

New Hampshire Medicaid Annual Report



State Fiscal Year 2007

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

August 2008

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

Table of Contents

<i>New Hampshire Medicaid Overview</i>	<i>1</i>
The Medicaid Program.....	1
NH Medicaid Covered Services	2
NH Medicaid Coverage and Service Limