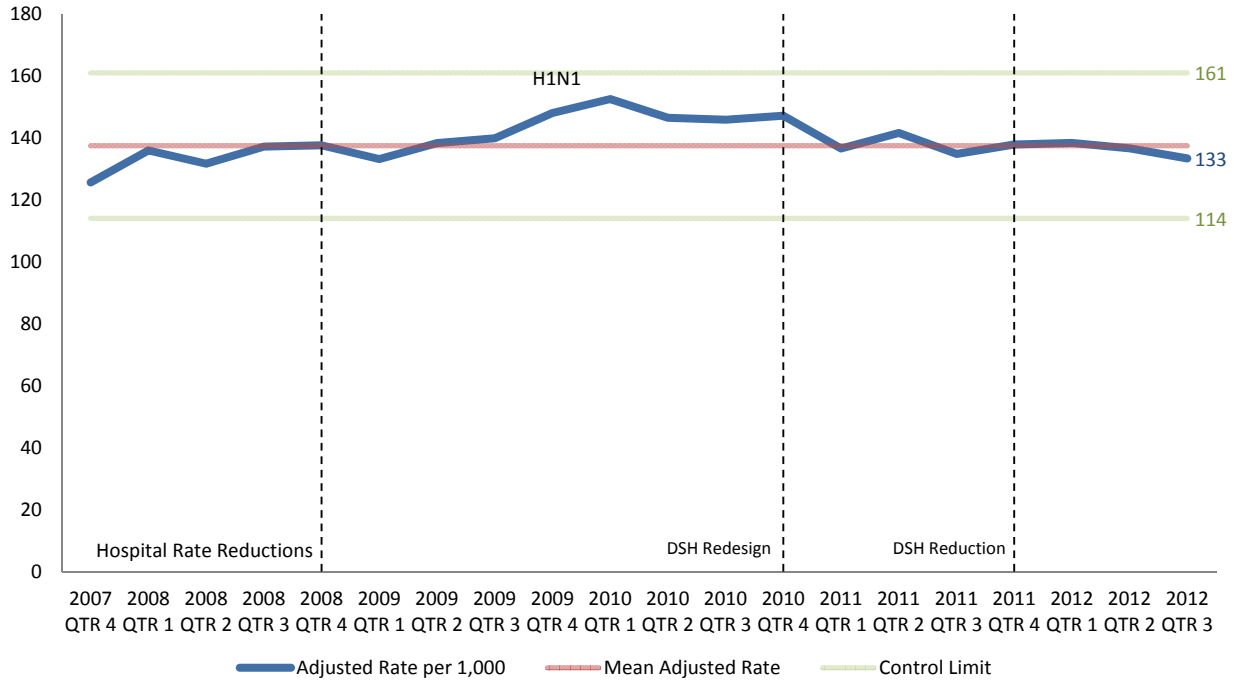


Figure 40. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adult, Families and Children Aid Categories

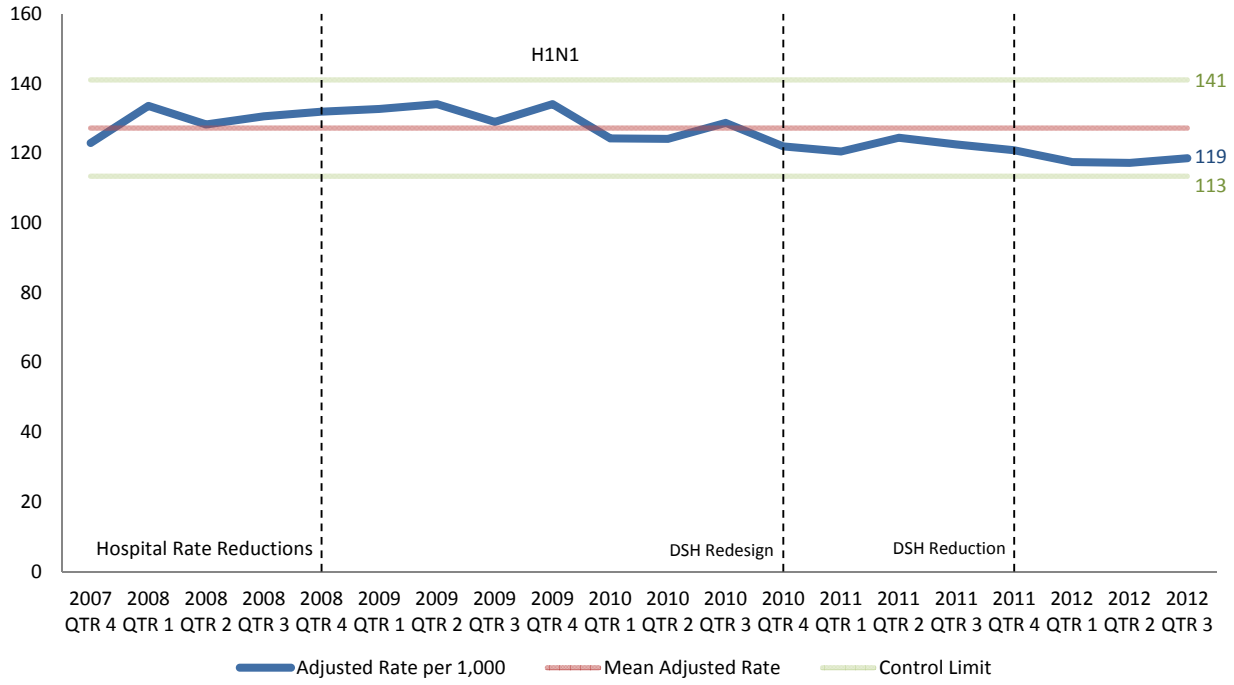


Figure 41. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Counties

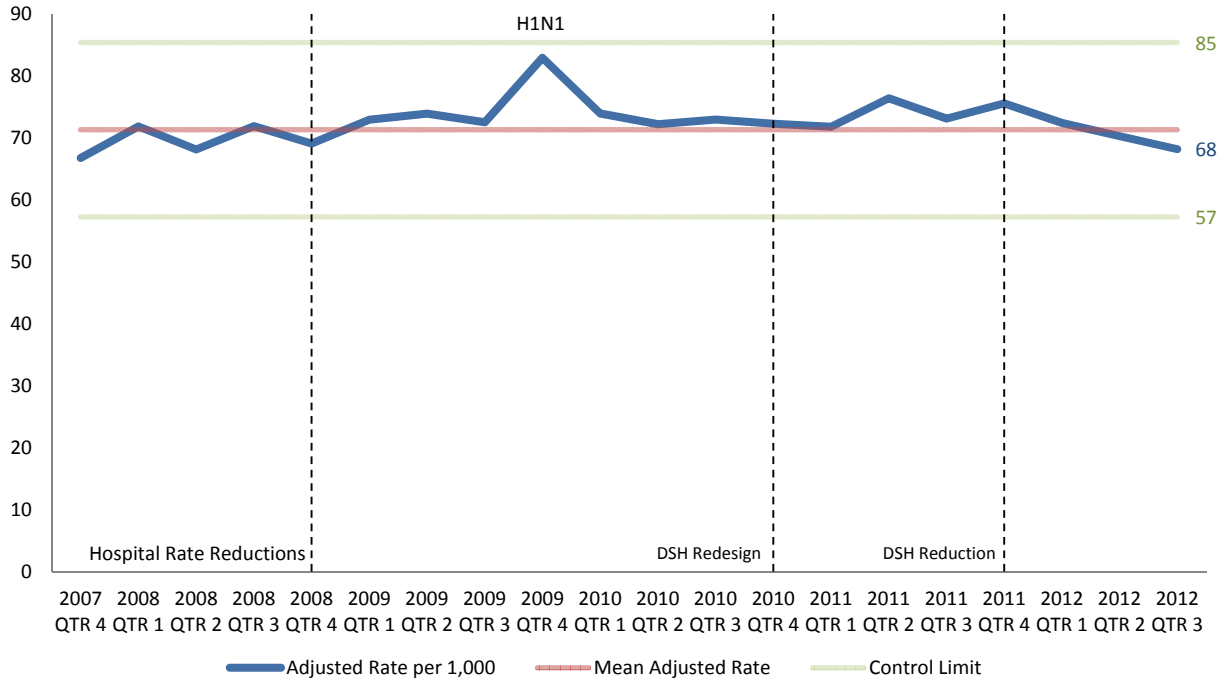
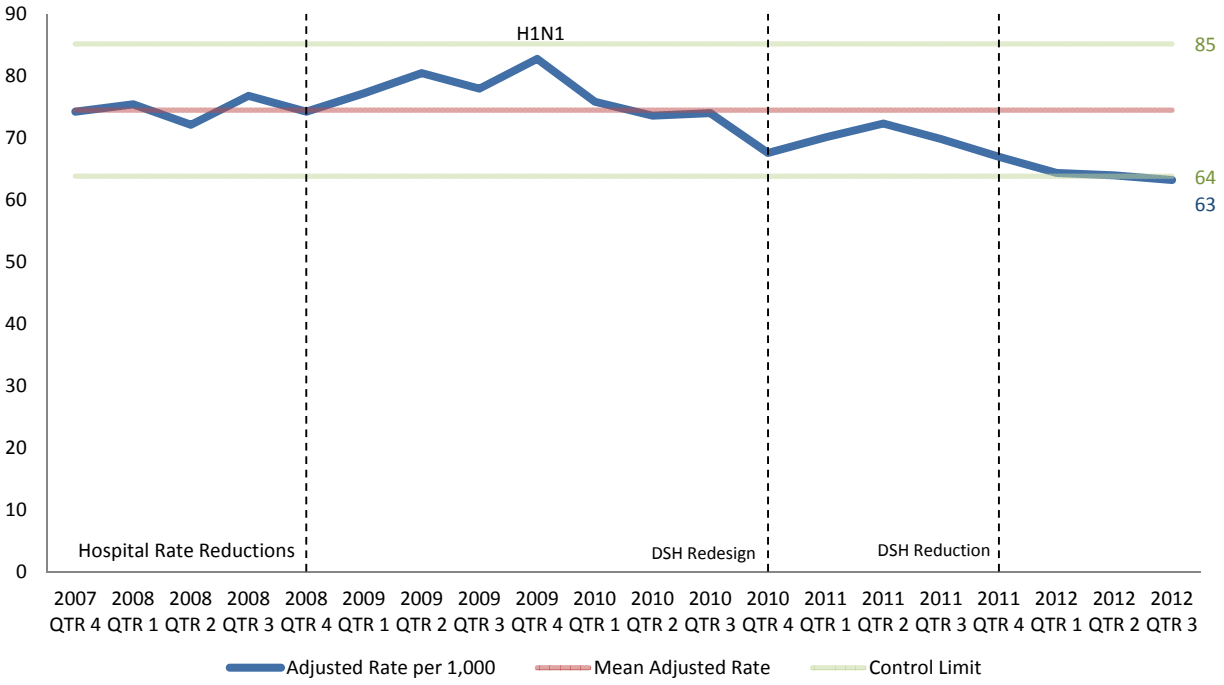


Figure 42. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Counties



Seasonally Adjusted Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions

Figures in this section show the trend in quarterly use of inpatient hospitals for ambulatory care sensitive conditions (ACSC) by New Hampshire Medicaid beneficiaries as indicated by Medicaid claims data. Rates of hospitalization for an ACSC are considered to be a measure of appropriate primary healthcare delivery. While not all admissions for these conditions are avoidable, appropriate ambulatory care can help prevent, or control, acute episodes, and improve the management of these illnesses or conditions. A disproportionately high rate of ACSC admissions may reflect underutilization of appropriate primary care. The ambulatory care sensitive conditions included in this measure are: asthma, dehydration, bacterial pneumonia, urinary tract infection, and gastroenteritis, which are commonly grouped together as ACSC's.

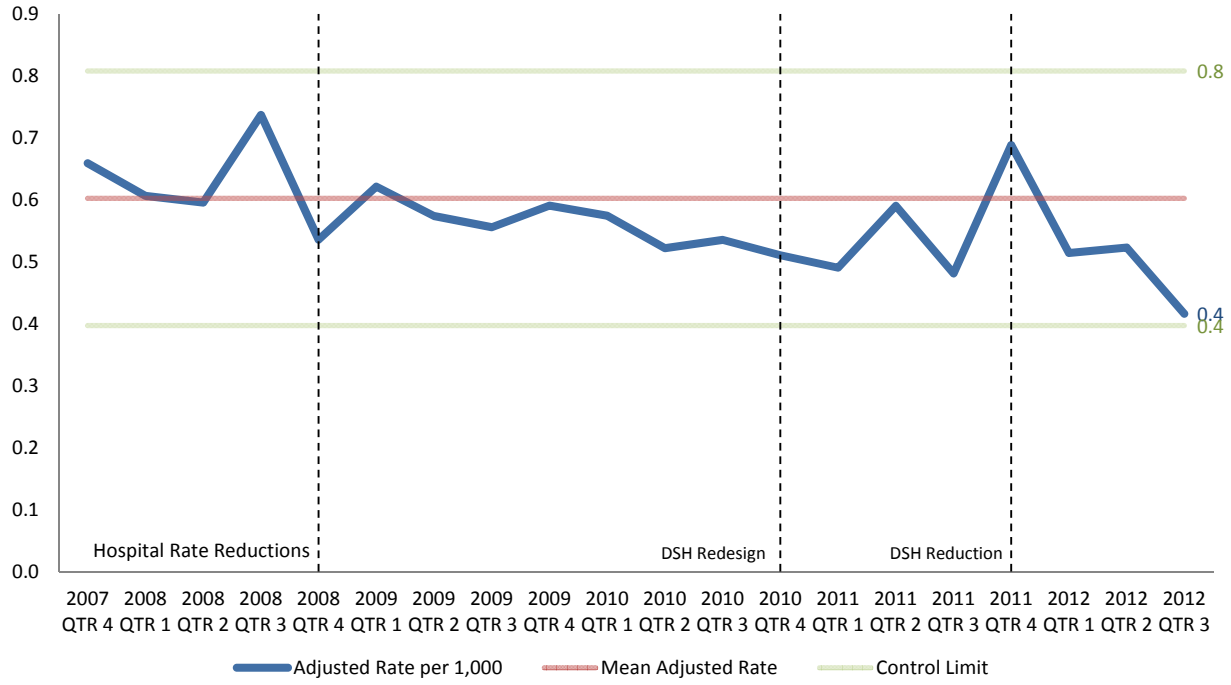
Data is only presented for the total Medicaid population due to the small number of cases that occur each quarter, broken out by age and eligibility groupings, and broken out for metropolitan and non-metropolitan areas of the State.

The data has been adjusted to remove seasonality that in New Hampshire reliably results in higher than average rates in the first calendar quarter and lower than average rates in the third calendar quarter (due to seasonality of respiratory infections).

For this measure, a rate above the control limits is the trigger indicating a potential access problem requiring further investigation. Higher rates, especially in conjunction with lower use of primary care, could indicate an access problem.

The rates shown in the figure do not cross the upper control limits, and therefore do not indicate a potential access problem.

Figure 43. Seasonally Adjusted Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population



Seasonally Adjusted Total Inpatient Hospital Utilization

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

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

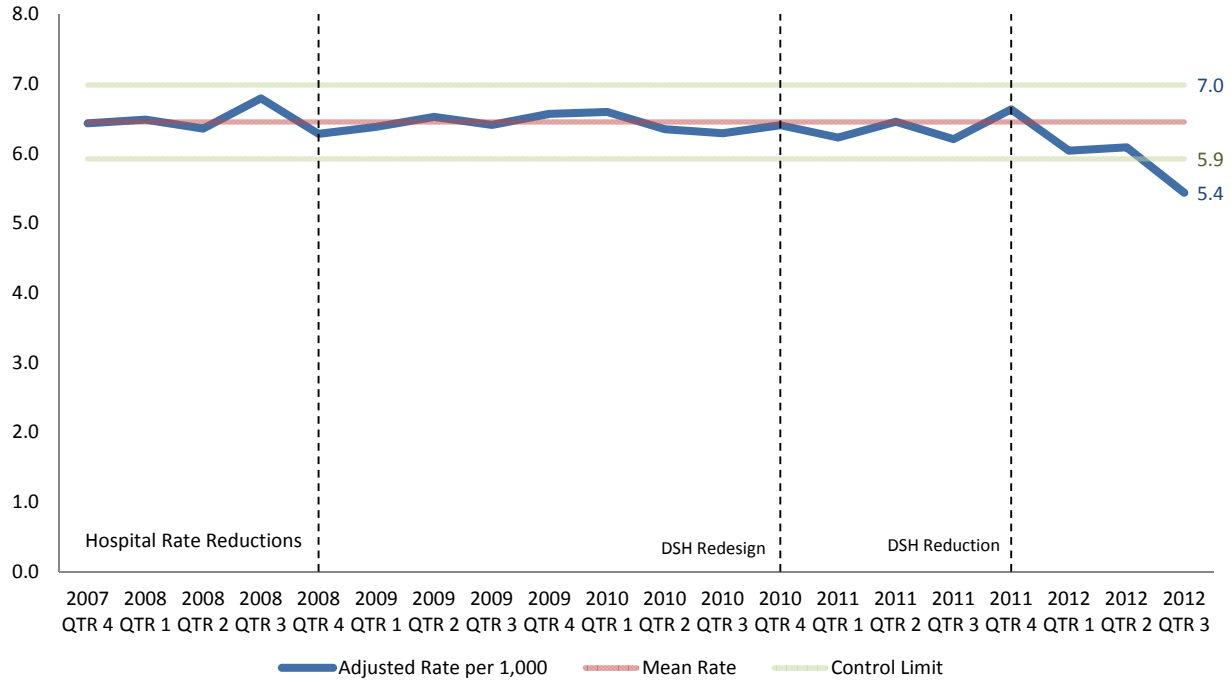
The data presented has been adjusted to remove seasonality that in New Hampshire reliably results in higher than average rates in the first calendar quarter and lower than average rates in the third calendar quarter (due to seasonality of respiratory infections). Maternity discharges (both mothers and new-borns) have also been removed due to declining birth rates in the Medicaid and general population. Given how common these services are in the New Hampshire Medicaid population including them would skew the results and lead to misinterpretation.[*]

For the total inpatient hospital utilization measure, a rate either above or below the control limits is the trigger indicating a potential access problem requiring further investigation. Higher rates, in conjunction with lower use of primary care could indicate an access problem. Rates below the control limit could indicate more appropriate use of care (a goal of the program), but would still be investigated if provider enrollment data indicates the potential for reduced inpatient hospital access.

[*] Prior reports did include delivery claims.

The rates shown in the figure does cross the lower control limits in Quarter 3 of 2012, and could indicate a potential access problem. However, the reduction in the rate is not due to an access problem. As noted earlier in the report, NH Medicaid transitioned its separate CHIP program to a Medicaid expansion program on July 1, 2012. Unlike the other measures in report, the former CHIP program population has significantly less utilization of inpatient services than the rest of the Medicaid population (CHIP program population is young population that is healthier than the rest of the Medicaid population). Hence, while the new group contributed an additional 30,000 member months to the denominator of the rate for Quarter 3, their contribution to the numerator was proportionally much less. Children in the former CHIP program are one fifth as likely to be hospitalized as the existing Medicaid beneficiary population. Even though the control limits have been adjusted, the magnitude of the difference between Title XIX inpatient utilization and Title XXI inpatient utilization is evident. A re-baseline of the measure or separate child and adult rends will presented in the next quarterly report.

Figure 44. Seasonally Adjusted Inpatient Hospital Utilization* per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population



Annual Utilization of Preventive and Office/Clinic Health Services

Figures in this section show the trend in the percent of continuously enrolled New Hampshire Medicaid beneficiaries who made use of at least one expected service as indicated by Medicaid claims data. Measure definitions follow those specified by the National Committee on Quality Assurance (NCQA). These measures are calculated using annual data because expected service use is based on an annual (or greater) period. Only continuously enrolled beneficiaries (with no more than a one month gap in cover-

* Excludes maternity

age) are included to ensure adequate time for the expected service use to occur. Where available, national NCQA averages for Medicaid are reported on the charts.

Measures presented include:

- Six or More Well-Child Visits in the First 15 Months of Life,
- Well-Child Visits in the Third Through Sixth Years of Life,
- Adolescent Well-Care Visits,
- Child Access to Preventive/Ambulatory Health Services by Age,
- Adult Access to Preventive/Ambulatory Health Services by Age, and
- Follow-Up After Hospitalization for Mental Illness by 7 and 30 Days.

Measures are presented for the total Medicaid population and broken out for metropolitan and non-metropolitan areas of the state; except for the Mental Illness Follow-up measures (volume is too low to support meaningful sub-state analysis).

For charts based on annual data, control limits are not presented (annual data does not provide enough experience for meaningful limits). Instead, 95% confidence intervals are presented. The confidence interval takes into account random variability in the data to allow for comparison of rates over time. The 95% confidence interval is the range of values that, with 95% certainty includes the underlying rate for the entire population. As the number of beneficiaries represented in the rate increase, the confidence intervals become narrower.

If the current period of data deviates to such a degree that its confidence interval does not overlap with the prior period's confidence interval it will indicate a potential access problem requiring further investigation. Additionally, if a slowly changing trend is observed and the current period's confidence interval does not overlap with any of the previous three confidence intervals it will indicate a potential access problem requiring further investigation.

Analysis of the trends and confidence intervals do not indicate a potential access problem.

Figure 45. Percent of Continuously Enrolled NH Medicaid Beneficiaries With Six or More Well-Child Visits in the First 15 Months of Life, CY 2007-2011: Total Population

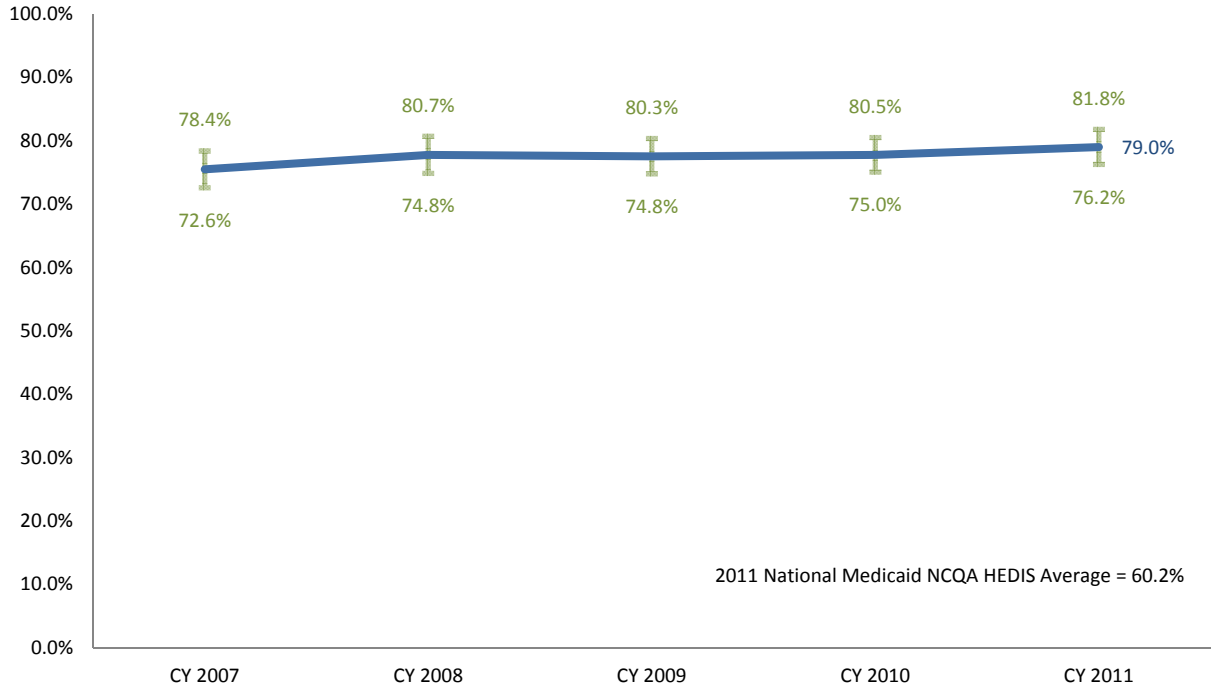


Figure 46. Percent of Continuously Enrolled NH Medicaid Beneficiaries With Six or More Well-Child Visits in the First 15 Months of Life, CY 2007-2011: Metropolitan Counties

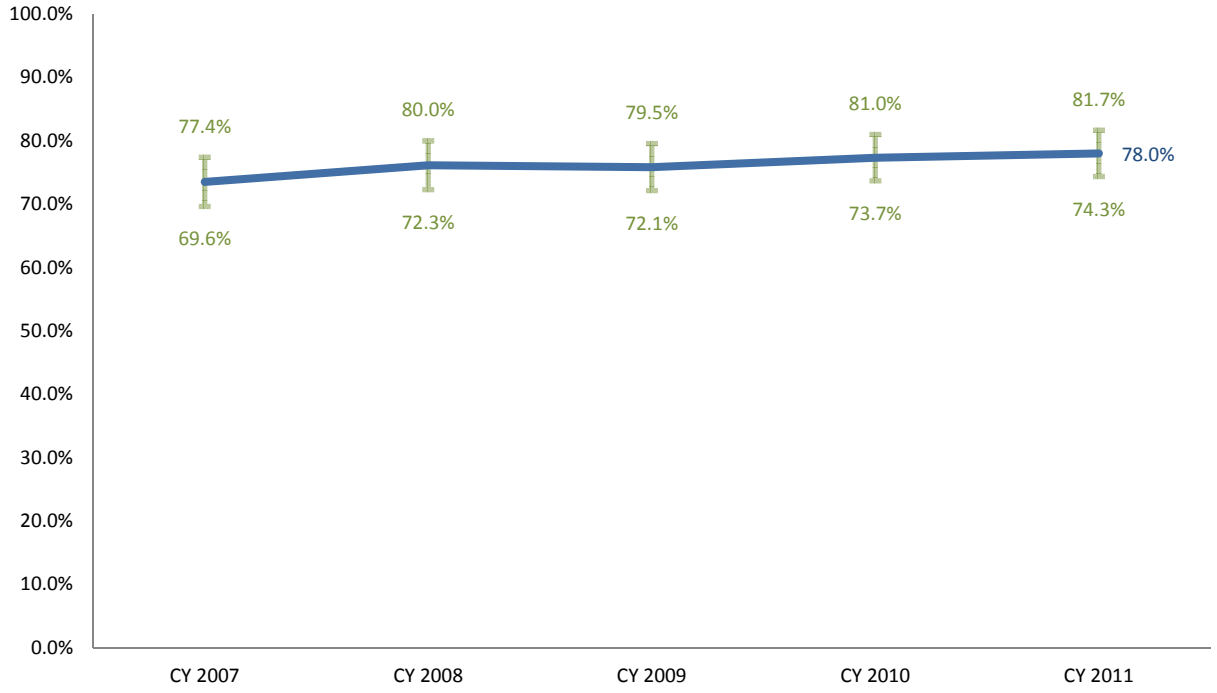


Figure 47. Percent of Continuously Enrolled NH Medicaid Beneficiaries With Six or More Well-Child Visits in the First 15 Months of Life, CY 2007-2011: Non-Metropolitan Counties

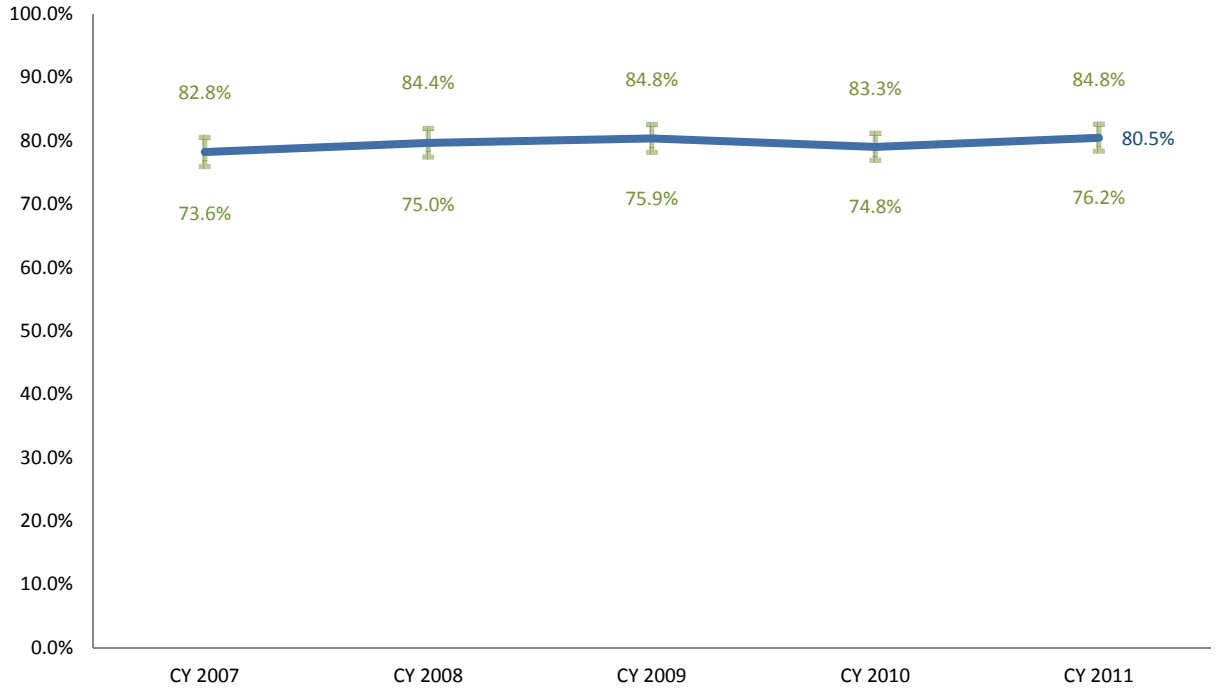


Figure 48. Percent of Continuously Enrolled NH Medicaid Beneficiaries in the Third Through Sixth Years of Life With a Well-Child Visit, CY 2007-2011: Total Population

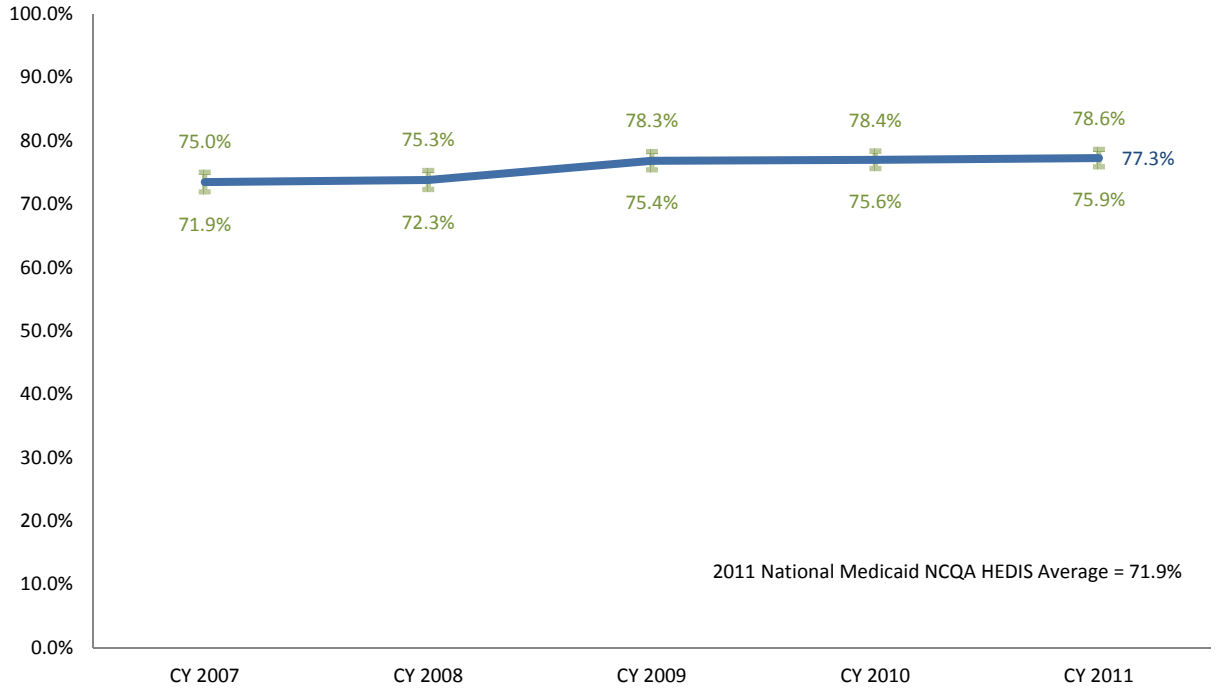


Figure 49. Percent of Continuously Enrolled NH Medicaid Beneficiaries in the Third Through Sixth Years of Life With a Well-Child Visit, CY 2007-2011: Metropolitan Counties

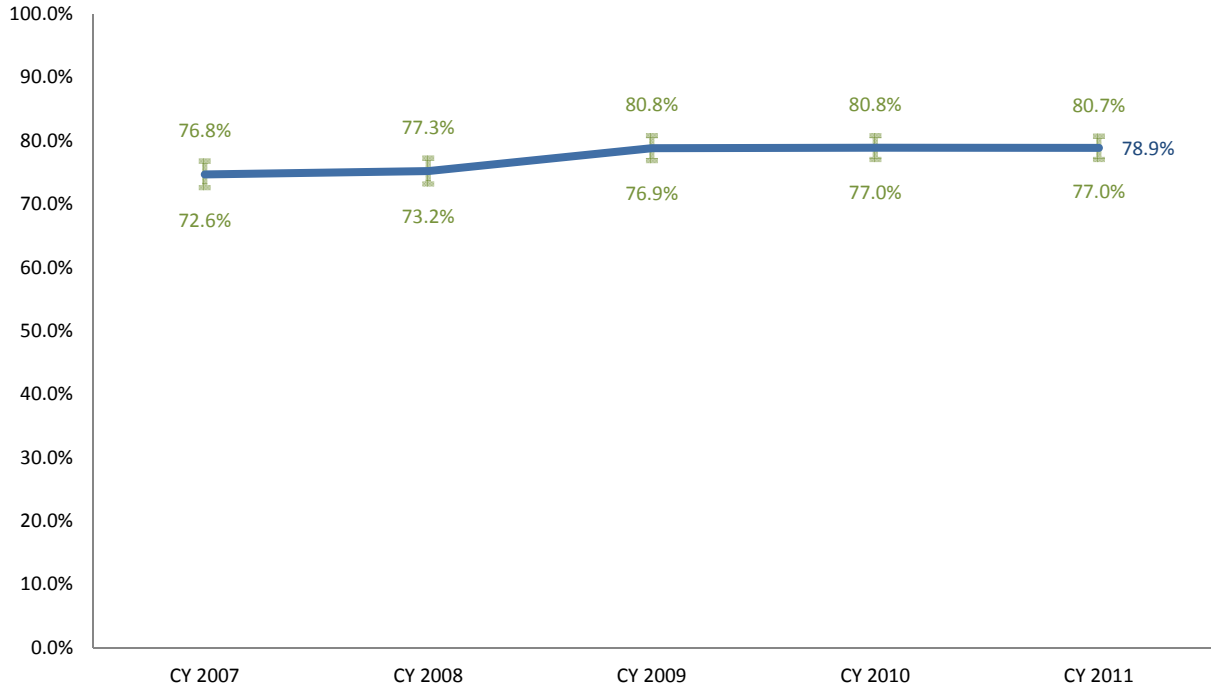


Figure 50. Percent of Continuously Enrolled NH Medicaid Beneficiaries in the Third Through Sixth Years of Life With a Well-Child Visit, CY 2007-2011: Non-Metropolitan Counties

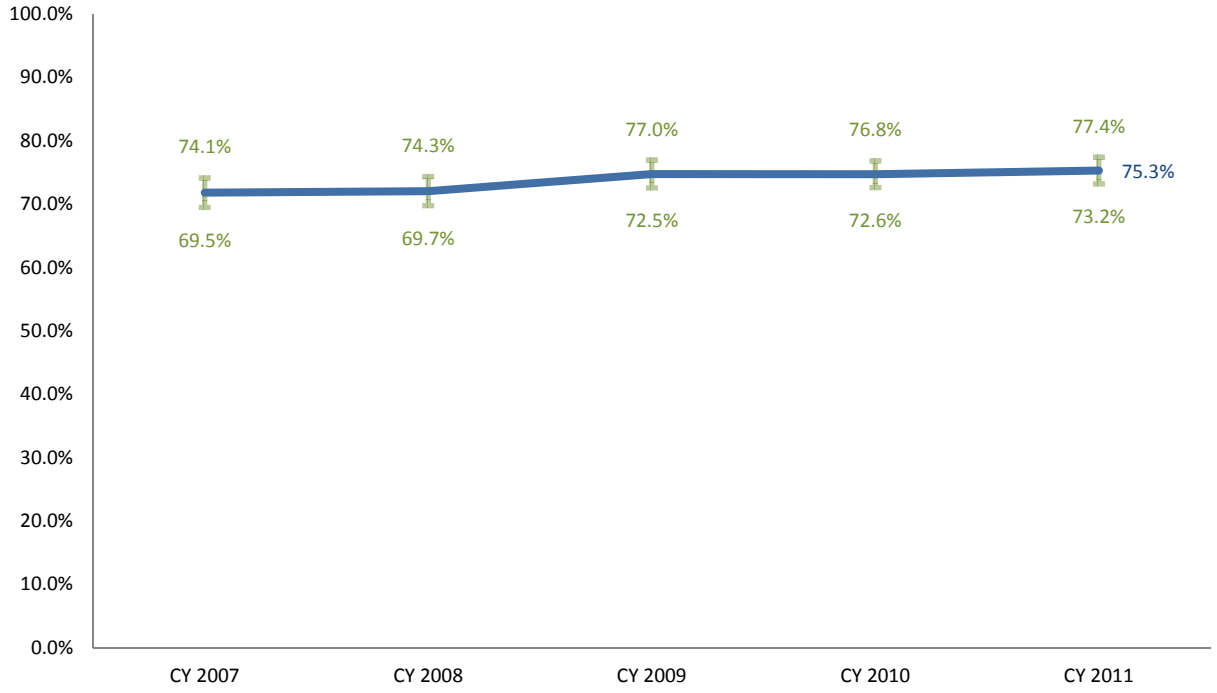


Figure 51. Percent of Continuously Enrolled Adolescent NH Medicaid Beneficiaries With a Well-Care Visit, CY 2007-2011: Total Population

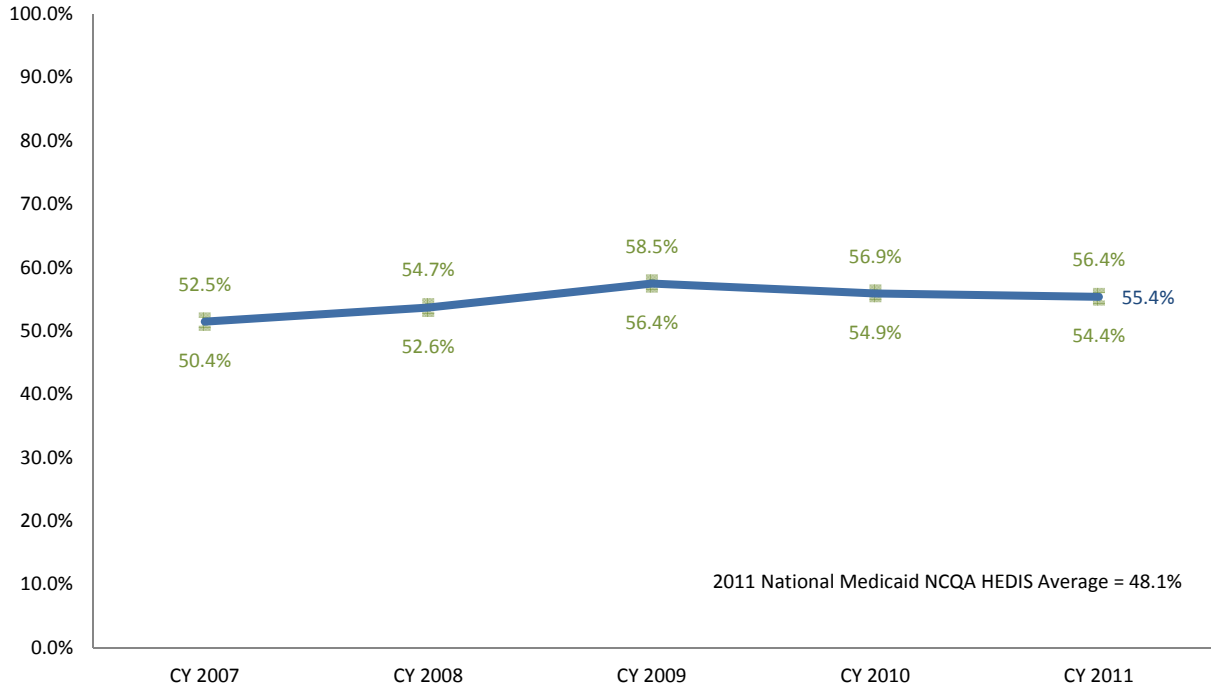


Figure 52. Percent of Continuously Enrolled Adolescent NH Medicaid Beneficiaries With a Well-Care Visit, CY 2007-2011: Metropolitan Counties

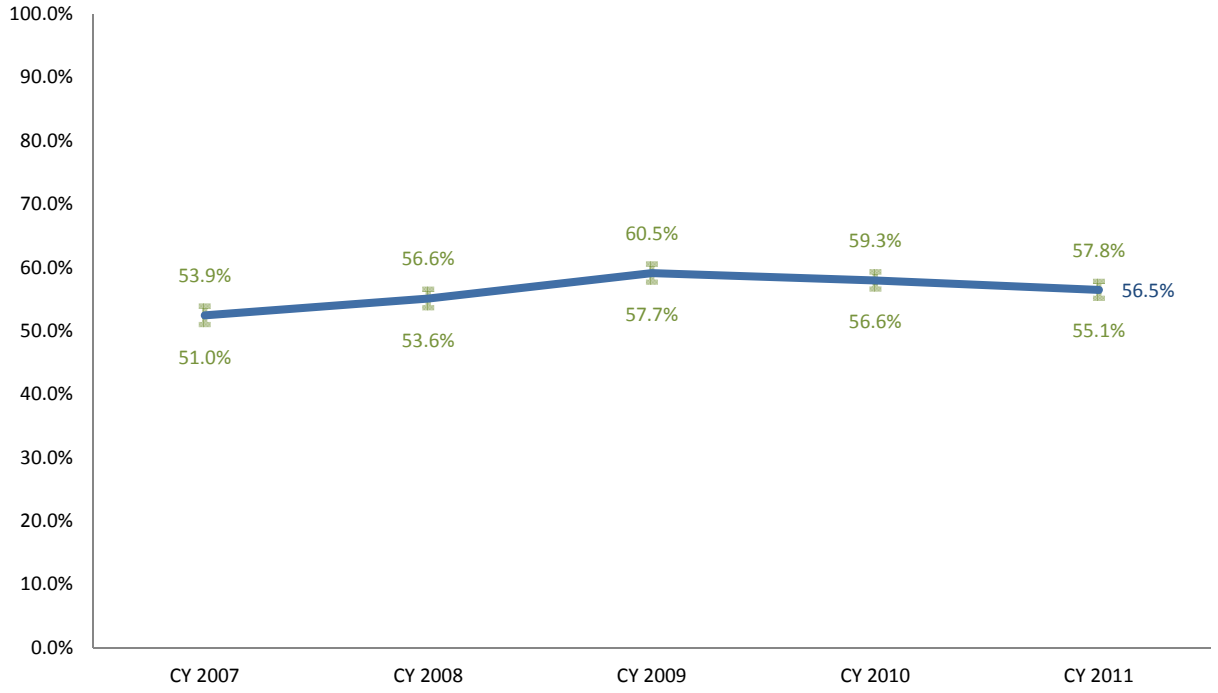


Figure 53. Percent of Continuously Enrolled Adolescent NH Medicaid Beneficiaries With a Well-Care Visit, CY 2007-2011: Non-Metropolitan Counties

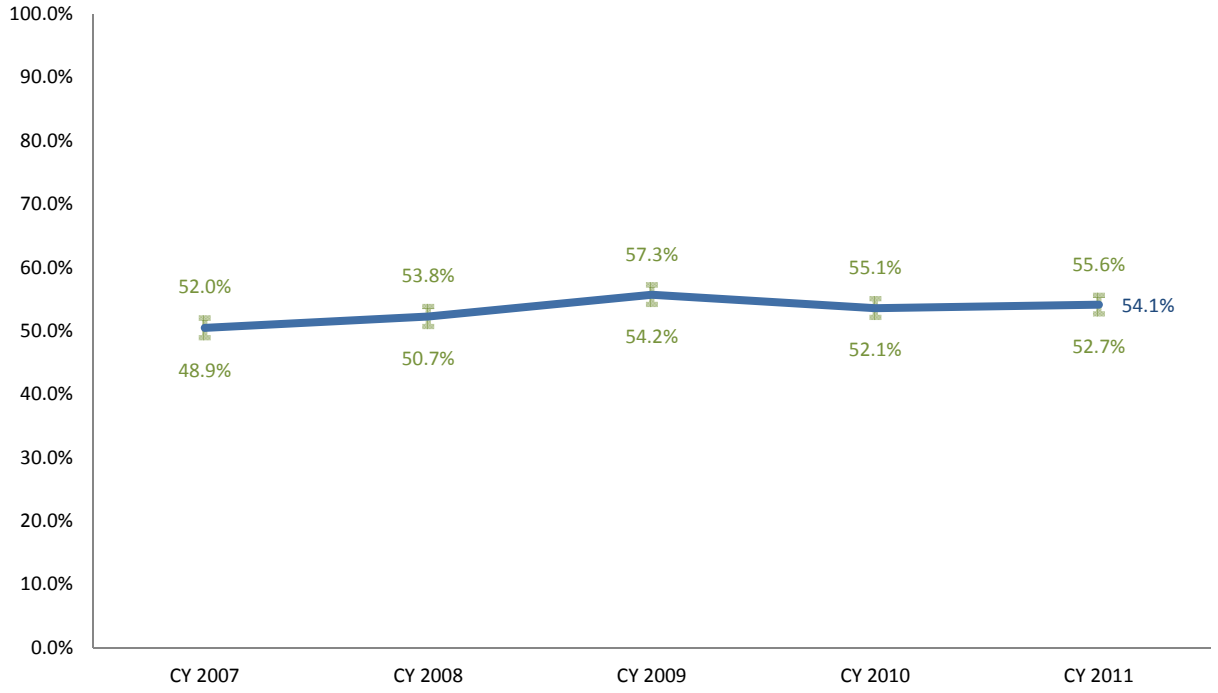


Figure 54. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 0 to 11 Months

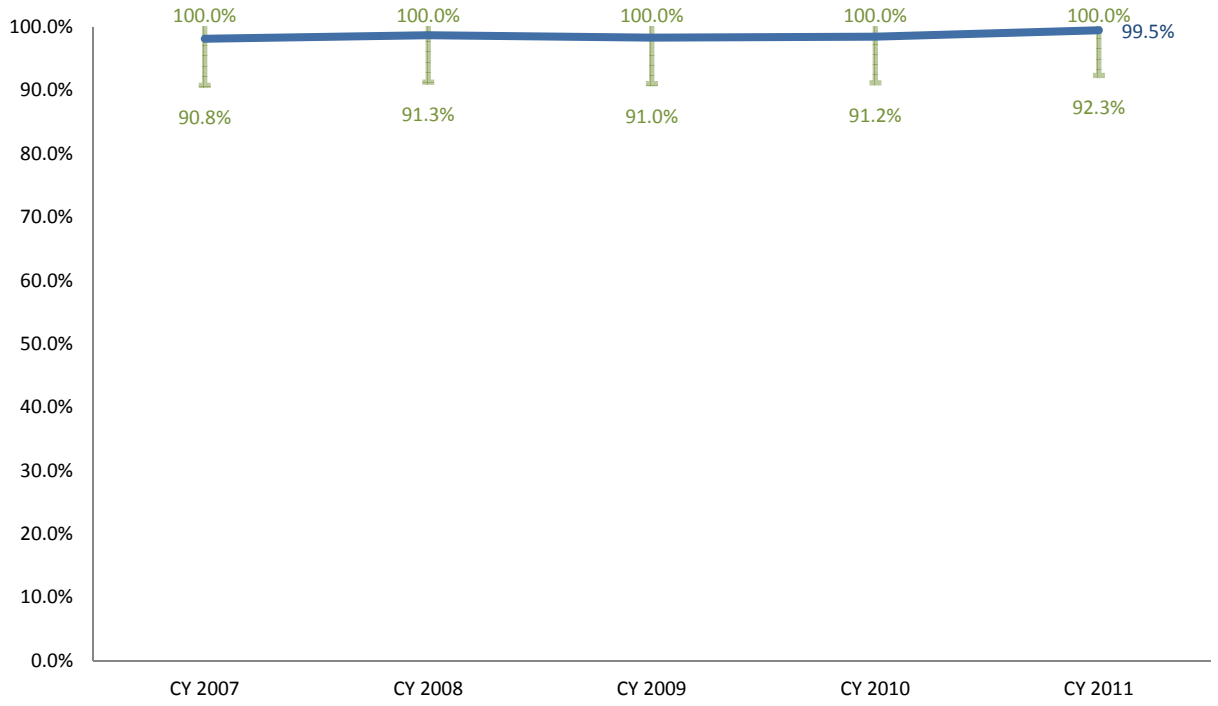


Figure 55. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 12 to 24 Months

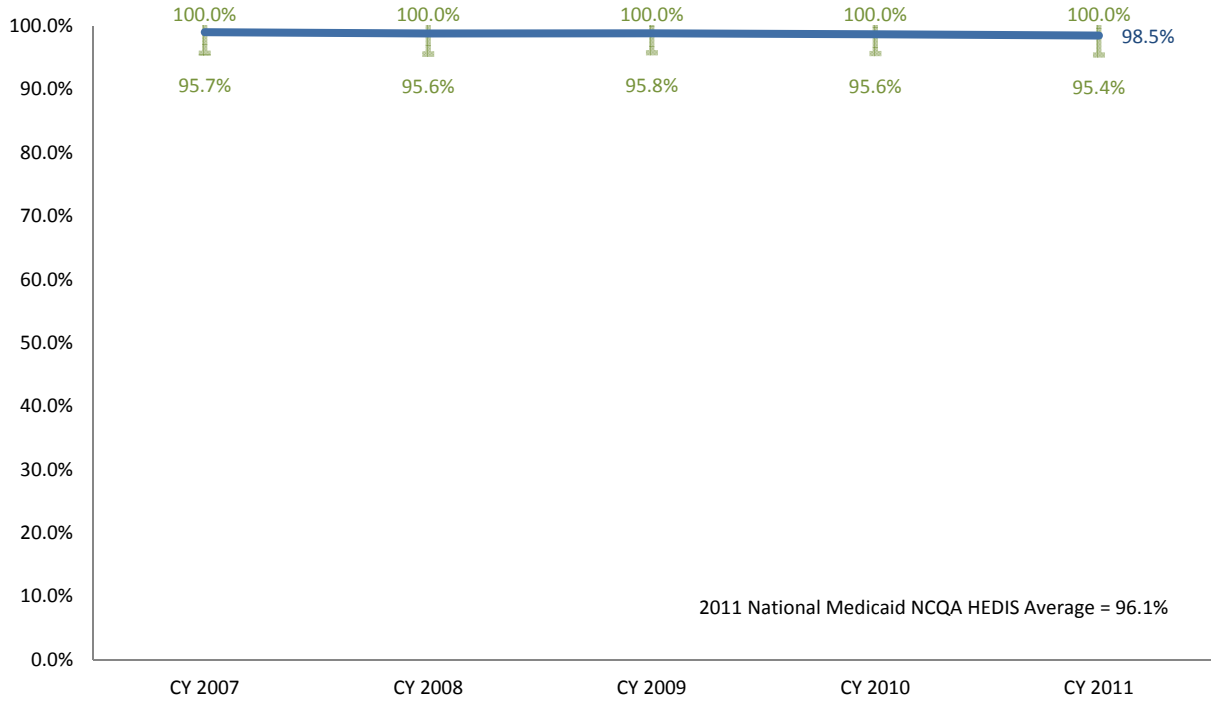


Figure 56. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, SFY 2007-2011 by Age: 25 Months to 6 Years

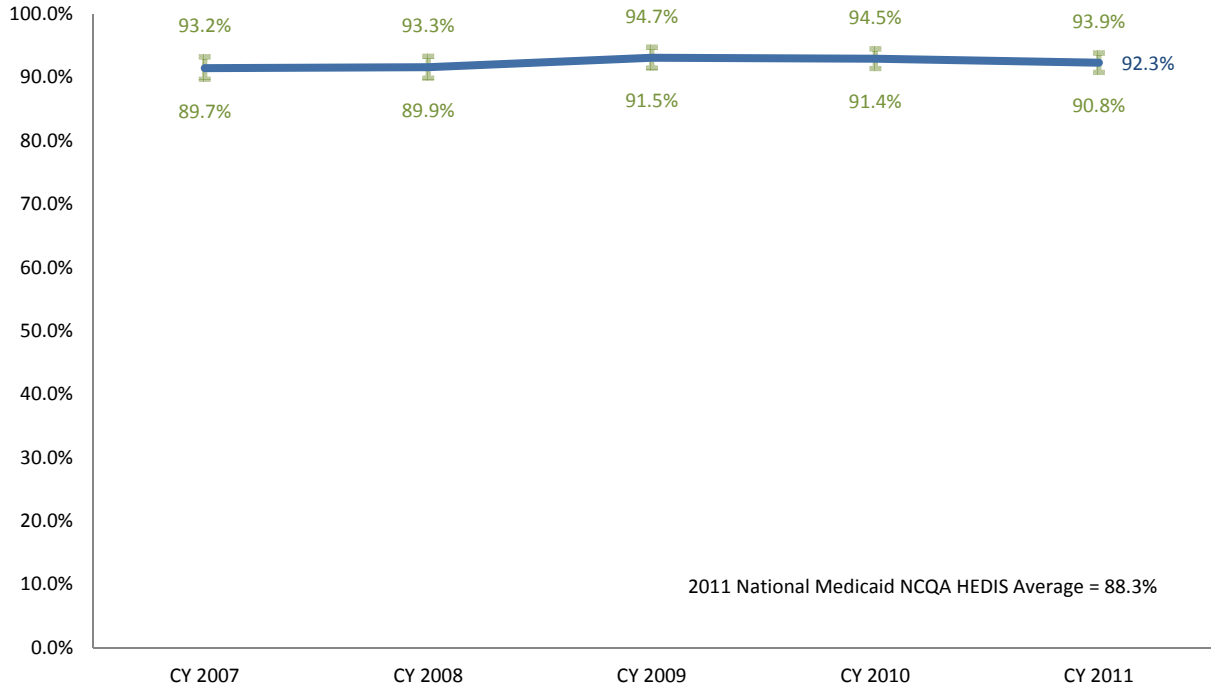


Figure 57. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, SFY 2007-2011 by Age: 7 to 11 Years

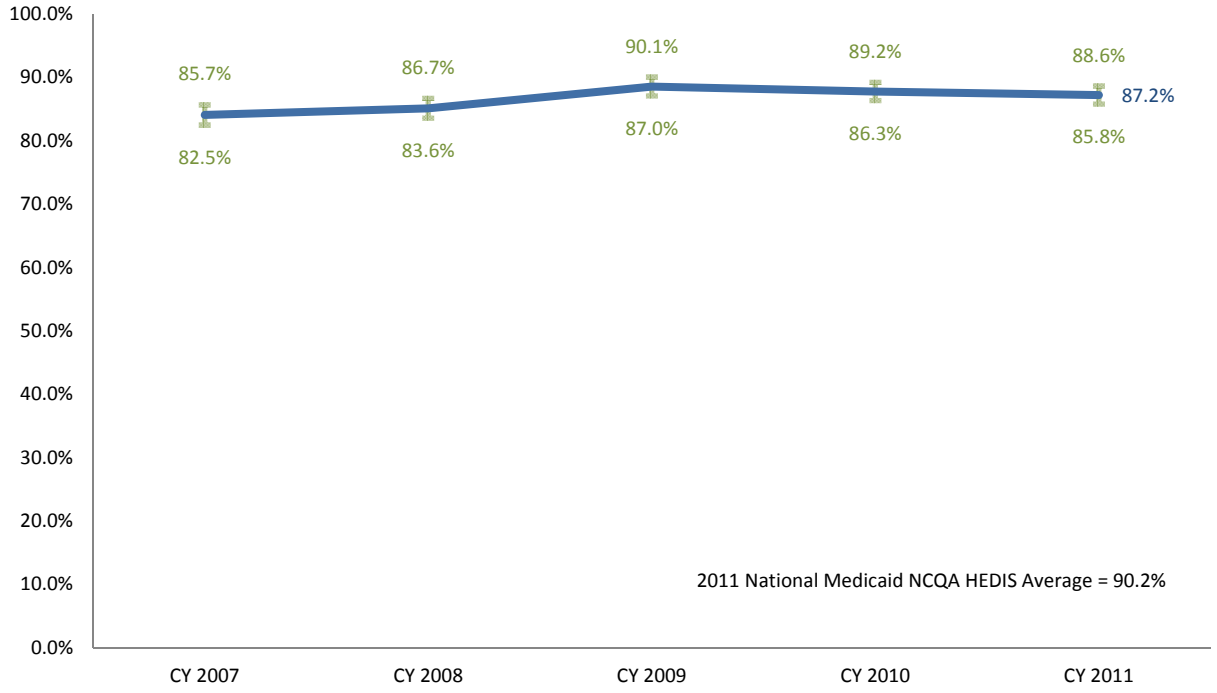


Figure 58. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 12 to 19 Years

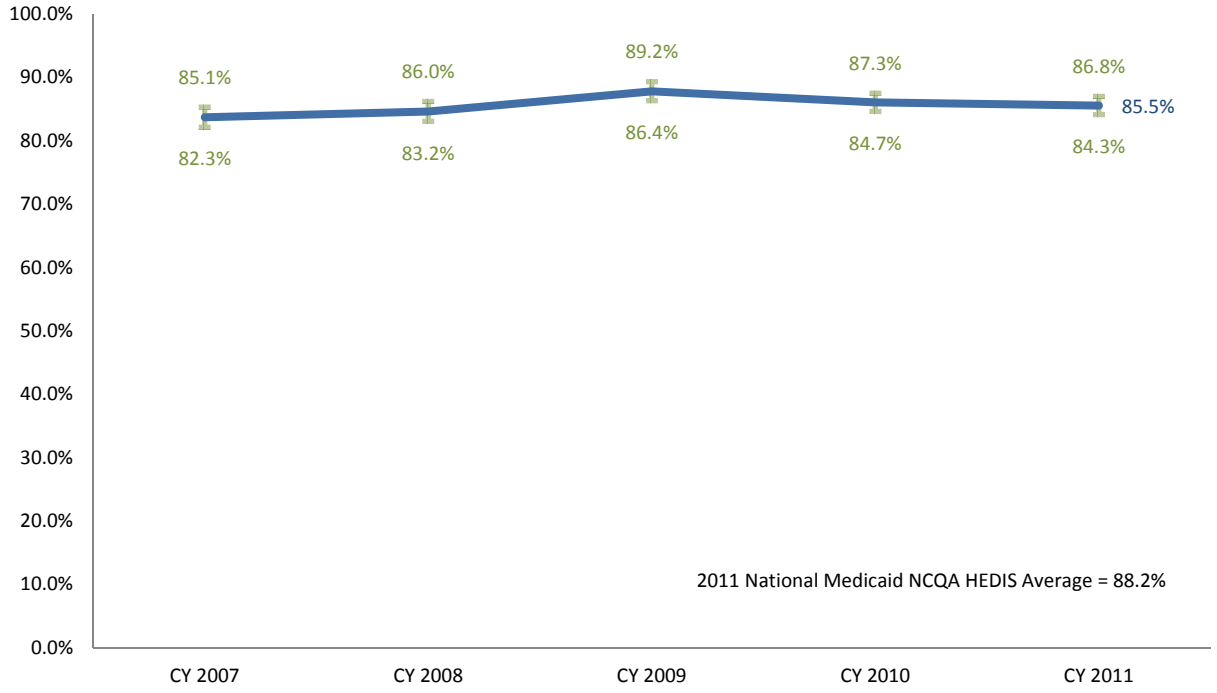


Figure 59. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Metropolitan Counties

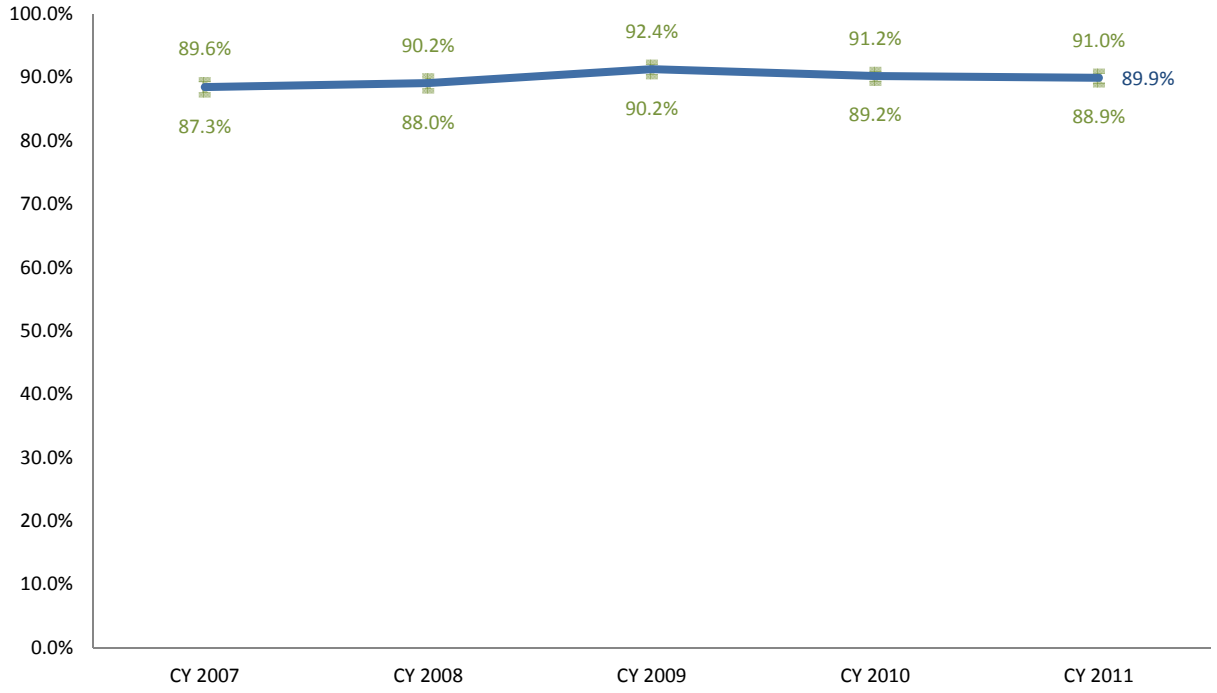


Figure 60. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Non-Metropolitan Counties

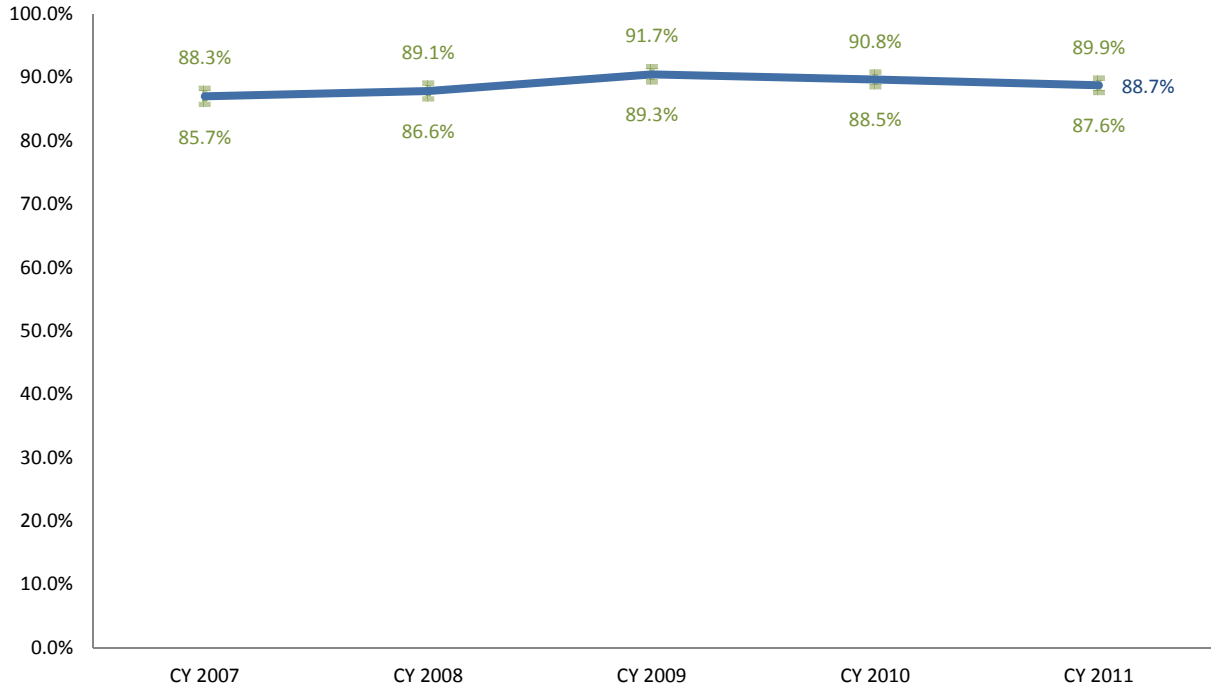


Figure 61. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 20 to 44 Years

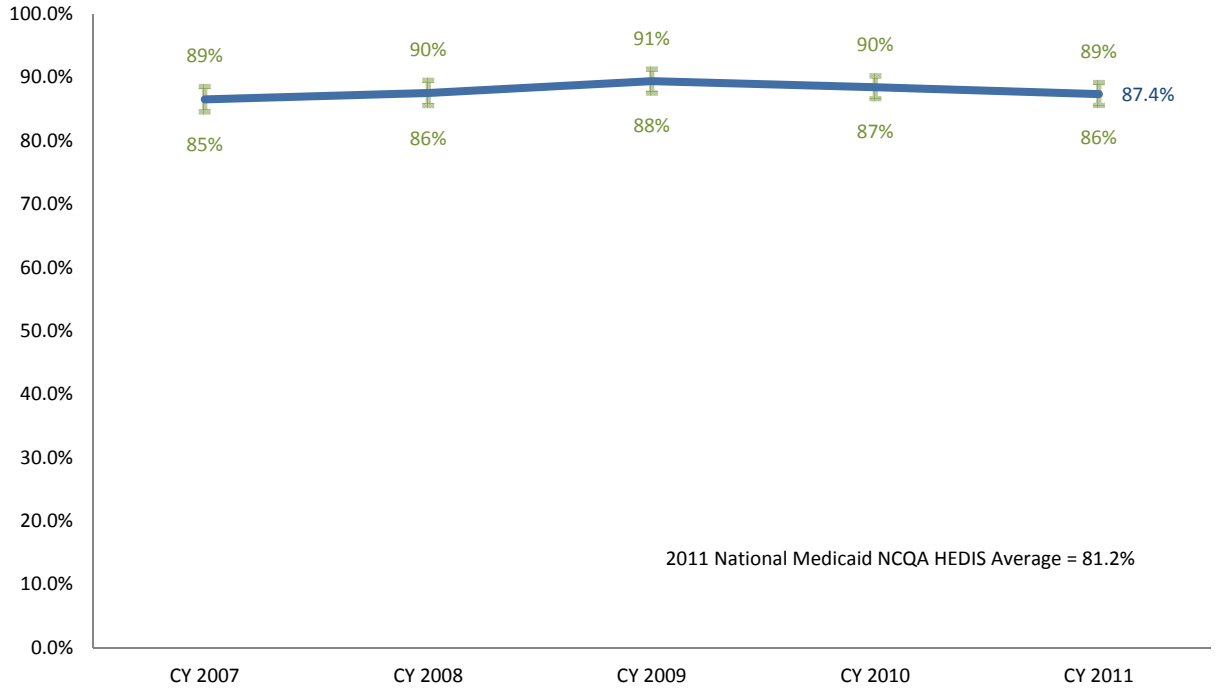


Figure 62. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 45 to 64 Years

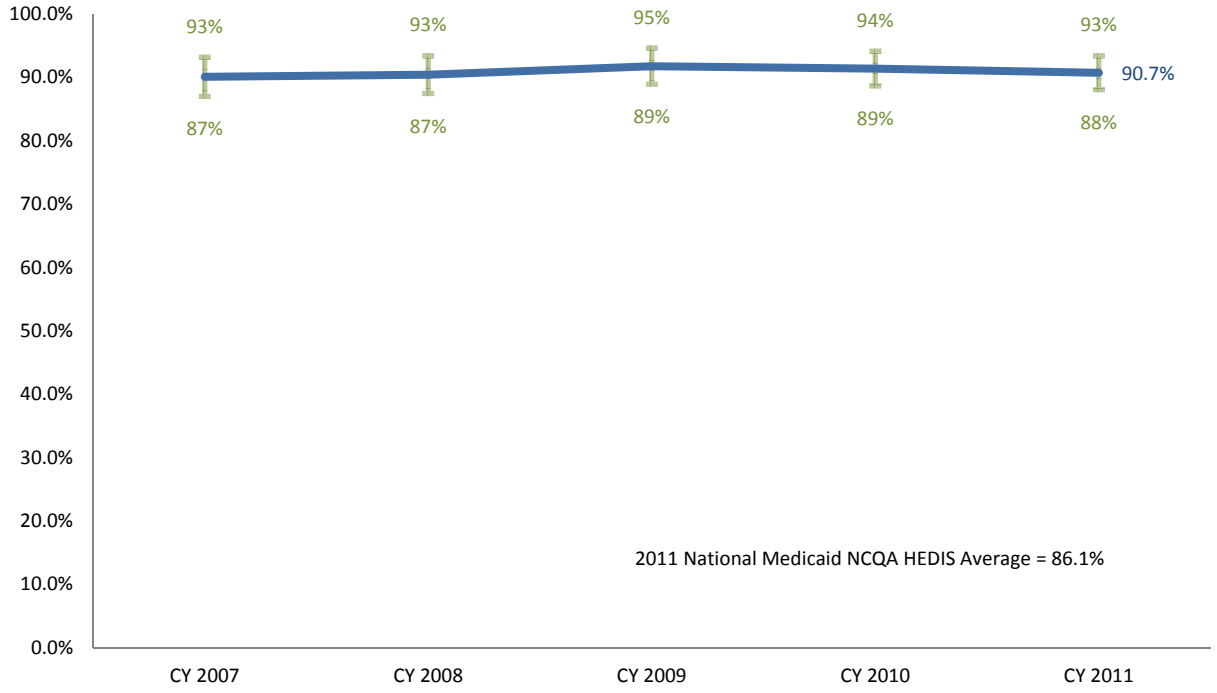


Figure 63. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Metropolitan Counties

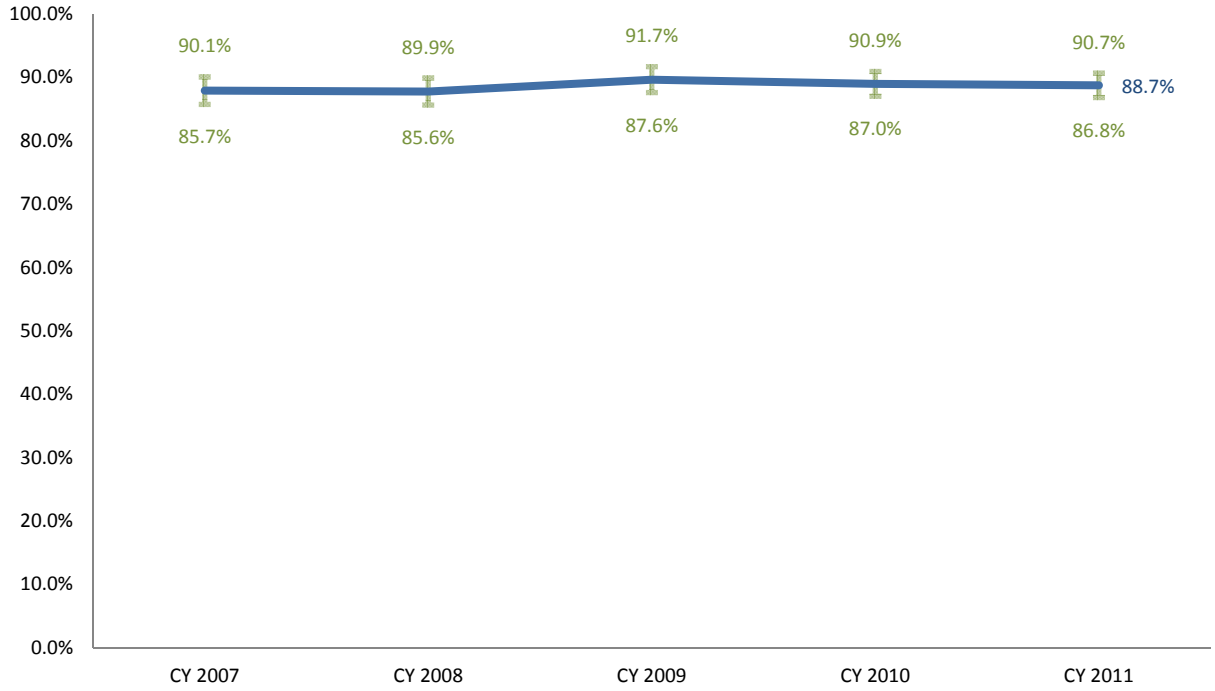


Figure 64. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Non-Metropolitan Counties

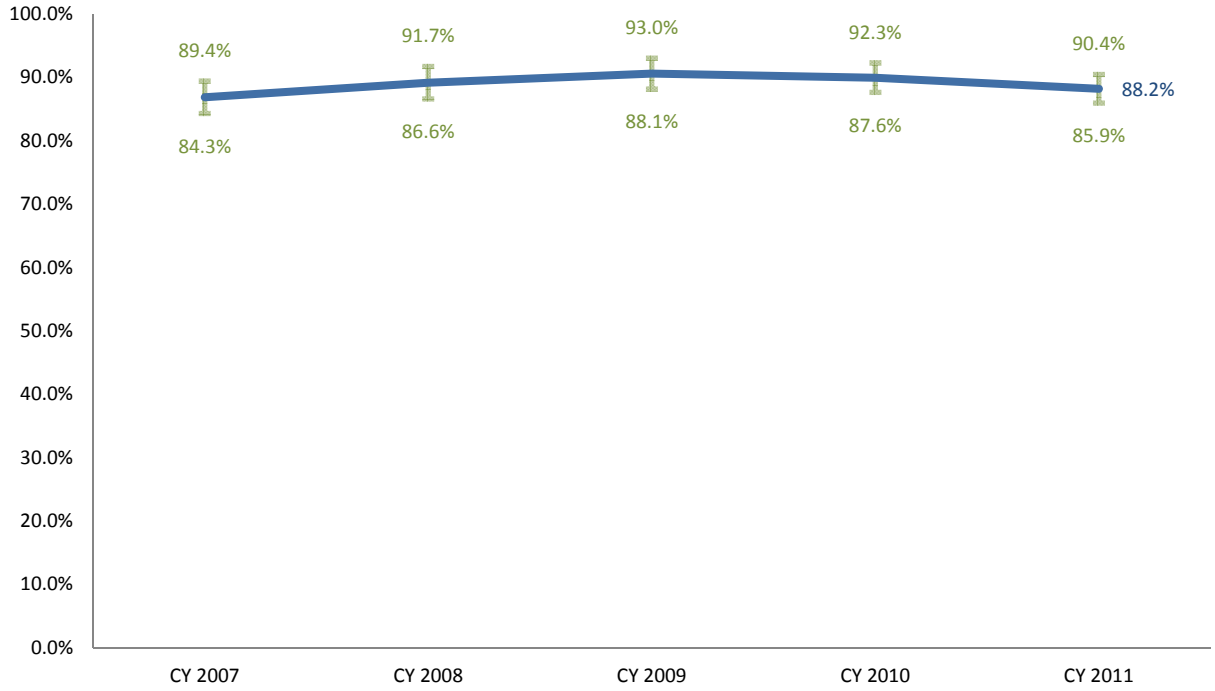


Figure 65. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Seven 7 Days, CY 2007-2011 by Age: 6 to 18 Years

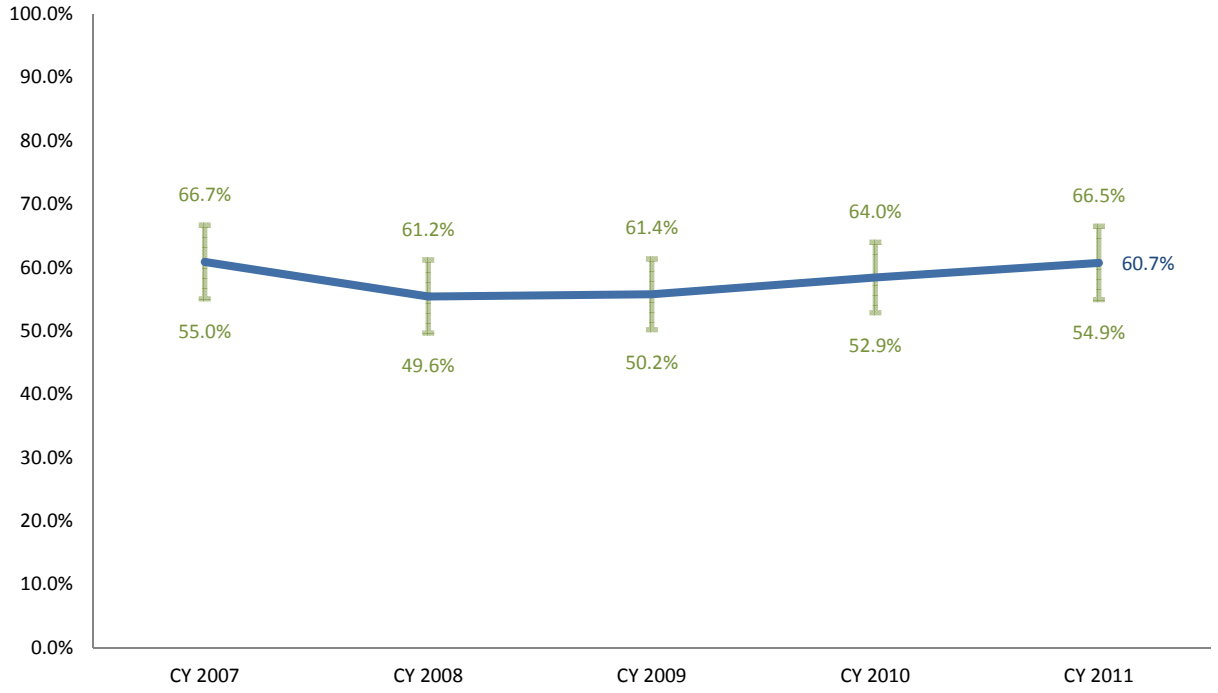


Figure 66. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Within 7 Days, CY 2007-2011 by Age: 19 and Older

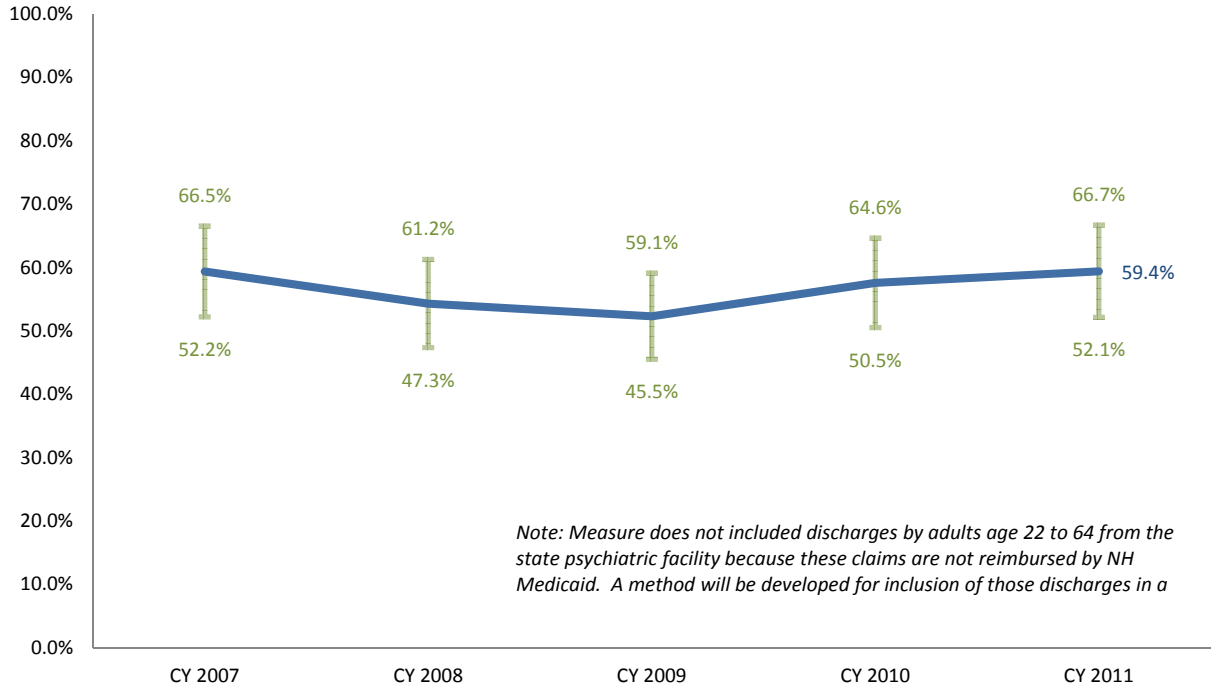


Figure 67. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Within 30 Days, CY 2007-2011 by Age: 6 to 18 Years

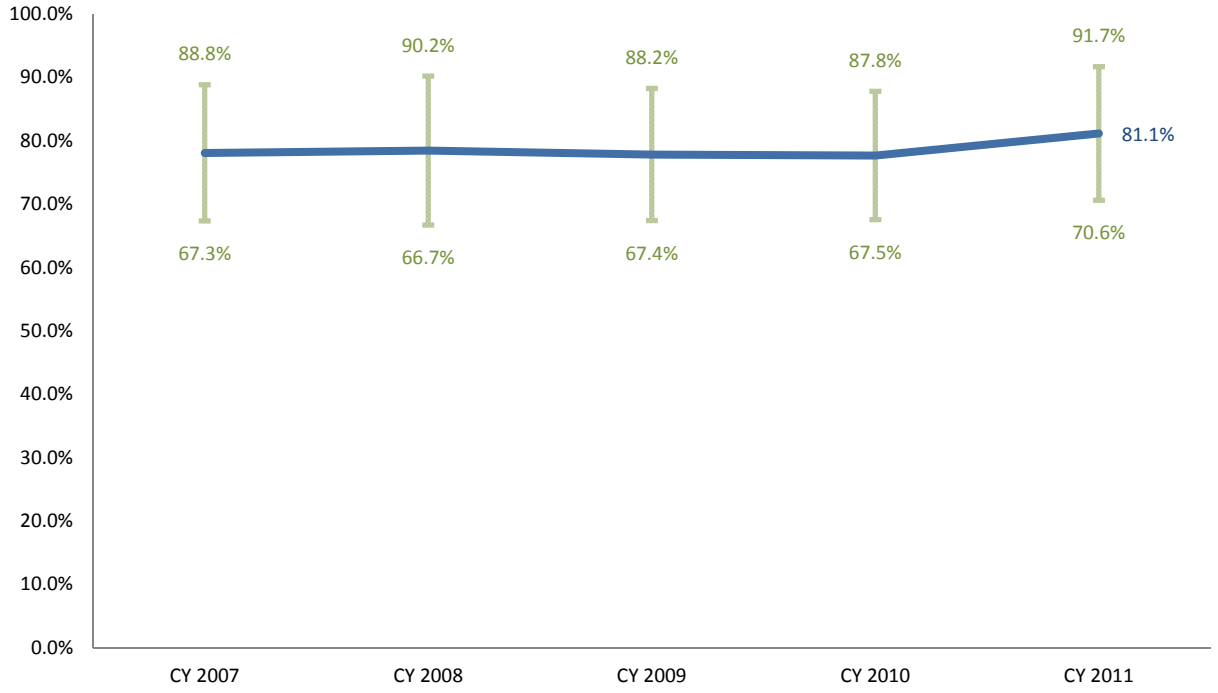
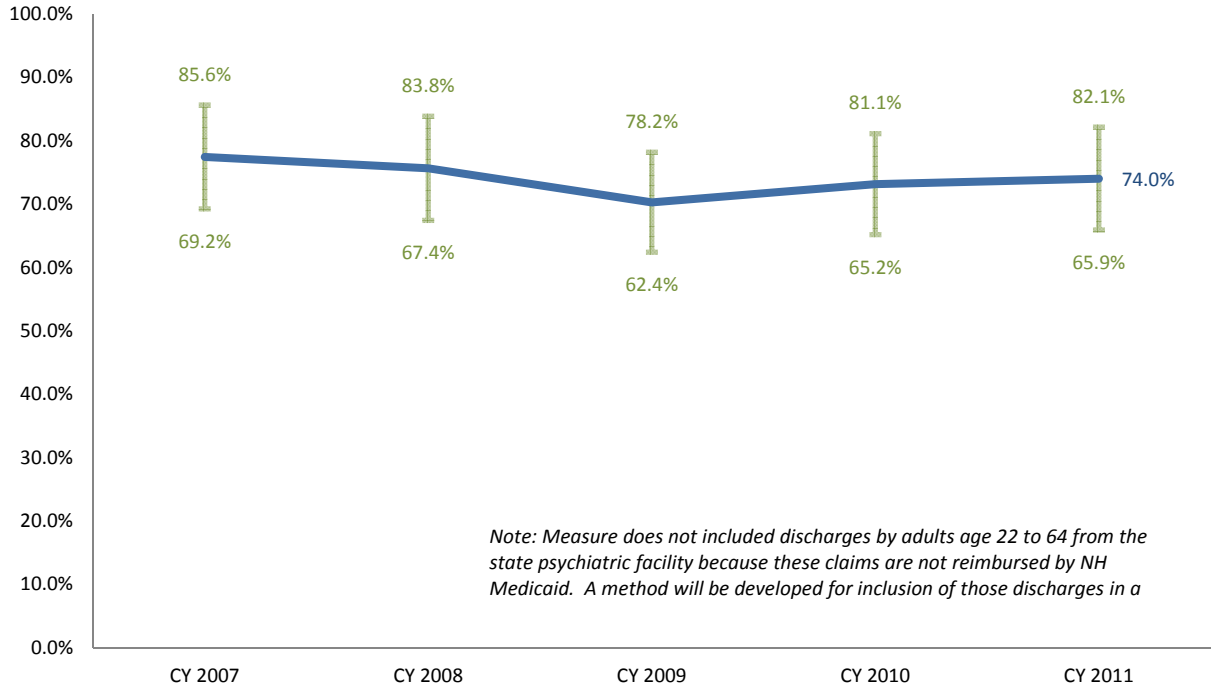


Figure 68. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Within 30 Days, CY 2007-2011 by Age: 19 and Older



Beneficiary Assistance and Satisfaction

Beneficiary Requests for Assistance Accessing Providers

As detailed further in the Beneficiary Engagement chapter of this report, New Hampshire Medicaid maintains a Client Services unit with a toll free number that responds to beneficiary requests for assistance in finding providers. Client Services systematically tracks information about these requests in a database. An increasing trend in requests for assistance finding a provider could be an indication that there is an emerging access problem triggering the need for further research. Client Services also often receives information from beneficiaries regarding the reason they need help finding a provider. While this information is anecdotal, it too may lead to further research.

The information from Client Services is available on a timelier basis than utilization data that requires a lag period to allow for claims to be submitted and processed. In this report, and in future reporting, Client Services data will be one quarter more current than information based on claims data. Because of this, Client Services information provides the best early warning indicator of a potential access problem.

The figure below shows the trend in beneficiary requests for assistance finding a provider. Major New Hampshire Medicaid payment changes are indicated and control limits at the third standard deviation of the historical data are included to provide a trigger indicating a potential access problem requiring further investigation. The overall trend is presented, followed by detail on the trends by metropolitan and non-metropolitan areas of the State.

For overall call data and data from members living in metropolitan counties at no point during the time period does the control chart indicate a potential access issue requiring further research. However, the data for non-metropolitan counties in the fourth quarter of CY 2011 did cross the control limit, which resulted in further research and action.

Research determined that the spike in calls asking for provider assistance was because of the Lakes Region General Hospital's decision to close some of their practices to adult Medicaid beneficiaries. In late October, 2011, Client Services had 32 calls from adult Medicaid beneficiaries in the Lakes Region needing new primary care physicians. After Client Services performed telephone outreach to the same population, we had an additional 79 calls to find or discuss providers in the Lakes Region. The above calls, totaling 111, were 35% of the calls from non-metropolitan areas requiring assistance with providers. Please refer to the Conclusion section of Chapter Three for current analysis of the aftermath of the Lakes Regional General Hospital closure.

Since that time, after the assistance was provided, these types of calls have returned to the normal volume within the control limits.

Figure 69. Beneficiary Requests for Assistance Accessing Providers per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

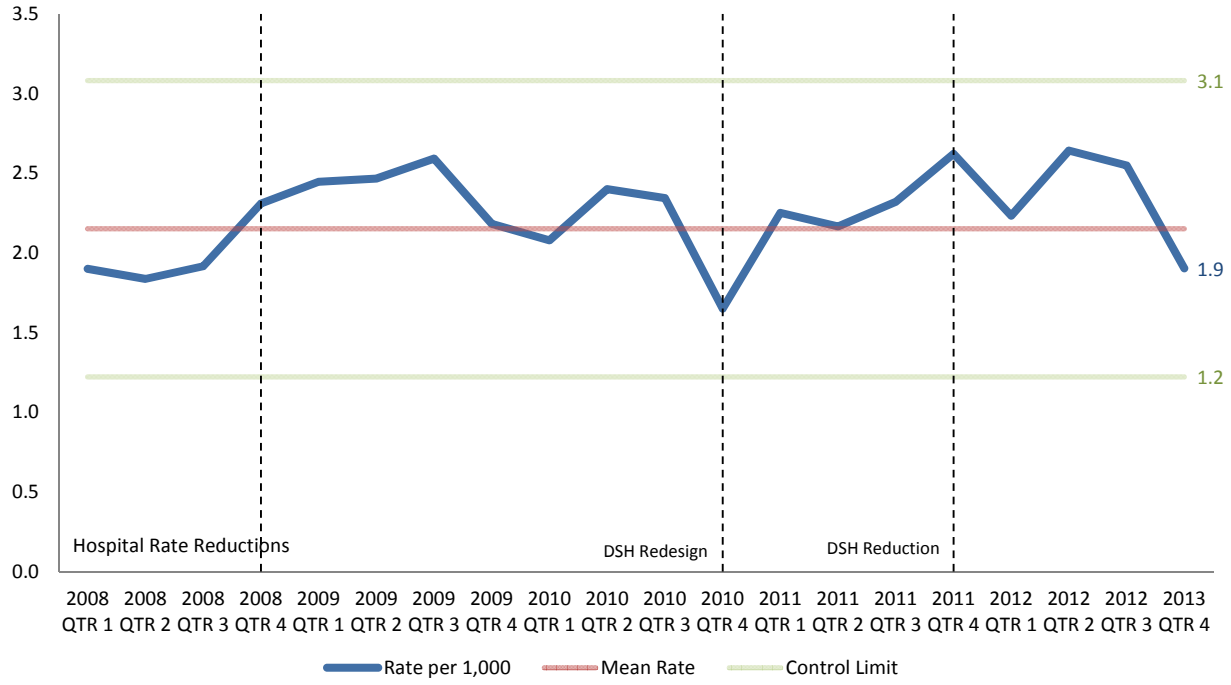


Figure 70. Beneficiary Requests for Assistance Accessing Providers per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Counties

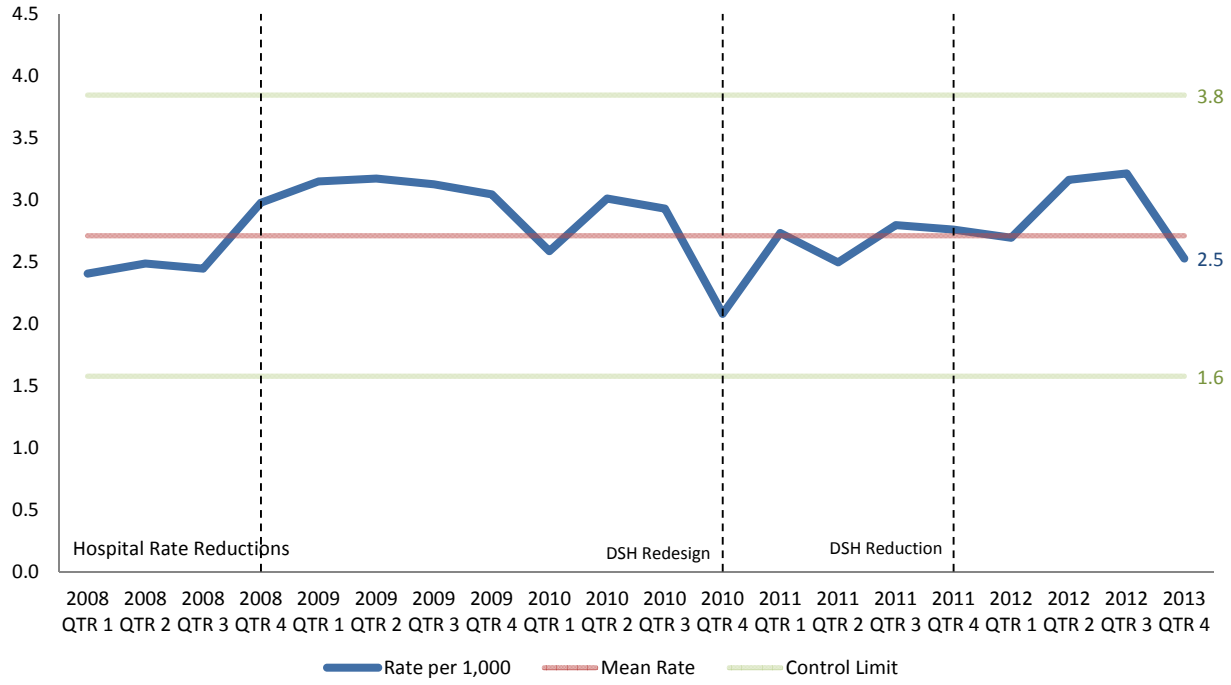
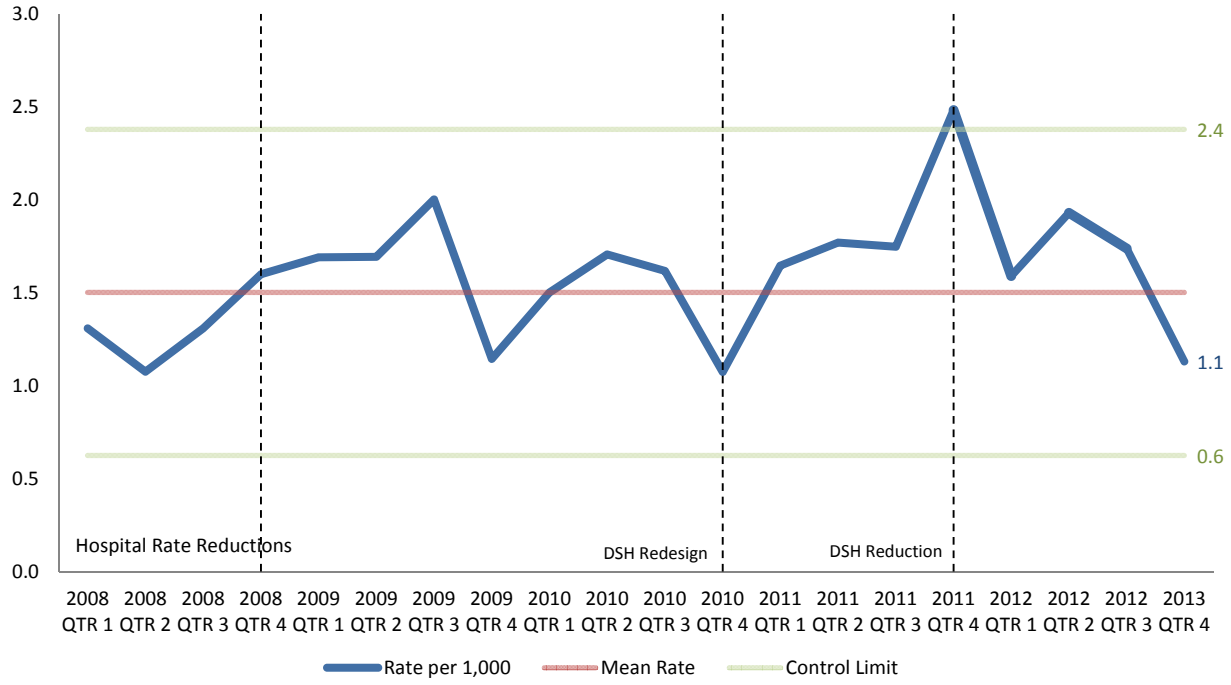


Figure 71. Beneficiary Requests for Assistance Accessing Providers per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Counties



Beneficiary Satisfaction Survey

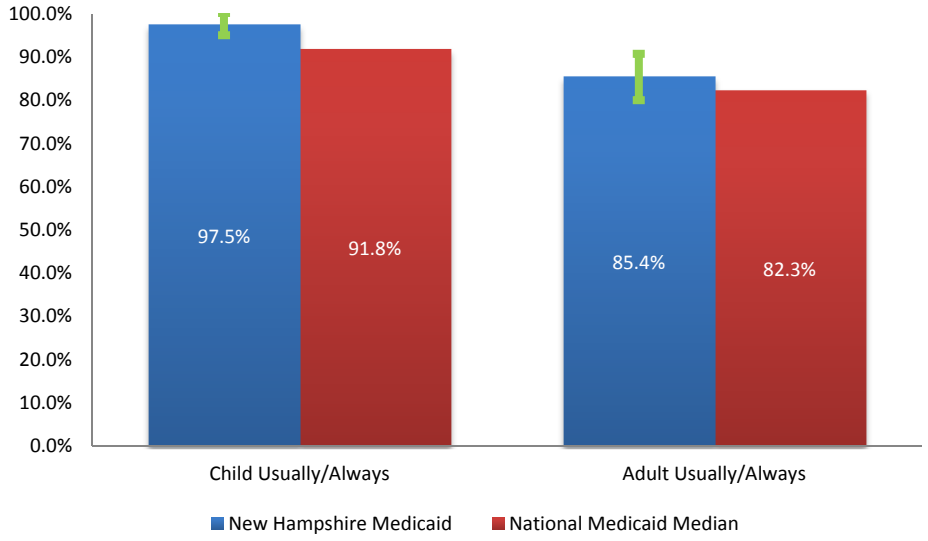
New Hampshire Medicaid recently contracted with a vendor to administer and report the results from the core Adult and Child versions of the Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Medicaid populations. The survey was administered in July and August 2012. Results for the following measures are presented below:

- ***Getting Needed Care***
- ***Getting Care Quickly***
- ***Rating of Personal Doctors***

Measures that show results less than the fiftieth percentile as defined by the most recent year available of NCQA Quality Compass for Medicaid Managed Care Organizations will prompt further investigation, beginning with deeper analysis of the data to see if demographic or regional differences are driving the lower than expected performance.

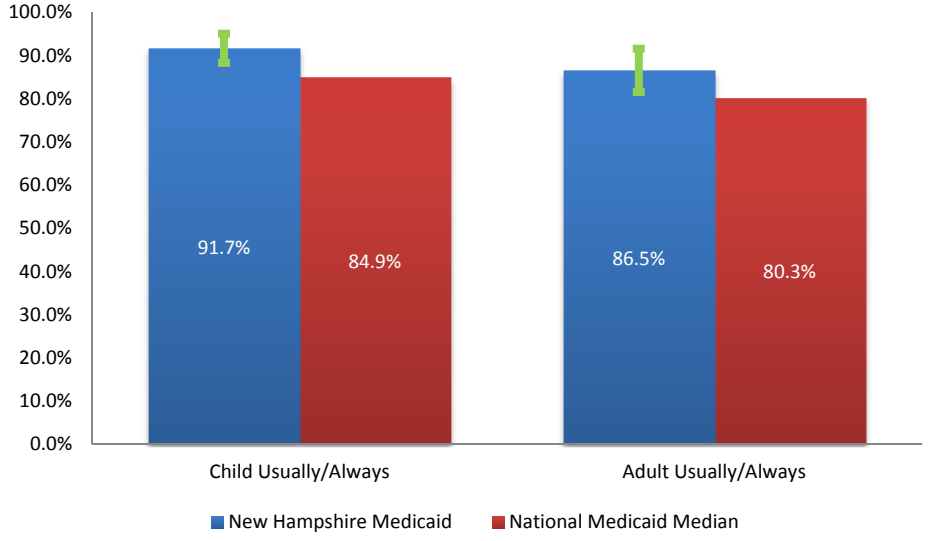
For the ***Getting Needed Care*** and ***Getting Care Quickly***, both adult and parent New Hampshire Medicaid survey respondents indicated an answer of "usually" or "always" at higher rates than the national Medicaid median. Respondents rated their child's personal doctor as an 8, 9 or 10 (out of a scale of 0 to 10), also at a rate higher than the national Medicaid median. However, adult respondents were slightly less likely to rate their personal doctor as an 8, 9, or 10 than the national median. While the confidence interval for the New Hampshire rate for this measure overlaps with the national median, we plan on researching the rate further by exploring the survey data to determine what factors might be driving the result.

Figure 72. Percent of CAHPS Survey Respondents Who Needed Care Right Away in the Last 6 months and Reported Getting it as Soon as Needed Usually or Always, CY 2012



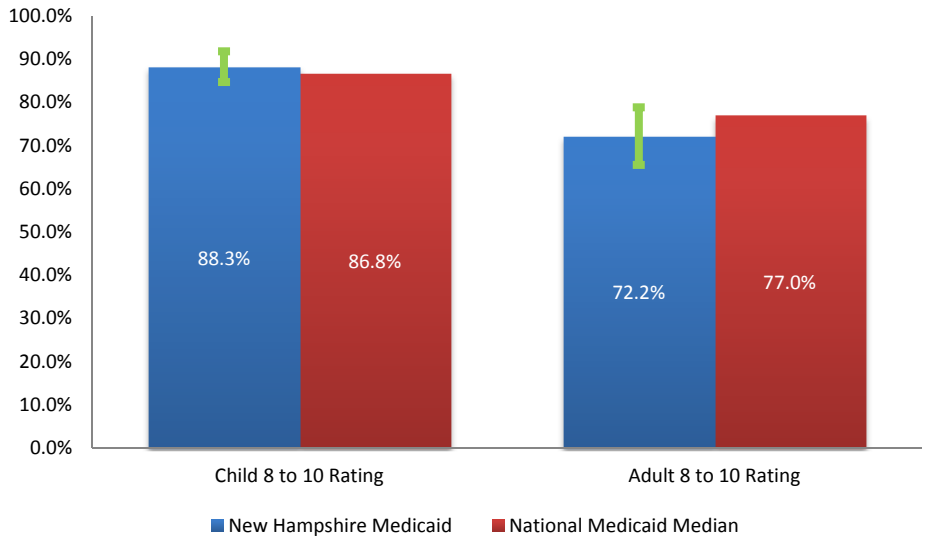
Note: vertical green bar for New Hampshire data represents 95% confidence interval

Figure 73. Percent of CAHPS Survey Respondents Who Got an Appointment That Wasn't Needed Right Away for Health Care In the Last 6 months and Reported Getting it as Soon as Needed Usually or Always, CY 2012



Note: vertical green bar for New Hampshire data represents 95% confidence interval

Figure 74. Percent of CAHPS Survey Respondents Rating Their Or Their Child's Personal Doctor as an 8, 9, or 10 on a Scale of 0 to 10, CY 2012



Note: vertical green bar for New Hampshire data represents 95% confidence interval

Conclusion

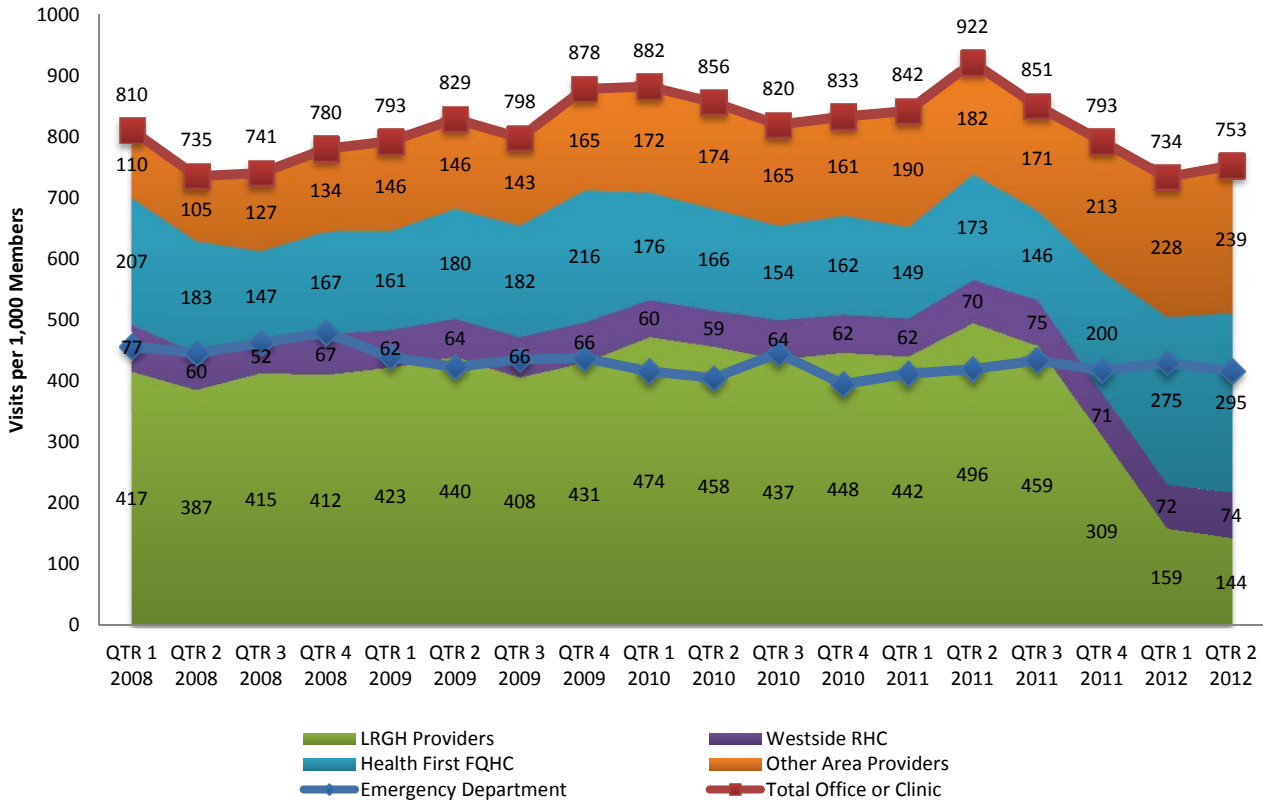
In this quarter, all but three measures are within normal limits, with no detectable negative trends except for the above noted trend in member to obstetrician/gynecologist provider ratios. This report includes measures of beneficiary enrollment trends, provider availability, utilization of hospital, primary care and behavioral health services, and beneficiary engagement trends over the most recent five-year period. With the following exceptions, all measures are within normal limits:

- In Figure 42, the current quarter data point of 63 emergency room visits per 1,000 beneficiaries drops below the lower control limit of 64 emergency room visits per 1,000 beneficiaries, by one visit. This is not due to an access problem. Rather, it is either due to the inclusion of the additional 11,000 CHIP children that use hospital services at a much lower rate that Medicaid children, or the desired effect of implementing the four visit Emergency Department limit in March 2012, implemented to discourage the use of emergency rooms for non-emergency care.
- In Figure 44, the current quarter data point drops below the lower control limit of 6 inpatient visits per 1,000 beneficiaries. Again, this is not due to an access issue, but rather the integration of the CHIP population which is one fifth as likely to be hospitalized as the Medicaid population into the Medicaid program.
- In Figure 18, the trend in the ratio of members to obstetricians/gynecologists in non-metropolitan areas did cross the upper control limit. While DHHS has not had any indication of an access problem from either increased beneficiary requests to the call center or through reports of provider disenrollment, and the metropolitan area ratio is comparable to the non-metropolitan ratio, DHHS does plans to research the reasons why the measure has exceeded the control limit and take action as the research indicates. DHHS will report on its findings in the next quarterly report.

One historical data point in Figure 71, Beneficiary Request for Assistance, in the fourth quarter of 2011 exceeds the control limit. This situation was related to LRGHealthcare (LRGH) redirecting its adult patients to other local practices. Corrective action was taken as described in the introduction to that measure. As a result, call volume returned to a normal level in the following quarter, indicating resolution of the LRGH event and no problems have occurred since. Analysis was recently conducted to research the impact of the Lakes Regional action on the beneficiaries. The analysis looks at the trend in use of office visit and emergency dept. use by non-dual adult members residing in towns served by the LRGH provider groups (Figure 75).

As expected, beneficiaries have continued to obtain primary/preventative care at other physician practices and at FQHC/RHCs in the LRGH catchment area. There was a temporary dip in overall use of office/clinic services, but that decline ended in the third quarter 2012. Also on a positive note, there has been no change in emergency department utilization at LRGH, or Concord Hospital which is the next likely option for beneficiaries in the Lakes Region, or overall.

Figure 75. LRGH Service Area Non-Medicare Dual Adults 19 to 64 Year Old ED and Office/Clinic Utilization Trend by Provider Group, CY 2008-2012



In some cases, this report shows trends are improving. The ratio of beneficiaries to active in-state primary care providers in Figure 10 indicates that an increasing number of providers are offering primary care services to Medicaid beneficiaries. Emergency room utilization for conditions potentially treatable

in a primary care setting in Figure 28 through Figure 33 is improving, most notably in Figure 30, blind and disabled adult categories, Figure 31, adults in the children and family aid categories, and Figure 33, the non-metropolitan areas. The trends in total emergency room use in Figure 34 through Figure 42 are also improving in some categories, most notably in Figure 37, foster children, and Figure 42, non-metropolitan areas. Nine of the eleven well child measures in Figure 45 through Figure 53 show upward improvements over the past five years, with the remaining two measures above national average.

Figure 19 through Figure 27, Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000, indicate a spike in utilization during the 2009 time period and a steady leveling off since that time. The spike relates to the H1N1 pandemic that occurred then, with the leveling off of utilization demonstrating a return to non-pandemic utilization levels. At all times, the data points did not exceed the control limits.

Recently available CAHPS data, first published in this report in Figure 72 and 73, indicates New Hampshire Medicaid beneficiaries receive needed care and get care quickly at or above national averages.

4. Beneficiary Engagement

New Hampshire Medicaid engages beneficiaries in a variety of ways to keep abreast of medical needs, population characteristics, and beneficiary satisfaction with provider availability and quality of services. The Medical Care Advisory Committee and the New Hampshire Medicaid Client Services Unit help New Hampshire Medicaid understand the needs of Medicaid beneficiaries, monitor beneficiary trends, and respond with corrective action as needed.

New Hampshire Medicaid Client Services Unit

For the past twenty years, New Hampshire Medicaid has operated a client services call center as a service to beneficiaries, and also as a means of engaging with beneficiaries to determine and assist with beneficiary needs. It has also been used as a real-time surveillance tool to monitor access problems as phone calls from beneficiaries alert staff to disruptions to access and provider availability. The New Hampshire Medicaid Client Services Unit engages with Medicaid beneficiaries on a daily basis. They manage beneficiaries' concerns, requests for information, provider access and availability difficulties, and as a result, are on the forefront of New Hampshire Medicaid's efforts to understand beneficiaries' needs, and monitor, identify, and respond to provider access difficulties. In addition to anecdotal evidence of access concerns, the Client Services Unit systematically provides New Hampshire Medicaid with a weekly beneficiary call report in order to monitor beneficiary concerns.

New Hampshire Medicaid's Client Services Unit engages Medicaid beneficiaries by phone and in writing regarding services available to them. All beneficiaries are informed from the outset that assistance is available from the Client Services Unit should they have any difficulty with provider access and availability or with scheduling appointments. Beneficiaries' membership cards are sent to them in a card carrier that contains the toll-free telephone number of the Client Services Unit, as well as information concerning the availability of assistance finding doctors and dentists. The mailing also informs beneficiaries of the availability of assistance with transportation options and costs and professional interpretation services so that these common difficulties do not become barriers to healthcare access. Additionally, the Medicaid Client Services Unit sends any family where the new enrollee is a child a welcome packet with an informational flyer. This flyer provides basic information concerning Medicaid services and providers. New Hampshire Medicaid contact information is provided on the back of this flyer.

The Client Services Unit calls all new enrollees to determine if the clients' current health care providers are enrolled in the Medicaid program. If any clients need help accessing new or additional providers, that need will be determined during this initial phone call. If help is needed, Client Services will provide the clients with a list (via e-mail, verbally, by regular mail, or fax) of currently enrolled Medicaid providers who are able to serve them.

The Medicaid Client Services Unit's weekly report is produced every Monday for the previous week. The key components of this report are the number of beneficiary call logs started and completed, the number of incoming beneficiary calls taken live or sent to voicemail, and the number of beneficiary from clients seeking assistance finding a provider.

There is a separate log for each call, detailing the issues presented, discussed, and resolved. Client Services strives to respond to all calls as they come in. For those beneficiary calls that go to voicemail, staff returns more than 98% of the calls the same day.

Beneficiary calls to the Client Services Unit asking for assistance to locate a provider are tracked by requested provider type. The number of calls is given, as well as the total number of Medicaid beneficiaries requesting providers. For example, one caller may ask for the name of a dentist for her 4 children. This request is logged in as one call and four beneficiaries.

From the period of 2007 – 2011, New Hampshire Medicaid has seen no significant spikes in beneficiary calls requesting assistance finding providers who accept Medicaid, with the exception of the time period when one of the State's hospital systems, Lakes Region General Hospital (LRGH), notified beneficiaries in November 2011 that it would be closing its physician practices to some Medicaid beneficiaries. Medicaid beneficiaries were the first to alert New Hampshire Medicaid of this closure notification and potential disruption in beneficiaries' access to care. Client Services Unit staff immediately informed the Medicaid Director, Medicaid Finance Director, and other Medicaid staff of the LRGH action. A corrective action plan was immediately developed and implemented. The Client Services Unit helped each beneficiary who needed help finding alternative providers. Engaging with beneficiaries through their phone calls and reviewing the beneficiary call center report helps New Hampshire Medicaid monitors access to care.

When a beneficiary calls New Hampshire Medicaid requesting assistance finding a provider, the Client Services Unit locates providers, through a search of its provider database by provider type, within a 25-mile radius of the beneficiary's home. Client Services provides the list of appropriate providers to the beneficiary over the phone, by postal mail, email, or fax, according to each beneficiary's preference. The provider list includes providers' names, street addresses, and phone numbers.

New Hampshire Medicaid, through its Client Services Unit, has found alternative providers for every beneficiary told by their providers that they no longer accept Medicaid. Client Services maintains a database of providers who accept new Medicaid patients, by regularly calling providers' offices for updated information. All difficulties presented by beneficiaries concerning healthcare access issues have been successfully addressed and resolved by the Medicaid Client Services Unit.

New Hampshire Medicaid also engages beneficiaries and potential beneficiaries by providing brochures and other informational materials to approximately 1,900 locations statewide, including schools, hospitals, town/city welfare offices, courthouses, legal assistance programs, and unemployment offices. Additional distribution points include childcare providers, soup kitchens/food pantries, homeless shelters, and health care providers (ob-gyn, pediatric, and primary care). Targeted outreach is currently being conducted for adolescents, culturally/racially diverse groups, and the recently unemployed. New Hamp-

shire Medicaid also helps families access health care coverage at the community level through its Application Assistors program. Application assistors are stationed at nineteen hospitals, eleven Federally Qualified Health Centers (FQHC) and community health centers, and other primary care provider and referral organization sites.

Medical Care Advisory Committee (MCAC)

New Hampshire Medicaid created the New Hampshire Medical Advisory Committee (MCAC), well over twenty years ago, to advise the Medicaid Director about New Hampshire Medicaid health policy, planning, and medical care services. The primary purpose of New Hampshire's MCAC is to serve as a source of consumer and stakeholder involvement in the Medicaid program. The MCAC has also had an advisory role in the design and implementation of Medicaid Managed Care in New Hampshire. New Hampshire's MCAC meets on a monthly basis and, among other things, reviews and recommends Medicaid policy and planning proposals; discusses various Medicaid provider and beneficiary issues; and ensures communication between MCAC members and the New Hampshire Medicaid leadership. It has been and will continue to be used to provide a forum for reviewing data and analysis that addresses issues related to Medicaid beneficiary access to care in New Hampshire and for planning Step Two of the transition to managed care.

The New Hampshire MCAC has 21 members, comprised of Medicaid beneficiaries [5], beneficiary/consumer advocacy groups members of the general public concerned about health service delivery to Medicaid Beneficiaries [4]; healthcare professionals who serve Medicaid beneficiaries [8], and other knowledgeable individuals with experience in healthcare, rural health, Medicaid law and policy, healthcare financing, quality assurance, patient's rights, health planning, pharmacy care [4], and those familiar with the healthcare needs of low-income population groups and the Medicaid population.

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

Stakeholder Meetings

As a part of the process of determining and/or implementing major policy change at the Department of Health and Human Services, 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. The purpose of stakeholder meetings are to: 1. Begin the process of sustained dialogue leading to shared understanding; 2. Set principles and strategies to guide transformation; and 3. Outline the approach for moving forward.

Stakeholder meetings have occurred multiple times on a variety of subjects over the past several years. Most relevant to this reporting are the following: In 2008, stakeholders were brought together to engage in a Healthcare transformation project designed to examine business processes to streamline and drive out non-value added activities that contribute to costs that could better be directed to the care of

clients. The stakeholder council meetings were organized into three subject matter groups of public health/medical services, human services, and long term care services. The MCAC has representation on each council. Ultimately, the discussions led to the "Front Door" project, which streamlines how clients enter and access services in New Hampshire.

In 2009 and into 2010, chief executive and finance officers from New Hampshire's 26 acute care hospitals and two rehabilitation hospitals were brought together in a series of meetings to explore alternative payment methods in the Disproportionate Share Program which ultimately resulted in a revised distribution methodology of available DSH dollars proportional to the amount of uncompensated care provided by hospitals.

The New Hampshire Department of Health and Human Services has just completed twelve information sessions throughout the State on the new Medicaid Care Management program. The meetings focused on those who rely on Medicaid services as well as family members and caregivers and for human service agency case managers or service coordinators who work with them. Information covered included the first step of the new Medicaid Care Management program scheduled to launch later this year. The first step encompasses those Medicaid services that address medical needs, such as doctor visits, inpatient and outpatient hospital visits, prescriptions, mental health services, home health services, speech therapy, and audiology services. The Department has recently begun planning for scheduling a second round of Medicaid Care Management community forums.

The New Hampshire Medical Advisory Committee receives a formal, comprehensive report on the Medicaid Care Management program on a monthly basis, effective Oct 2012.

In summary,

- New Hampshire Medicaid regularly engages with Medicaid beneficiaries directly and indirectly, via beneficiary advocates and Medicaid providers, through its participation in the Medical Care Advisory Committee. The MCAC meets on a monthly basis.
- In addition to MCAC meetings, DHHS holds stakeholder meetings from time to time when considering or implementing major policy changes.
- New Hampshire Medicaid regularly engages with Medicaid beneficiaries who call the hotline managed by the Medicaid Client Services Unit. The Unit entertains about 800 calls per week to and from beneficiaries posing a variety of questions ranging from benefit verifications to assistance finding transportation or a doctor.

5. Plan for Monitoring Access

The State of New Hampshire monitors access to care and produces an access report on a quarterly basis under its monitoring plan. New Hampshire Medicaid will continue to review and revise the monitoring plan itself to ensure the continued relevance of the selected indicators and to expand it over time to include other Medicaid benefits, including behavioral health, long-term care services, and managed care. The access monitoring plan is based upon a two-tier detection system. The first detection method is based on the systematic, ongoing monitoring that is used to address access issues that develop gradually over time. The second method is the real-time and individualized detection of discrete access issues that are generally handled by the Medicaid Client Services Unit.

Surveillance through systematic, ongoing monitoring is one method of detecting an access issue. The following situation in systematic reporting will trigger the deployment of an Access Response Team:

- A data point above the upper control limit or below the lower control limit, depending on the measure; or
- The current period data for a given measure deviates to a degree that the confidence interval does not overlap with the prior period's confidence interval.

Should a systemic access issue be detected through New Hampshire's quarterly access monitoring report, New Hampshire Medicaid would activate an Access Response Team to research the specific cause(s) of the problem and make recommendations for responsive action. The members of the Access Response Team would be drawn from several of the following functional areas: client services, financial management and reimbursement, benefits management, provider network management, and data analytics. The Team would be responsible for determining the cause of the access issue, proposing responsive actions, including assessing the need to make modifications to the access monitoring systems. The Medical Care Advisory Committee (MCAC) will serve as a resource to engage stakeholders in this process of resolving any identified access issue. The Team would then submit a proposed response for the review and approval by the State Medicaid Director and the Department's Medicaid Executive Team. 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, but responsive action plans will set a target date for resolution of the identified access issue; and, in all cases, the target date will be set sometime within one year of the date that the responsive action plan was approved by the Medicaid Executive Team. Possible responsive actions 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, transportation assistance, or enrollment in Medicaid Managed Care;

- 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; or
- Restructuring rates and targeting them to address the particular underserved areas.

Surveillance by the Medicaid Client Services Unit is a second method of detecting any discrete events which create an access to care issue. This Unit manages a call center, providing ombudsman services to clients who need assistance, maintaining an up-to-date network reference guide, and offering referrals to providers upon request by any recipient or recipient representative, and providing transportation assistance and transportation reimbursement. The Unit is dedicated to resolving Medicaid recipient concerns on a real time, case-by-case basis. The client call tracking logs maintained on each of these individual responses to recipient concerns are a rich source of information about multiple discrete access issues; examination of these logs can assist in identifying indications of a trend across discrete access issues, which may require prompt intervention. New Hampshire has long had in place a toll free 800 number that beneficiaries can call for assistance. The phone number appears on the Medicaid member card, in the member welcome packet, and in all beneficiary communications and outreach materials. Should a discrete access issue be detected, NH would investigate facts directly from those providers implicated, analyze client impact, confirm alternative provider availability, and augment resources to the Client Services Unit to include additional staff and extended hours of operations if needed. Specific messaging to Medicaid beneficiaries potentially impacted would be issued as deemed necessary via media outlets, community network partners, and social media including Facebook and Twitter. A written synopsis of access issues identified in each quarter, if any, and New Hampshire Medicaid program's responses to them, is included in the following quarter's access monitoring report.

Quarterly access monitoring reports are available under "Medicaid Access Monitoring" at www.dhhs.nh.gov/ombp/publications.htm.

Access Monitoring under Medicaid Managed Care

In 2011, the New Hampshire Legislature directed the Commissioner of the Department of Health and Human Services (DHHS) to develop a comprehensive, statewide managed care program for all Medicaid beneficiaries. Upon CMS approval and successful readiness reviews, DHHS will begin enrolling Medicaid beneficiaries into one of three Managed Care Organizations (MCOs) and support beneficiaries through the transition into a managed care program. Managed Care contractors are currently developing their networks in response to the State's desire for adequate access within the managed care program, and are required to demonstrate compliance prior to being approved to proceed with enrollment. The MCOs will provide a comprehensive risk-based, capitated program for providing healthcare services to beneficiaries enrolled in the New Hampshire Medicaid Program and provide for all aspects of managing such program.

With this new Care Management program, DHHS has the opportunity to develop a comprehensive New Hampshire Medicaid Quality Strategy, building on New Hampshire legislative goals of value, quality assurance, and efficiency, and focused on the health of Medicaid beneficiaries. DHHS' Quality Strategy,

currently in the review and approval process, will serve to assure stakeholders that New Hampshire's managed care organizations (MCOs) are in contract compliance, have committed adequate resources to perform internal monitoring and ongoing quality improvement, and actively contribute to healthcare improvement for the State's most vulnerable citizens. New Hampshire is creating a comprehensive outreach and education plan to assure diverse methods of engaging clients. All New Hampshire Medicaid beneficiaries will be encouraged to enroll in managed care and will be given the opportunity to choose the managed care plan that best suits their needs. The Quality Strategy articulates the MCO reporting that will provide data driven analysis to New Hampshire Medicaid and CMS of MCO provider-network adequacy. In addition, New Hampshire's External Quality Review Organization (EQRO), for which the procurement process is underway, through validation of MCO data and reporting, will serve as an additional level of provider network adequacy and access oversight.

Upon Medicaid Care Management implementation, access issues will be addressed by the MCOs in the first instance. New Hampshire Medicaid will monitor compliance with each MCO's contractual responsibilities, including, responsibilities for assuring access and quality, and will continue to assure access to care for New Hampshire Medicaid beneficiaries.

To help ensure appropriate access to healthcare services for Medicaid beneficiaries in its managed care program and pursuant to DHHS' Care Management Contract with the MCOs, the MCOs are required, inter alia, to:

- implement procedures that ensure that Medicaid beneficiaries have access to an ongoing source of primary care appropriate to their individual needs;
- provide non-emergent medical transportation to ensure Medicaid beneficiaries receive medically necessary services and ensure that a beneficiary's lack of transportation is not a barrier to accessing care;
- maintain a Member Services Department to assist Medicaid beneficiaries and their family members obtain services under the Care Management Program;
- operate a New Hampshire specific call center to handle member inquiries;
- develop and facilitate a Medicaid member advisory board composed of members who represent an MCO's member population;
- hold bi-annual, in-person regional member meetings to obtain feedback and take questions from members;
- conduct a member satisfaction survey (CAHPS) to gain a broader perspective of member opinions;
- ensure that services are provided in a culturally competent manner to all Medicaid members, including those with limited English proficiency;
- develop appropriate methods of communicating and working with its members who do not speak English as a first language, as well as members who are visually and hearing impaired, and accommodating members with physical and cognitive disabilities and different literacy levels, learning styles, and capabilities;

- develop, implement, and maintain a Grievance System under which Medicaid members, or providers acting on their behalf, may challenge the denial of coverage or payment for medical assistance and which includes a grievance process, an appeal process, and access to the State's fair hearing system; and
- publish a Provider Directory that shall be approved by DHHS.

In addition to the member-focused provisions in the managed care contracts, DHHS will require each MCO to ensure provider availability for its Medicaid beneficiaries and to:

- have provider networks with a sufficient number of providers with sufficient capacity, expertise and geographic distribution, to provide for all Medicaid-covered services, and with reasonable choice for beneficiaries to meet their needs;
- submit to annual, external, independent review of the timeliness of and access to services covered under each MCO contract with DHHS;
- develop and maintain a statewide provider network that adequately meets the physical and behavioral health needs of enrolled Medicaid beneficiaries;
- report significant changes to the provider network to DHHS, with a transition plan to address member access to needed services, within seven days of any significant change;
- develop an active provider advisory board composed of a broad spectrum of provider types;
- develop a provider satisfaction survey, which is required to be approved by DHHS and administered by a third party semi-annually;
- provide the results of the provider satisfaction survey to DHHS and post on the MCOs' website;
- meet contractual geographic access standards for all Medicaid beneficiaries in additions to maintaining a provider network sufficient to provide all services to all of its Medicaid members;
- make services available for beneficiaries twenty-four hours a day, seven days a week, when medically necessary; and
- develop and maintain a statewide provider network that adequately meets all covered physical and behavioral health needs of the covered population that provides for coordination and collaboration among providers and disciplines. See full text of Access and Network Management managed care contract provisions attached as Appendix B.

New Hampshire Medicaid will manage and monitor MCO performance and compliance with all contract provisions, including those addressing access, provider availability, and delivery of quality care. With a primary goal of quality care, New Hampshire Medicaid requires the MCOs to:

- provide for the delivery of quality care to improve the health status of beneficiaries, or if a beneficiary's health condition is such that it cannot be improved then to maintain the beneficiary's health;
- comply with the Quality Strategy for the New Hampshire Medicaid Care Management Program;
- have an ongoing quality assessment and performance improvement program for the services it provides beneficiaries;

- approach all clinical and non-clinical aspects of quality assessment and performance improvement based on Continuous Quality Improvement (CQI)/Total Quality Management (TQM);
- have mechanisms in place that detect both under- and over-utilization of services;
- develop and operate a Quality Assessment and Performance Improvement (QAPI) Program and to submit a QAPI Program Annual Summary as specified by DHHS;
- maintain a QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes;
- adopt evidence-based clinical practice guidelines built upon high quality data and strong evidence considering the needs of Medicaid beneficiaries;
- collaborate with DHHS's External Quality Review Organization (EQRO) to develop studies, surveys, and other analytic activities to assess the quality of care and services provided to beneficiaries, and shall supply data to the EQRO.

6. Summary and Conclusion

Ensuring access to care is a priority of the New Hampshire Medicaid program. The foregoing report provides specific data and analysis that establish historical and current access levels for physician services, inpatient and outpatient services, rate structures, and the impact of DSH payments, all of which establish the following:

- The data showing historical and current access levels for physician services, inpatient and outpatient services, set forth in Chapter 3, are within normal limits, with no detectable negative trends except for member to provider ratios for obstetrician/gynecologists in non-metropolitan areas, which while DHHS has no other indications of an access issue, it will be researching the issue and reporting its findings and any needed actions taken in the next quarterly report.
- The data showing the historical access to care based on participating provider network size and capacity, service utilization trends, and rate levels, set forth in Chapter 3, are within normal limits, with no detectable negative trends.
- The trend analysis on data elements demonstrate that rate changes which occurred in 2008 and Disproportionate Share Program changes (described in Chapter 2) have not changed access levels.
- CAHPS survey results are above the national Medicaid average for getting needed care and getting care quickly indicators.
- New Hampshire Medicaid presented evidence, set forth in Chapter 5 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.
- Provider access monitoring plans and procedures, set forth in Chapter 5, 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.
- 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 5, to resolve access issues for New Hampshire Medicaid beneficiaries.

In conclusion, New Hampshire Medicaid data indicates that Medicaid beneficiaries have similar access to healthcare as the general population in New Hampshire. Nothing has been detected in those control charts that would indicate a negative healthcare access trend. To the extent potential provider-access issues have been identified at any point during the time period examined, i.e. 2007-2011, New Hampshire Medicaid has intervened and resolved them.

New Hampshire Medicaid routinely monitors access indicators, i.e. beneficiary enrollment and demographics, provider enrollment and availability, and beneficiary utilization of health care services and will produce a quarterly data report similar to the report set forth above to measure and monitor beneficiary access to healthcare in New Hampshire. With the ability to identify access issues as they arise comes the concomitant ability of New Hampshire Medicaid to respond effectively to correct those issues. Although the data indicate no existing or projected access problems, should an access issue be identified through these monitoring systems, DHHS is ready to take corrective action measures on both a localized and system-wide basis through the processes set forth in this report.

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

By increasing New Hampshire Medicaid's monitoring of the strength of provider network activity; surveying network capacity; conducting client surveys to assess their experiences with providers and their needs relative to access; increasing outreach to providers and beneficiaries; and transforming the New Hampshire Medicaid program from a fee-for-service plan to a managed care approach, New Hampshire will continue to ensure access for its Medicaid beneficiaries.

7. Appendices

Appendix A: New Hampshire Medicaid Community Health Center Access and Capacity

Data was collected in May 2012 with the assistance of Bi-State Primary Care Association.

Facility		Current Medicaid Patient Count	Capacity for additional patients	Wait time for routine appointments	Wait time for urgent appointments	Notes
Lamprey Newmarket	Metro	847	250	10 days	Same day or within 24 hours: Sick or acute patients	Could add provider capacity and take 1,300 in existing space
Lamprey Raymond	Metro	932	300	15 days	Same day or within 24 hours: Sick or acute patients	Additional staff - Could accommodate another 800
Manchester Community Health Center	Metro	3,553	500	New : Prenatal - 1-2 days Pediatrics 1-2 weeks Adults 6-8 weeks Established: Routine 1 week Physical Exams 4-6weeks	Walk ins: Not available Urgent care:1-2 days based on the urgency; if the situation warrants it, urgent needs are triaged to local ER	1,500 Pediatric patients currently enrolled in NHHK will transition from Dartmouth to MCHC. Will probably have room for another 500 Medicaid patients given current provider capacity
Harbor Care Clinic Harbor Homes - Nashua	Metro	88	Open availability for additional clients	Same day	Immediate	
Families First in Portsmouth	Metro	1,500	100 patients/300 in Oct. w/new physician	Same day: Children and adults 2 mornings a week: Pregnant women seen for routine visits	2 mornings a week: Walk- in's Same day slots: Every day for anyone who calls in the morning	
White Mountain CHC in Conway	NonMetro	1,334	134	2 weeks	Same day	
Goodwin Community Health in Somersworth	Metro	3,099	2,500	3-5 days	Same day	Slots kept open daily for acutes and will be starting walk-in times
Lamprey Health Care Nashua	Metro	2,628	2,000 and could add provider capacity to take 3,000 more if necessary	Within 48 hours: new mother/child 10 days: Adults, non-urgent enroll visit or regular check-up	Within 24 hours: acute visit Same day: When possible	
Family Health Center (Concord Hospital)	NonMetro	3,708	10 per week	Same day to within 90 days - complete physical for all patients Within 2 weeks: OB intake appt	Same day	
Family Health Center (Hillsborough)	NonMetro	686	1 per week	Same day to within 90 days - complete physical for all patients Within 2 weeks: OB intake appt	Same day	
Mid-state Health Center - Plymouth	NonMetro	900	Significant or good capacity to see more patients	Same day or a few days. Some clinicians could be a month	Same day or next day	

Facility		Current Medicaid Patient Count	Capacity for additional patients	Wait time for routine appointments	Wait time for urgent appointments	Notes
Coos County Family Health Services	NonMetro	1,742	1,000	Child.&preg.women: Same day Adults: 0-7 days	Urgent: Same day; 4 hrs a week July: Every afternoon opened for same day and for walk- ins (with a Family Nurse Practitioner that has just been hired) Right now, 4 hours/wk of open slots for walk-ins/same days.	
Ammonoosuc Comm. Health Srvs - Littleton	NonMetro	924 < age 19; 393 > age 20	Depending on the site, the access is variable, however when sent there, will work towards accommodating.	Same day visit per need basis:ACHS & non-ACHS patients. Medical records need to be received & reviewed prior to establishing the patient as a health home patient. Each provider however based on a panel size may have variable capacity to accept more patients.	Same day/maybe at alternative site	
Health First in Franklin	NonMetro	1,391	600	3 wks: Routine follow up & non acute appt 4 wks: Full entry visits new patients 5 wks: Full physicals	Same day or next day. During peak days, Mon. & Fri. may be two days. New NP on staff for acute patients.	499 out of 1,391 new clients that came after LRGH stopped seeing Medicaid adults in regular outpatient practices and had 302 new uninsured clients

Appendix B: Tabular Version of Data in Trend Charts

Figure 4. NH Medicaid Enrollment, CY 2007-2012: Total Population

Time Period	Average Members
2007 QTR 1	82,880
2007 QTR 2	83,462
2007 QTR 3	83,444
2007 QTR 4	83,391
2008 QTR 1	84,380
2008 QTR 2	85,632
2008 QTR 3	86,783
2008 QTR 4	88,024
2009 QTR 1	90,866
2009 QTR 2	94,059
2009 QTR 3	96,178
2009 QTR 4	97,444
2010 QTR 1	98,287
2010 QTR 2	99,162
2010 QTR 3	99,813
2010 QTR 4	99,974
2011 QTR 1	100,362
2011 QTR 2	100,922
2011 QTR 3	100,952
2011 QTR 4	100,675
2012 QTR 1	100,426
2012 QTR 2	100,808
2012 QTR 3	110,351

Note: On 7/1/13 NH Medicaid transitioned its separate CHIP program into a Medicaid expansion program

Figure 5. NH Medicaid Enrollment, CY 2007-2012: Child, Families and Children Eligibility Group

and

Figure 6. NH Medicaid Enrollment, CY 2007-2012: Child Foster Care and Blind and Disabled Population

Time Period	Blind and Disabled	Families and Children	Foster Care
2007 QTR 1	522	60,041	1,935
2007 QTR 2	526	60,522	1,981
2007 QTR 3	515	60,448	1,944
2007 QTR 4	525	60,383	1,940
2008 QTR 1	536	60,962	1,953
2008 QTR 2	564	61,879	1,966
2008 QTR 3	580	62,672	1,908
2008 QTR 4	599	63,478	1,890
2009 QTR 1	604	65,423	1,867
2009 QTR 2	618	67,856	1,878
2009 QTR 3	619	69,560	1,805
2009 QTR 4	628	70,597	1,814
2010 QTR 1	605	71,192	1,793
2010 QTR 2	596	71,756	1,781
2010 QTR 3	597	72,260	1,717
2010 QTR 4	613	72,450	1,739
2011 QTR 1	598	72,788	1,720
2011 QTR 2	611	73,199	1,745
2011 QTR 3	597	73,450	1,663
2011 QTR 4	606	73,447	1,668
2012 QTR 1	612	73,433	1,679
2012 QTR 2	641	73,857	1,723
2012 QTR 3	634	83,271	1,730

Note: On 7/1/13 NH Medicaid transitioned its separate CHIP program into a Medicaid expansion program

Figure 7. NH Medicaid Enrollment, CY 2007-2012: Adult Population by Eligibility Group

Time Period	Aged	Blind and Disabled	Families and Children
2007 QTR 1	672	7,080	12,630
2007 QTR 2	668	7,238	12,528
2007 QTR 3	681	7,351	12,506
2007 QTR 4	690	7,486	12,367
2008 QTR 1	713	7,682	12,535
2008 QTR 2	711	7,894	12,618
2008 QTR 3	723	8,102	12,798
2008 QTR 4	746	8,354	12,956
2009 QTR 1	760	8,653	13,559
2009 QTR 2	767	8,898	14,043
2009 QTR 3	776	9,116	14,301
2009 QTR 4	779	9,157	14,469
2010 QTR 1	792	9,287	14,619
2010 QTR 2	802	9,400	14,827
2010 QTR 3	815	9,488	14,934
2010 QTR 4	826	9,576	14,768
2011 QTR 1	848	9,702	14,705
2011 QTR 2	849	9,872	14,646
2011 QTR 3	884	9,945	14,411
2011 QTR 4	902	9,953	14,098
2012 QTR 1	910	9,918	13,873
2012 QTR 2	927	9,935	13,721
2012 QTR 3	946	9,993	13,773

Figure 8. NH Medicaid Enrollment, CY 2007-2012: Metropolitan and Non-Metropolitan Counties

Time Period	Metro Counties	Non-Metro Counties
2007 QTR 1	45,220	35,115
2007 QTR 2	45,484	35,459
2007 QTR 3	45,606	35,297
2007 QTR 4	45,716	35,214
2008 QTR 1	46,166	35,661
2008 QTR 2	46,796	36,284
2008 QTR 3	47,454	36,687
2008 QTR 4	48,272	37,090
2009 QTR 1	49,874	38,250
2009 QTR 2	51,925	39,364
2009 QTR 3	53,131	40,115
2009 QTR 4	53,878	40,489
2010 QTR 1	54,421	40,864
2010 QTR 2	54,926	41,228
2010 QTR 3	55,541	41,423
2010 QTR 4	55,813	41,606
2011 QTR 1	56,115	41,917
2011 QTR 2	56,510	42,366
2011 QTR 3	56,626	42,541
2011 QTR 4	56,778	42,687
2012 QTR 1	56,684	42,768
2012 QTR 2	56,733	42,838
2012 QTR 3	62,035	47,178

Note: On 7/1/13 NH Medicaid transitioned its separate CHIP program into a Medicaid expansion program

Figure 9. Active NH Medicaid In-State Physician Providers Compared to Licensed Providers With NH Billing Address, 2012

Geographic Area	Active Medicaid Providers	Active Non-Medicaid Providers
Total In-State	3,505	408
Metropolitan	1,933	155
Non-Metropolitan	1,572	253

Figure 10. Ratio of NH Medicaid/CHIP Beneficiaries to Active In-State Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatricians), CY 2007-2012

Time Period	Providers	Average Members	Rate per 1,000
2007 QTR 4	1920	88,397	46
2008 QTR 1	1901	89,208	47
2008 QTR 2	1966	90,587	46
2008 QTR 3	1989	91,966	46
2008 QTR 4	2071	93,492	45
2009 QTR 1	2082	96,075	46
2009 QTR 2	2145	98,820	46
2009 QTR 3	2247	100,950	45
2009 QTR 4	2308	102,277	44
2010 QTR 1	2348	103,301	44
2010 QTR 2	2367	104,295	44
2010 QTR 3	2441	105,273	43
2010 QTR 4	2442	105,906	43
2011 QTR 1	2467	106,518	43
2011 QTR 2	2472	107,362	43
2011 QTR 3	2525	107,813	43
2011 QTR 4	2496	108,308	43
2012 QTR 1	2552	108,101	42
2012 QTR 2	2536	108,013	43
2012 QTR 3	2569	108,097	42

Figure 11. Ratio of NH Medicaid/CHIP Beneficiaries to Active In-State Primary Care Providers, CY 2007-2012: Metropolitan Areas

Time Period	Providers	Average Members	Rate per 1,000
2007 QTR 4	1,152	49,524	43
2008 QTR 1	1,155	49,965	43
2008 QTR 2	1,193	50,709	43
2008 QTR 3	1,212	51,555	43
2008 QTR 4	1,229	52,594	43
2009 QTR 1	1,248	54,074	43
2009 QTR 2	1,246	55,894	45
2009 QTR 3	1,289	57,200	44
2009 QTR 4	1,322	58,054	44
2010 QTR 1	1,352	58,647	43
2010 QTR 2	1,355	59,285	44
2010 QTR 3	1,416	60,038	42
2010 QTR 4	1,407	60,437	43
2011 QTR 1	1,427	60,755	43
2011 QTR 2	1,424	61,178	43
2011 QTR 3	1,459	61,337	42
2011 QTR 4	1,443	61,558	43
2012 QTR 1	1,486	61,373	41
2012 QTR 2	1,459	61,348	42
2012 QTR 3	1,490	61,463	41

Figure 12. Ratio of NH Medicaid/CHIP Beneficiaries to Active In-State Primary Care Providers, CY 2007-2012: Non-Metropolitan Areas

Time Period	Providers	Average Members	Rate per 1,000
2007 QTR 4	768	38,873	51
2008 QTR 1	746	39,243	53
2008 QTR 2	773	39,878	52
2008 QTR 3	777	40,411	52
2008 QTR 4	842	40,897	49
2009 QTR 1	834	42,001	50
2009 QTR 2	899	42,926	48
2009 QTR 3	958	43,750	46
2009 QTR 4	986	44,224	45
2010 QTR 1	996	44,654	45

Time Period	Providers	Average Members	Rate per 1,000
2010 QTR 2	1,012	45,010	44
2010 QTR 3	1,025	45,235	44
2010 QTR 4	1,035	45,469	44
2011 QTR 1	1,040	45,763	44
2011 QTR 2	1,048	46,184	44
2011 QTR 3	1,066	46,477	44
2011 QTR 4	1,053	46,750	44
2012 QTR 1	1,066	46,728	44
2012 QTR 2	1,077	46,666	43
2012 QTR 3	1,079	46,634	43

Figure 13. Ratio of NH Medicaid/CHIP Child Beneficiaries to Active In-State Pediatricians, CY 2007-2011

Time Period	Providers	0 to 18 members	Rate per 1,000
2007 QTR 4	214	68,527	320
2008 QTR 1	210	68,975	328
2008 QTR 2	206	70,059	340
2008 QTR 3	217	71,044	327
2008 QTR 4	222	72,152	325
2009 QTR 1	223	73,850	331
2009 QTR 2	224	75,873	339
2009 QTR 3	237	77,560	327
2009 QTR 4	236	78,742	334
2010 QTR 1	238	79,481	334
2010 QTR 2	237	80,133	338
2010 QTR 3	246	80,844	329
2010 QTR 4	244	81,456	334
2011 QTR 1	243	81,927	337
2011 QTR 2	244	82,573	338
2011 QTR 3	245	83,063	339
2011 QTR 4	243	83,684	344
2012 QTR 1	247	83,646	339
2012 QTR 2	242	83,758	346
2012 QTR 3	242	84,313	348

Figure 14. Ratio of NH Medicaid/CHIP Child Beneficiaries to Active In-State Pediatricians, CY 2007-2012: Metropolitan Areas

Time Period	Providers	Average Members	Rate per 1,000
2007 QTR 4	134	37,990	284
2008 QTR 1	132	38,225	290
2008 QTR 2	129	38,819	301
2008 QTR 3	137	39,431	288
2008 QTR 4	137	40,195	293
2009 QTR 1	137	41,181	301
2009 QTR 2	138	42,534	308
2009 QTR 3	141	43,576	309
2009 QTR 4	140	44,352	317
2010 QTR 1	143	44,792	313
2010 QTR 2	140	45,189	323
2010 QTR 3	147	45,758	311
2010 QTR 4	146	46,149	316
2011 QTR 1	146	46,404	318
2011 QTR 2	147	46,788	318
2011 QTR 3	150	47,014	313
2011 QTR 4	149	47,354	318
2012 QTR 1	149	47,253	317
2012 QTR 2	147	47,362	322
2012 QTR 3	148	47,704	322

Figure 15. Ratio of NH Medicaid/CHIP Child Beneficiaries to Active In-State Pediatricians, CY 2007-2012: Non-Metropolitan Areas

Time Period	Providers	Average Members	Rate per 1,000
2007 QTR 4	80	30,536	382
2008 QTR 1	78	30,750	394
2008 QTR 2	77	31,240	406
2008 QTR 3	80	31,614	395
2008 QTR 4	85	31,957	376
2009 QTR 1	86	32,669	380
2009 QTR 2	86	33,339	388
2009 QTR 3	96	33,984	354
2009 QTR 4	96	34,389	358
2010 QTR 1	95	34,689	365
2010 QTR 2	97	34,943	360
2010 QTR 3	99	35,085	354
2010 QTR 4	98	35,307	360
2011 QTR 1	97	35,522	366
2011 QTR 2	97	35,785	369
2011 QTR 3	95	36,049	379
2011 QTR 4	94	36,330	386
2012 QTR 1	98	36,393	371
2012 QTR 2	95	36,395	383
2012 QTR 3	94	36,609	389

Figure 16. Ratio of NH Medicaid Adult Female Beneficiaries Age 18 to 64 to Active In-State Obstetricians/Gynecologists, CY 2007-2012

Time Period	Providers	F 19 - 64 Members	Rate per 1,000
2007 QTR 2	160	14,612	91.3
2007 QTR 3	156	14,667	94.0
2007 QTR 4	155	14,637	94.4
2008 QTR 1	152	14,805	97.4
2008 QTR 2	157	15,085	96.1
2008 QTR 3	157	15,269	97.3
2008 QTR 4	150	15,467	103.1
2009 QTR 1	153	15,947	104.2
2009 QTR 2	154	16,391	106.4
2009 QTR 3	156	16,667	106.8
2009 QTR 4	156	16,686	107.0
2010 QTR 1	151	16,743	110.9
2010 QTR 2	151	16,944	112.2
2010 QTR 3	156	17,071	109.4
2010 QTR 4	157	17,070	108.7
2011 QTR 1	157	17,046	108.6
2011 QTR 2	158	17,140	108.5
2011 QTR 3	156	17,108	109.7
2011 QTR 4	160	17,047	106.5
2012 QTR 1	151	17,052	112.9
2012 QTR 2	154	16,962	110.1
2012 QTR 3	151	17,098	113.2

Figure 17. Ratio of NH Medicaid Adult Female Beneficiaries Age 19 to 64 to Active In-State Obstetricians/Gynecologists, CY 2007-2012: Metropolitan Areas

Time Period	Providers	Average Members	Rate per 1,000
2007 QTR 2	97	8,459	87.2
2007 QTR 3	94	8,525	90.7
2007 QTR 4	95	8,540	89.9
2008 QTR 1	93	8,617	92.7
2008 QTR 2	95	8,772	92.3
2008 QTR 3	91	8,882	97.6
2008 QTR 4	89	9,026	101.4
2009 QTR 1	90	9,297	103.3

Time Period	Providers	Average Members	Rate per 1,000
2009 QTR 2	88	9,592	109.0
2009 QTR 3	89	9,749	109.5
2009 QTR 4	90	9,778	108.6
2010 QTR 1	86	9,819	114.2
2010 QTR 2	84	9,955	118.5
2010 QTR 3	87	10,028	115.3
2010 QTR 4	86	10,046	116.8
2011 QTR 1	86	10,024	116.6
2011 QTR 2	88	10,024	113.9
2011 QTR 3	85	9,967	117.3
2011 QTR 4	86	9,889	115.0
2012 QTR 1	83	9,895	119.2
2012 QTR 2	86	9,800	113.9
2012 QTR 3	88	9,889	112.4

Figure 18. Ratio of NH Medicaid Adult Female Beneficiaries Age 19 to 64 to Active In-State Obstetricians/Gynecologists, CY 2007-2012: Non-Metropolitan Areas

Time Period	Providers	Average Members	Rate per 1,000
2007 QTR 2	63	6,154	97.7
2007 QTR 3	62	6,142	99.1
2007 QTR 4	60	6,097	101.6
2008 QTR 1	59	6,188	104.9
2008 QTR 2	62	6,313	101.8
2008 QTR 3	66	6,387	96.8
2008 QTR 4	61	6,441	105.6
2009 QTR 1	63	6,650	105.6
2009 QTR 2	66	6,800	103.0
2009 QTR 3	67	6,918	103.3
2009 QTR 4	66	6,909	104.7
2010 QTR 1	65	6,924	106.5
2010 QTR 2	67	6,989	104.3
2010 QTR 3	69	7,043	102.1
2010 QTR 4	71	7,024	98.9
2011 QTR 1	71	7,022	98.9
2011 QTR 2	70	7,115	101.6
2011 QTR 3	71	7,140	100.6
2011 QTR 4	74	7,158	96.7
2012 QTR 1	68	7,157	105.3
2012 QTR 2	68	7,162	105.3
2012 QTR 3	63	7,209	114.4

Figure 19. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	95006	248641	382	361
2007 QTR 2	86942	250387	347	350
2007 QTR 3	82644	250333	330	351
2007 QTR 4	90983	250172	364	360
2008 QTR 1	98124	253141	388	366
2008 QTR 2	91854	256897	358	361
2008 QTR 3	90591	260349	348	370
2008 QTR 4	96665	264072	366	362
2009 QTR 1	109231	272598	401	378
2009 QTR 2	110575	282178	392	395
2009 QTR 3	105470	288533	366	389
2009 QTR 4	117563	292332	402	398
2010 QTR 1	119994	294860	407	384
2010 QTR 2	113349	297486	381	385
2010 QTR 3	107316	299440	358	381
2010 QTR 4	112532	299922	375	371
2011 QTR 1	118182	301086	393	371
2011 QTR 2	112857	302767	373	376

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2011 QTR 3	104176	302856	344	366
2011 QTR 4	112266	302025	372	368
2012 QTR 1	119015	301277	395	372
2012 QTR 2	112069	302423	371	370
2012 QTR 3	111922	331054	338	359

Figure 20. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2011: Children, Blind and Disabled Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	793	1565	507	472
2007 QTR 2	766	1579	485	430
2007 QTR 3	611	1545	395	457
2007 QTR 4	709	1574	450	459
2008 QTR 1	762	1607	474	431
2008 QTR 2	775	1691	458	426
2008 QTR 3	681	1739	392	351
2008 QTR 4	621	1797	346	402
2009 QTR 1	752	1813	415	433
2009 QTR 2	853	1853	460	440
2009 QTR 3	750	1856	404	495
2009 QTR 4	920	1885	488	469
2010 QTR 1	878	1814	484	407
2010 QTR 2	775	1788	433	430
2010 QTR 3	707	1791	395	433
2010 QTR 4	784	1838	427	401
2011 QTR 1	743	1795	414	415
2011 QTR 2	809	1832	442	408
2011 QTR 3	671	1791	375	470
2011 QTR 4	843	1819	463	411
2012 QTR 1	778	1835	424	430
2012 QTR 2	857	1923	446	426
2012 QTR 3	800	1902	421	460

Figure 21. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Children and Families Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	60965	180123	338	309
2007 QTR 2	53953	181565	297	301
2007 QTR 3	48844	181344	269	300
2007 QTR 4	57054	181148	315	309
2008 QTR 1	62666	182886	343	313
2008 QTR 2	56420	185637	304	308
2008 QTR 3	53514	188016	285	317
2008 QTR 4	59431	190435	312	306
2009 QTR 1	69033	196269	352	321
2009 QTR 2	67568	203568	332	336
2009 QTR 3	60991	208680	292	326
2009 QTR 4	72941	211791	344	338
2010 QTR 1	74682	213575	350	319
2010 QTR 2	68549	215267	318	322
2010 QTR 3	62693	216779	289	323
2010 QTR 4	69305	217350	319	313
2011 QTR 1	74702	218364	342	312
2011 QTR 2	70082	219597	319	323
2011 QTR 3	62464	220350	283	316
2011 QTR 4	71122	220342	323	317
2012 QTR 1	75763	220300	344	314
2012 QTR 2	69292	221572	313	313
2012 QTR 3	70985	249813	284	314

Figure 22. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Foster Care Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 2	1853	5942	312	310
2007 QTR 3	1575	5831	270	290
2007 QTR 4	1825	5821	314	311
2008 QTR 1	1947	5859	332	315
2008 QTR 2	1964	5899	333	331
2008 QTR 3	1724	5723	301	323
2008 QTR 4	1725	5670	304	302
2009 QTR 1	1955	5600	349	331
2009 QTR 2	1934	5633	343	342
2009 QTR 3	1738	5414	321	344
2009 QTR 4	1925	5441	354	351
2010 QTR 1	1841	5378	342	325
2010 QTR 2	1735	5344	325	323
2010 QTR 3	1689	5152	328	352
2010 QTR 4	1810	5216	347	344
2011 QTR 1	1813	5160	351	334
2011 QTR 2	1891	5235	361	359
2011 QTR 3	1568	4990	314	337
2011 QTR 4	1664	5004	333	330
2012 QTR 1	1721	5036	342	324
2012 QTR 2	1644	5168	318	308
2012 QTR 3	1643	5189	317	333

Figure 23. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Aged Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	956	2015	474	498
2007 QTR 2	970	2003	484	495
2007 QTR 3	1074	2042	526	514
2007 QTR 4	1084	2070	524	513
2008 QTR 1	1056	2138	494	505
2008 QTR 2	1152	2134	540	552
2008 QTR 3	1167	2170	538	526
2008 QTR 4	1223	2239	546	535
2009 QTR 1	1287	2280	564	577
2009 QTR 2	1315	2300	572	584
2009 QTR 3	1388	2329	596	582
2009 QTR 4	1426	2336	610	598
2010 QTR 1	1386	2376	583	597
2010 QTR 2	1429	2405	594	607
2010 QTR 3	1537	2446	628	614
2010 QTR 4	1492	2479	602	590
2011 QTR 1	1378	2544	542	554
2011 QTR 2	1424	2546	559	571
2011 QTR 3	1383	2652	521	510
2011 QTR 4	1625	2705	601	589
2012 QTR 1	1568	2731	574	587
2012 QTR 2	1577	2780	567	564
2012 QTR 3	1602	2838	564	557

Figure 24. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Blind and Disabled Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	11172	21241	526	533
2007 QTR 2	11037	21713	508	528
2007 QTR 3	12127	22052	550	536
2007 QTR 4	12171	22458	542	541
2008 QTR 1	12502	23046	542	538

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2008 QTR 2	12587	23682	532	552
2008 QTR 3	13842	24307	569	555
2008 QTR 4	13768	25063	549	548
2009 QTR 1	14572	25958	561	557
2009 QTR 2	15464	26695	579	602
2009 QTR 3	17183	27348	628	612
2009 QTR 4	17137	27471	624	622
2010 QTR 1	17493	27860	628	623
2010 QTR 2	16967	28199	602	625
2010 QTR 3	17593	28463	618	603
2010 QTR 4	17140	28727	597	595
2011 QTR 1	17252	29105	593	588
2011 QTR 2	17031	29615	575	597
2011 QTR 3	17232	29835	578	563
2011 QTR 4	17128	29858	574	572
2012 QTR 1	18126	29754	609	604
2012 QTR 2	17989	29804	604	612
2012 QTR 3	17247	29978	575	560

Figure 25. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Families and Children

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	19192	37891	507	501
2007 QTR 2	18362	37585	489	485
2007 QTR 3	18413	37518	491	492
2007 QTR 4	18140	37101	489	497
2008 QTR 1	19191	37605	510	505
2008 QTR 2	18956	37854	501	497
2008 QTR 3	19663	38393	512	513
2008 QTR 4	19896	38868	512	521
2009 QTR 1	21632	40678	532	526
2009 QTR 2	23441	42129	556	552
2009 QTR 3	23420	42904	546	547
2009 QTR 4	23214	43408	535	544
2010 QTR 1	23714	43857	541	535
2010 QTR 2	23894	44482	537	533
2010 QTR 3	23097	44803	516	516
2010 QTR 4	22001	44305	497	505
2011 QTR 1	22294	44115	505	500
2011 QTR 2	21620	43939	492	489
2011 QTR 3	20857	43234	482	483
2011 QTR 4	19884	42294	470	478
2012 QTR 1	21058	41618	506	501
2012 QTR 2	20705	41164	503	499
2012 QTR 3	19638	41319	475	478

Figure 26. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Areas

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	55229	135660	407	385
2007 QTR 2	50733	136451	372	375
2007 QTR 3	48469	136818	354	377
2007 QTR 4	53232	137148	388	385
2008 QTR 1	57652	138497	416	393
2008 QTR 2	54524	140389	388	392
2008 QTR 3	52955	142363	372	396
2008 QTR 4	56662	144815	391	389
2009 QTR 1	64205	149621	429	405
2009 QTR 2	64932	155774	417	421
2009 QTR 3	62730	159393	394	419
2009 QTR 4	70363	161634	435	432
2010 QTR 1	70953	163264	435	410

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2010 QTR 2	67423	164779	409	413
2010 QTR 3	63938	166623	384	408
2010 QTR 4	66462	167439	397	394
2011 QTR 1	69820	168346	415	391
2011 QTR 2	67126	169531	396	399
2011 QTR 3	62117	169878	366	389
2011 QTR 4	67274	170333	395	392
2012 QTR 1	70839	170051	417	393
2012 QTR 2	66425	170198	390	389
2012 QTR 3	66444	186106	357	379

Figure 27. Seasonally Adjusted Physician/APRN/Clinic Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Areas

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	39537	105344	375	353
2007 QTR 2	35953	106376	338	343
2007 QTR 3	33930	105891	320	342
2007 QTR 4	37521	105642	355	352
2008 QTR 1	40227	106982	376	353
2008 QTR 2	37075	108853	341	346
2008 QTR 3	37317	110061	339	362
2008 QTR 4	39773	111271	357	354
2009 QTR 1	44812	114750	391	366
2009 QTR 2	45414	118093	385	390
2009 QTR 3	42562	120344	354	378
2009 QTR 4	46958	121467	387	383
2010 QTR 1	48819	122591	398	373
2010 QTR 2	45668	123685	369	375
2010 QTR 3	43136	124270	347	371
2010 QTR 4	45836	124819	367	364
2011 QTR 1	48149	125751	383	359
2011 QTR 2	45523	127098	358	363
2011 QTR 3	41811	127623	328	350
2011 QTR 4	44787	128061	350	346
2012 QTR 1	47967	128304	374	351
2012 QTR 2	45443	128515	354	355
2012 QTR 3	45204	141534	319	341

Figure 28. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	5185	248641	21	18
2007 QTR 2	4257	250387	17	18
2007 QTR 3	3502	250333	14	17
2007 QTR 4	4795	250172	19	18
2008 QTR 1	5823	253141	23	20
2008 QTR 2	4399	256897	17	18
2008 QTR 3	4189	260349	16	20
2008 QTR 4	4955	264072	19	18
2009 QTR 1	6014	272598	22	19
2009 QTR 2	5467	282178	19	20
2009 QTR 3	4603	288533	16	19
2009 QTR 4	6727	292332	23	22
2010 QTR 1	6283	294860	21	18
2010 QTR 2	5144	297486	17	18
2010 QTR 3	4479	299440	15	18
2010 QTR 4	5359	299922	18	17
2011 QTR 1	6047	301086	20	17
2011 QTR 2	5749	302767	19	20
2011 QTR 3	4481	302856	15	18

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2011 QTR 4	5978	302025	20	19
2012 QTR 1	5595	300366	19	16
2012 QTR 2	4860	302423	16	17
2012 QTR 3	4923	331054	15	18

Figure 29. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Children and Families Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	3538	180123	20	16
2007 QTR 2	2691	181565	15	16
2007 QTR 3	2032	181344	11	15
2007 QTR 4	3222	181148	18	17
2008 QTR 1	3920	182886	21	17
2008 QTR 2	2754	185637	15	16
2008 QTR 3	2529	188016	13	18
2008 QTR 4	3048	190435	16	15
2009 QTR 1	4091	196269	21	17
2009 QTR 2	3532	203568	17	18
2009 QTR 3	2704	208680	13	17
2009 QTR 4	4472	211791	21	20
2010 QTR 1	4204	213575	20	16
2010 QTR 2	3186	215267	15	16
2010 QTR 3	2587	216779	12	16
2010 QTR 4	3356	217350	15	14
2011 QTR 1	4202	218364	19	16
2011 QTR 2	3803	219597	17	18
2011 QTR 3	2725	220350	12	16
2011 QTR 4	3969	220342	18	17
2012 QTR 1	3839	220099	17	14
2012 QTR 2	3165	221572	14	15
2012 QTR 3	3172	249813	13	17

Figure 30. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Blind and Disabled Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	505	21241	24	24
2007 QTR 2	525	21713	24	25
2007 QTR 3	563	22052	26	25
2007 QTR 4	537	22458	24	23
2008 QTR 1	635	23046	28	28
2008 QTR 2	555	23682	23	25
2008 QTR 3	626	24307	26	25
2008 QTR 4	650	25063	26	25
2009 QTR 1	630	25958	24	24
2009 QTR 2	693	26695	26	27
2009 QTR 3	756	27348	28	27
2009 QTR 4	846	27471	31	30
2010 QTR 1	809	27860	29	29
2010 QTR 2	718	28199	25	27
2010 QTR 3	781	28463	27	27
2010 QTR 4	741	28727	26	25
2011 QTR 1	660	29105	23	23
2011 QTR 2	742	29615	25	26
2011 QTR 3	676	29835	23	22
2011 QTR 4	767	29858	26	25
2012 QTR 1	667	29211	23	23
2012 QTR 2	712	29804	24	25
2012 QTR 3	734	29978	24	24

Figure 31. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adults, Children and Families Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	1057	37891	28	26
2007 QTR 2	972	37585	26	26
2007 QTR 3	850	37518	23	25
2007 QTR 4	953	37101	26	24
2008 QTR 1	1166	37605	31	30
2008 QTR 2	994	37854	26	26
2008 QTR 3	966	38393	25	28
2008 QTR 4	1160	38868	30	28
2009 QTR 1	1186	40678	29	28
2009 QTR 2	1151	42129	27	28
2009 QTR 3	1086	42904	25	28
2009 QTR 4	1316	43408	30	29
2010 QTR 1	1170	43857	27	25
2010 QTR 2	1164	44482	26	26
2010 QTR 3	1048	44803	23	26
2010 QTR 4	1186	44305	27	25
2011 QTR 1	1099	44115	25	24
2011 QTR 2	1122	43939	26	26
2011 QTR 3	1027	43234	24	26
2011 QTR 4	1148	42294	27	26
2012 QTR 1	997	41398	24	23
2012 QTR 2	909	41164	22	22
2012 QTR 3	935	41319	23	25

Figure 32. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Areas

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	2595	135660	19	16
2007 QTR 2	2079	136451	15	16
2007 QTR 3	1666	136818	12	15
2007 QTR 4	2353	137148	17	16
2008 QTR 1	3027	138497	22	18
2008 QTR 2	2214	140389	16	17
2008 QTR 3	2109	142363	15	18
2008 QTR 4	2443	144815	17	16
2009 QTR 1	3130	149621	21	18
2009 QTR 2	2832	155774	18	19
2009 QTR 3	2401	159393	15	19
2009 QTR 4	3585	161634	22	21
2010 QTR 1	3342	163264	20	17
2010 QTR 2	2702	164779	16	18
2010 QTR 3	2424	166623	15	18
2010 QTR 4	2988	167439	18	17
2011 QTR 1	3371	168346	20	17
2011 QTR 2	3349	169531	20	21
2011 QTR 3	2621	169878	15	19
2011 QTR 4	3514	170333	21	20
2012 QTR 1	3364	170261	20	17
2012 QTR 2	2966	170198	17	18
2012 QTR 3	2927	186106	16	19

Figure 33. Seasonally Adjusted Emergency Department Utilization for Conditions Potentially Treatable in Primary Care per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Areas

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	2575	105344	24	21
2007 QTR 2	2162	106376	20	21
2007 QTR 3	1817	105891	17	21
2007 QTR 4	2420	105642	23	22
2008 QTR 1	2781	106982	26	23
2008 QTR 2	2169	108853	20	21
2008 QTR 3	2057	110061	19	22
2008 QTR 4	2491	111271	22	21
2009 QTR 1	2874	114750	25	22
2009 QTR 2	2618	118093	22	23
2009 QTR 3	2189	120344	18	22
2009 QTR 4	3122	121467	26	24
2010 QTR 1	2920	122591	24	21
2010 QTR 2	2425	123685	20	20
2010 QTR 3	2039	124270	16	20
2010 QTR 4	2358	124819	19	18
2011 QTR 1	2658	125751	21	19
2011 QTR 2	2385	127098	19	19
2011 QTR 3	1844	127623	14	17
2011 QTR 4	2441	128061	19	18
2012 QTR 1	2216	128001	17	15
2012 QTR 2	1875	128515	15	15
2012 QTR 3	1964	141534	14	17

Figure 34. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	17222	248641	69	68
2007 QTR 2	16748	250387	67	67
2007 QTR 3	15941	250333	64	65
2007 QTR 4	16757	250172	67	68
2008 QTR 1	18374	253141	73	71
2008 QTR 2	17808	256897	69	69
2008 QTR 3	18419	260349	71	73
2008 QTR 4	18006	264072	68	69
2009 QTR 1	20153	272598	74	72
2009 QTR 2	21464	282178	76	76
2009 QTR 3	20619	288533	71	73
2009 QTR 4	23071	292332	79	80
2010 QTR 1	21792	294860	74	72
2010 QTR 2	21481	297486	72	72
2010 QTR 3	21069	299440	70	72
2010 QTR 4	20200	299922	67	68
2011 QTR 1	21318	301086	71	69
2011 QTR 2	22616	302767	75	74
2011 QTR 3	21039	302856	69	71
2011 QTR 4	21087	302025	70	70
2012 QTR 1	20977	301277	70	68
2012 QTR 2	20641	302423	68	67
2012 QTR 3	21354	331054	65	66

Figure 35. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Blind and Disabled Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	85	1565	54	51
2007 QTR 2	76	1579	48	47
2007 QTR 3	81	1545	52	59

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 4	81	1574	51	53
2008 QTR 1	106	1607	66	59
2008 QTR 2	103	1691	61	60
2008 QTR 3	83	1739	48	54
2008 QTR 4	98	1797	55	56
2009 QTR 1	92	1813	51	45
2009 QTR 2	123	1853	66	65
2009 QTR 3	104	1856	56	63
2009 QTR 4	125	1885	66	68
2010 QTR 1	124	1814	68	61
2010 QTR 2	106	1788	59	58
2010 QTR 3	86	1791	48	54
2010 QTR 4	95	1838	52	53
2011 QTR 1	130	1795	72	65
2011 QTR 2	118	1832	64	63
2011 QTR 3	105	1791	59	66
2011 QTR 4	96	1819	53	54
2012 QTR 1	113	1835	62	55
2012 QTR 2	104	1923	54	50
2012 QTR 3	80	1902	42	47

Figure 36. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Children and Families Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	9445	180123	52	49
2007 QTR 2	8798	181565	48	48
2007 QTR 3	7888	181344	43	47
2007 QTR 4	9037	181148	50	50
2008 QTR 1	9914	182886	54	51
2008 QTR 2	9282	185637	50	50
2008 QTR 3	9212	188016	49	53
2008 QTR 4	9140	190435	48	48
2009 QTR 1	11013	196269	56	52
2009 QTR 2	11527	203568	57	56
2009 QTR 3	10353	208680	50	54
2009 QTR 4	12879	211791	61	61
2010 QTR 1	11870	213575	56	52
2010 QTR 2	11277	215267	52	52
2010 QTR 3	10210	216779	47	51
2010 QTR 4	10290	217350	47	47
2011 QTR 1	11796	218364	54	50
2011 QTR 2	12438	219597	57	56
2011 QTR 3	10815	220350	49	53
2011 QTR 4	11601	220342	53	53
2012 QTR 1	11780	220300	53	50
2012 QTR 2	11245	221572	51	49
2012 QTR 3	11566	249813	46	50

Figure 37. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Children, Foster Care Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	271	5806	47	46
2007 QTR 2	287	5942	48	46
2007 QTR 3	302	5831	52	54
2007 QTR 4	299	5821	51	53
2008 QTR 1	309	5859	53	51
2008 QTR 2	327	5899	55	53
2008 QTR 3	285	5723	50	52
2008 QTR 4	268	5670	47	49
2009 QTR 1	319	5600	57	56
2009 QTR 2	326	5633	58	55
2009 QTR 3	245	5414	45	48

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2009 QTR 4	277	5441	51	53
2010 QTR 1	272	5378	51	49
2010 QTR 2	293	5344	55	52
2010 QTR 3	249	5152	48	51
2010 QTR 4	254	5216	49	50
2011 QTR 1	258	5160	50	49
2011 QTR 2	257	5235	49	47
2011 QTR 3	207	4990	41	44
2011 QTR 4	208	5004	42	43
2012 QTR 1	216	5036	43	42
2012 QTR 2	225	5168	44	41
2012 QTR 3	231	5189	45	49

Figure 38. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adult, Aged Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	70	2015	35	35
2007 QTR 2	94	2003	47	47
2007 QTR 3	92	2042	45	47
2007 QTR 4	110	2070	53	53
2008 QTR 1	120	2138	56	54
2008 QTR 2	106	2134	50	50
2008 QTR 3	102	2170	47	49
2008 QTR 4	104	2239	46	47
2009 QTR 1	128	2280	56	54
2009 QTR 2	127	2300	55	55
2009 QTR 3	117	2329	50	53
2009 QTR 4	113	2336	48	49
2010 QTR 1	126	2376	53	51
2010 QTR 2	131	2405	54	54
2010 QTR 3	133	2446	54	57
2010 QTR 4	140	2479	56	57
2011 QTR 1	125	2544	49	47
2011 QTR 2	120	2546	47	47
2011 QTR 3	143	2652	54	56
2011 QTR 4	157	2705	58	58
2012 QTR 1	147	2731	54	51
2012 QTR 2	146	2780	53	52
2012 QTR 3	140	2838	49	50

Figure 39. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adult, Blind and Disabled Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	2541	21241	120	127
2007 QTR 2	2780	21713	128	129
2007 QTR 3	2975	22052	135	126
2007 QTR 4	2728	22458	121	124
2008 QTR 1	2959	23046	128	134
2008 QTR 2	3136	23682	132	133
2008 QTR 3	3597	24307	148	138
2008 QTR 4	3335	25063	133	136
2009 QTR 1	3264	25958	126	131
2009 QTR 2	3714	26695	139	140
2009 QTR 3	4126	27348	151	141
2009 QTR 4	3932	27471	143	146
2010 QTR 1	4013	27860	144	150
2010 QTR 2	4154	28199	147	148
2010 QTR 3	4478	28463	157	147
2010 QTR 4	4088	28727	142	145
2011 QTR 1	3754	29105	129	135
2011 QTR 2	4216	29615	142	143
2011 QTR 3	4338	29835	145	136

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2011 QTR 4	3980	29858	133	136
2012 QTR 1	3888	29754	131	136
2012 QTR 2	4095	29804	137	136
2012 QTR 3	4313	29978	144	133

Figure 40. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Adult, Families and Children Aid Categories

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	4810	37891	127	127
2007 QTR 2	4713	37585	125	125
2007 QTR 3	4603	37518	123	120
2007 QTR 4	4502	37101	121	123
2008 QTR 1	4966	37605	132	133
2008 QTR 2	4854	37854	128	128
2008 QTR 3	5140	38393	134	131
2008 QTR 4	5061	38868	130	132
2009 QTR 1	5337	40678	131	133
2009 QTR 2	5647	42129	134	134
2009 QTR 3	5674	42904	132	130
2009 QTR 4	5745	43408	132	134
2010 QTR 1	5387	43857	123	124
2010 QTR 2	5520	44482	124	124
2010 QTR 3	5913	44803	132	129
2010 QTR 4	5333	44305	120	122
2011 QTR 1	5255	44115	119	120
2011 QTR 2	5467	43939	124	124
2011 QTR 3	5431	43234	126	123
2011 QTR 4	5045	42294	119	121
2012 QTR 1	4833	41618	116	117
2012 QTR 2	4825	41164	117	117
2012 QTR 3	5022	41319	122	119

Figure 41. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Counties

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	9230	135660	68	66
2007 QTR 2	8834	136451	65	65
2007 QTR 3	8178	136818	60	62
2007 QTR 4	8884	137148	65	65
2008 QTR 1	10058	138497	73	70
2008 QTR 2	9807	140389	70	70
2008 QTR 3	10160	142363	71	74
2008 QTR 4	9707	144815	67	68
2009 QTR 1	11032	149621	74	71
2009 QTR 2	11803	155774	76	76
2009 QTR 3	11477	159393	72	74
2009 QTR 4	13003	161634	80	81
2010 QTR 1	12204	163264	75	72
2010 QTR 2	12200	164779	74	74
2010 QTR 3	12070	166623	72	75
2010 QTR 4	11744	167439	70	71
2011 QTR 1	12220	168346	73	70
2011 QTR 2	13275	169531	78	78
2011 QTR 3	12330	169878	73	75
2011 QTR 4	12486	170333	73	74
2012 QTR 1	12449	170051	73	71
2012 QTR 2	12262	170198	72	69
2012 QTR 3	12598	186106	68	68

Figure 42. Seasonally Adjusted Total Emergency Department Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Counties

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 1	7929	105344	75	73
2007 QTR 2	7847	106376	74	73
2007 QTR 3	7680	105891	73	74
2007 QTR 4	7810	105642	74	75
2008 QTR 1	8262	106982	77	76
2008 QTR 2	7932	108853	73	72
2008 QTR 3	8193	110061	74	76
2008 QTR 4	8228	111271	74	75
2009 QTR 1	9070	114750	79	78
2009 QTR 2	9600	118093	81	81
2009 QTR 3	9094	120344	76	77
2009 QTR 4	10012	121467	82	83
2010 QTR 1	9519	122591	78	76
2010 QTR 2	9198	123685	74	74
2010 QTR 3	8914	124270	72	73
2010 QTR 4	8401	124819	67	68
2011 QTR 1	9026	125751	72	70
2011 QTR 2	9289	127098	73	73
2011 QTR 3	8636	127623	68	69
2011 QTR 4	8541	128061	67	67
2012 QTR 1	8453	128304	66	65
2012 QTR 2	8306	128515	65	64
2012 QTR 3	8670	141534	61	63

Figure 43. Seasonally Adjusted Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 4	169	250172	0.68	0.66
2008 QTR 1	184	253141	0.73	0.61
2008 QTR 2	137	256897	0.53	0.60
2008 QTR 3	170	260349	0.65	0.74
2008 QTR 4	145	264072	0.55	0.54
2009 QTR 1	203	272598	0.74	0.62
2009 QTR 2	145	282178	0.51	0.57
2009 QTR 3	142	288533	0.49	0.56
2009 QTR 4	177	292332	0.61	0.59
2010 QTR 1	203	294860	0.69	0.57
2010 QTR 2	139	297479	0.47	0.52
2010 QTR 3	142	299417	0.47	0.54
2010 QTR 4	157	299971	0.52	0.51
2011 QTR 1	177	301082	0.59	0.49
2011 QTR 2	160	302660	0.53	0.59
2011 QTR 3	129	302651	0.43	0.48
2011 QTR 4	213	301803	0.71	0.69
2012 QTR 1	186	301850	0.62	0.51
2012 QTR 2	142	303195	0.47	0.52
2012 QTR 3	122	331054	0.37	0.42

Figure 44. Seasonally Adjusted Inpatient Hospital Utilization per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2007 QTR 3	1807	248643	7.3	6.6
2007 QTR 4	1691	250391	6.8	6.8
2008 QTR 1	1567	250349	6.3	6.3
2008 QTR 2	1526	250189	6.1	6.4
2008 QTR 3	1785	253173	7.1	6.4
2008 QTR 4	1601	257448	6.2	6.3
2009 QTR 1	1747	260936	6.7	6.8

Time Period	Visits	Member Months	Rate per 1,000	Adjusted Rate per 1,000
2009 QTR 2	1576	264654	6.0	6.3
2009 QTR 3	1895	273185	6.9	6.3
2009 QTR 4	1805	282785	6.4	6.4
2010 QTR 1	1827	289131	6.3	6.4
2010 QTR 2	1824	292935	6.2	6.6
2010 QTR 3	2118	295446	7.2	6.5
2010 QTR 4	1851	298086	6.2	6.2
2011 QTR 1	1861	300066	6.2	6.3
2011 QTR 2	1826	300622	6.1	6.4
2011 QTR 3	2043	301788	6.8	6.1
2011 QTR 4	1916	303366	6.3	6.4
2012 QTR 1	1856	303384	6.1	6.2
2012 QTR 2	1903	302570	6.3	6.6
2012 QTR 3	1779	331829	5.4	5.4

Note: excludes maternity and newborns

Figure 45. Percent of Continuously Enrolled NH Medicaid Beneficiaries With Six or More Well-Child Visits in the First 15 Months of Life, CY 2007-2011: Total Population

Time Period	6+ Visits	Members	Percent
CY 2007	2580	3418	75.5%
CY 2008	2705	3478	77.8%
CY 2009	2960	3817	77.5%
CY 2010	3113	4003	77.8%
CY 2011	3135	3968	79.0%

Figure 46. Percent of Continuously Enrolled NH Medicaid Beneficiaries With Six or More Well-Child Visits in the First 15 Months of Life, CY 2007-2011: Metropolitan Counties

Time Period	6+ Visits	Members	Percent
CY 2007	1373	1868	73.5%
CY 2008	1496	1965	76.1%
CY 2009	1596	2105	75.8%
CY 2010	1718	2222	77.3%
CY 2011	1741	2232	78.0%

Figure 47. Percent of Continuously Enrolled NH Medicaid Beneficiaries With Six or More Well-Child Visits in the First 15 Months of Life, CY 2007-2011: Non-Metropolitan Counties

Time Period	6+ Visits	Members	Percent
CY 2007	1121	1433	78.2%
CY 2008	1113	1397	79.7%
CY 2009	1261	1569	80.4%
CY 2010	1308	1655	79.0%
CY 2011	1339	1664	80.5%

Figure 48. Percent of Continuously Enrolled NH Medicaid Beneficiaries in the Third Through Sixth Years of Life With a Well-Child Visit, CY 2007-2011: Total Population

Time Period	Members with Visit	Members	Percent
CY 2007	8680	11815	73.5%
CY 2008	9215	12488	73.8%
CY 2009	10879	14158	76.8%
CY 2010	11772	15290	77.0%
CY 2011	12053	15601	77.3%

Figure 49. Percent of Continuously Enrolled NH Medicaid Beneficiaries in the Third Through Sixth Years of Life With a Well-Child Visit, CY 2007-2011: Metropolitan Counties

Time Period	Members with Visit	Members	Percent
CY 2007	4796	6421	74.7%
CY 2008	5191	6902	75.2%

Time Period	Members with Visit	Members	Percent
CY 2009	6170	7827	78.8%
CY 2010	6757	8563	78.9%
CY 2011	7059	8950	78.9%

Figure 50. Percent of Continuously Enrolled NH Medicaid Beneficiaries in the Third Through Sixth Years of Life With a Well-Child Visit, CY 2007-2011: Non-Metropolitan Counties

Time Period	Members with Visit	Members	Percent
CY 2007	3615	5035	71.8%
CY 2008	3763	5224	72.0%
CY 2009	4401	5888	74.7%
CY 2010	4758	6368	74.7%
CY 2011	4888	6492	75.3%

Figure 51. Percent of Continuously Enrolled Adolescent NH Medicaid Beneficiaries With a Well-Care Visit, CY 2007-2011: Total Population

Time Period	Members with Visit	Members	Percent
CY 2007	9100	17687	51.5%
CY 2008	9747	18161	53.7%
CY 2009	11759	20459	57.5%
CY 2010	12166	21760	55.9%
CY 2011	12088	21828	55.4%

Figure 52. Percent of Continuously Enrolled Adolescent NH Medicaid Beneficiaries With a Well-Care Visit, CY 2007-2011: Metropolitan Counties

Time Period	Members with Visit	Members	Percent
CY 2007	4933	9405	52.5%
CY 2008	5401	9802	55.1%
CY 2009	6551	11082	59.1%
CY 2010	6892	11892	58.0%
CY 2011	6767	11986	56.5%

Figure 53. Percent of Continuously Enrolled Adolescent NH Medicaid Beneficiaries With a Well-Care Visit, CY 2007-2011: Non-Metropolitan Counties

Time Period	Members with Visit	Members	Percent
CY 2007	4026	7976	50.5%
CY 2008	4193	8023	52.3%
CY 2009	4999	8973	55.7%
CY 2010	5110	9535	53.6%
CY 2011	5248	9693	54.1%

Figure 54. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 0 to 11 Months

Time Period	Members with Visit	Members	Percent with Visit
CY 2007	683	696	98.1%
CY 2008	678	687	98.7%
CY 2009	702	714	98.3%
CY 2010	703	714	98.5%
CY 2011	749	753	99.5%

Figure 55. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 12 to 24 Months

Time Period	Members with Visit	Members	Percent with Visit
CY 2007	3422	3456	99.0%
CY 2008	3614	3657	98.8%
CY 2009	3964	4010	98.9%

Time Period	Members with Visit	Members	Percent with Visit
CY 2010	4004	4057	98.7%
CY 2011	3915	3975	98.5%

Figure 56. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 25 Months to 6 Years

Time Period	Members with Visit	Members	Percent with Visit
CY 2007	10067	11007	91.5%
CY 2008	10728	11713	91.6%
CY 2009	12305	13217	93.1%
CY 2010	13475	14500	92.9%
CY 2011	13708	14850	92.3%

Figure 57. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 7 to 11 Years

Time Period	Members with Visit	Members	Percent with Visit
CY 2007	10722	12753	84.1%
CY 2008	11464	13469	85.1%
CY 2009	13342	15067	88.6%
CY 2010	14145	16118	87.8%
CY 2011	14296	16393	87.2%

Figure 58. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, SFY 2007-2011 by Age: 12 to 18 Years

Time Period	Members with Visit	Members	Percent with Visit
CY 2007	13221	15795	83.7%
CY 2008	13733	16232	84.6%
CY 2009	15947	18165	87.8%
CY 2010	16806	19532	86.0%
CY 2011	16945	19809	85.5%

Figure 59. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Metropolitan Counties

Time Period	Members with Visit	Members	Percent with Visit
CY 2007	22458	25383	88.5%
CY 2008	23927	26854	89.1%
CY 2009	27593	30219	91.3%
CY 2010	29517	32719	90.2%
CY 2011	30125	33492	89.9%

Figure 60. Percent of Continuously Enrolled NH Medicaid Child Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Non-Metropolitan Counties

Time Period	Members with Visit	Members	Percent with Visit
CY 2007	17761	20416	87.0%
CY 2008	18620	21197	87.8%
CY 2009	21231	23467	90.5%
CY 2010	22482	25073	89.7%
CY 2011	22799	25691	88.7%

Figure 61. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 20 to 44 Years

Time Period	Members with Visit	Members	Percent
CY 2007	7102	8207	87%
CY 2008	7377	8428	88%
CY 2009	8519	9528	89%
CY 2010	9188	10389	88%

Time Period	Members with Visit	Members	Percent
CY 2011	9022	10326	87%

Figure 62. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011 by Age: 45 to 64 Years

Time Period	Members with Visit	Members	Percent
CY 2007	3267	3627	90%
CY 2008	3536	3911	90%
CY 2009	3956	4311	92%
CY 2010	4216	4614	91%
CY 2011	4387	4836	91%

Figure 63. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Metropolitan Counties

Time Period	Members with Visit	Members	Percent
CY 2007	6201	7054	87.9%
CY 2008	6485	7389	87.8%
CY 2009	7381	8234	89.6%
CY 2010	7999	8991	89.0%
CY 2011	8088	9114	88.7%

Figure 64. Percent of Continuously Enrolled NH Medicaid Adult Beneficiaries With a Preventive or Other Ambulatory Service, CY 2007-2011: Non-Metropolitan Counties

Time Period	Members with Visit	Members	Percent
CY 2007	4396	5062	86.8%
CY 2008	4672	5241	89.1%
CY 2009	5282	5831	90.6%
CY 2010	5704	6342	89.9%
CY 2011	5842	6625	88.2%

Figure 65. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Seven 7 Days, CY 2007-2011 by Age: 6 to 18 Years

Time Period	Timely Follow-Up	Discharges	Percent
CY 2007	157	260	60.4%
CY 2008	119	218	54.6%
CY 2009	156	275	56.7%
CY 2010	168	291	57.7%
CY 2011	168	281	59.8%

Figure 66. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Within 7 Days, CY 2007-2011 by Age: 19 and Older

Time Period	Timely Follow-Up	Discharges	Percent
CY 2007	263	443	59.4%
CY 2008	234	431	54.3%
CY 2009	227	434	52.3%
CY 2010	255	443	57.6%
CY 2011	256	431	59.4%

Figure 67. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Within 30 Days, CY 2007-2011 by Age: 6 to 18 Years

Time Period	Timely Follow-Up	Discharges	Percent
CY 2007	203	260	78.1%
CY 2008	171	218	78.4%
CY 2009	214	275	77.8%
CY 2010	226	291	77.7%
CY 2011	228	281	81.1%

Figure 68. Percent of Discharges for Hospitalization for Mental Health Disorder Treatment Where the Member Had a Follow-Up Visit Within 30 Days, CY 2007-2011 by Age: 19 and Older

Time Period	Timely Follow-Up	Discharges	Percent
CY 2007	343	443	77.4%
CY 2008	326	431	75.6%
CY 2009	305	434	70.3%
CY 2010	324	443	73.1%
CY 2011	319	431	74.0%

Figure 69. Beneficiary Requests for Assistance Accessing Providers per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Total Population

Time Period	Calls	Member Months	Rate per 1,000
2007 QTR 1	674	248,641	2.7
2007 QTR 2	489	250,387	2.0
2007 QTR 3	422	250,333	1.7
2007 QTR 4	416	250,172	1.7
2008 QTR 1	481	253,141	1.9
2008 QTR 2	472	256,897	1.8
2008 QTR 3	499	260,349	1.9
2008 QTR 4	610	264,072	2.3
2009 QTR 1	667	272,598	2.4
2009 QTR 2	696	282,178	2.5
2009 QTR 3	748	288,533	2.6
2009 QTR 4	638	292,332	2.2
2010 QTR 1	613	294,860	2.1
2010 QTR 2	714	297,486	2.4
2010 QTR 3	702	299,440	2.3
2010 QTR 4	495	299,922	1.7
2011 QTR 1	678	301,086	2.3
2011 QTR 2	656	302,767	2.2
2011 QTR 3	703	302,856	2.3
2011 QTR 4	792	302,025	2.6
2012 QTR 1	673	300,366	2.2
2012 QTR 2	799	302,423	2.6
2012 QTR 3	844	331,054	2.5
2012 QTR 4	630	331,054	1.9

Figure 70. Beneficiary Requests for Assistance Accessing Providers per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Metropolitan Counties

Time Period	Calls	Member Months	Rate per 1,000
2007 QTR 1	454	135,660	3.3
2007 QTR 2	329	136,451	2.4
2007 QTR 3	285	136,818	2.1
2007 QTR 4	303	137,148	2.2
2008 QTR 1	333	138,497	2.4
2008 QTR 2	349	140,389	2.5
2008 QTR 3	348	142,363	2.4
2008 QTR 4	431	144,815	3.0
2009 QTR 1	471	149,621	3.1
2009 QTR 2	494	155,774	3.2
2009 QTR 3	498	159,393	3.1
2009 QTR 4	492	161,634	3.0
2010 QTR 1	422	163,264	2.6
2010 QTR 2	496	164,779	3.0
2010 QTR 3	488	166,623	2.9
2010 QTR 4	348	167,439	2.1
2011 QTR 1	460	168,346	2.7
2011 QTR 2	423	169,531	2.5
2011 QTR 3	475	169,878	2.8
2011 QTR 4	470	170,333	2.8
2012 QTR 1	458	170,262	2.7

Time Period	Calls	Member Months	Rate per 1,000
2012 QTR 2	538	170,198	3.2
2012 QTR 3	598	186,106	3.2
2012 QTR 4	470	186,106	2.5

Figure 71. Beneficiary Requests for Assistance Accessing Providers per 1,000 NH Medicaid Beneficiaries, CY 2007-2012: Non-Metropolitan Counties

Time Period	Calls	Member Months	Rate per 1,000
2007 QTR 1	206	105,344	2.0
2007 QTR 2	152	106,376	1.4
2007 QTR 3	130	105,891	1.2
2007 QTR 4	108	105,642	1.0
2008 QTR 1	140	106,982	1.3
2008 QTR 2	117	108,853	1.1
2008 QTR 3	144	110,061	1.3
2008 QTR 4	178	111,271	1.6
2009 QTR 1	194	114,750	1.7
2009 QTR 2	200	118,093	1.7
2009 QTR 3	241	120,344	2.0
2009 QTR 4	139	121,467	1.1
2010 QTR 1	184	122,591	1.5
2010 QTR 2	211	123,685	1.7
2010 QTR 3	201	124,270	1.6
2010 QTR 4	134	124,819	1.1
2011 QTR 1	207	125,751	1.6
2011 QTR 2	225	127,098	1.8
2011 QTR 3	223	127,623	1.7
2011 QTR 4	318	128,061	2.5
2012 QTR 1	204	128,001	1.6
2012 QTR 2	248	128,515	1.9
2012 QTR 3	246	141,534	1.7
2012 QTR 4	160	141,534	1.1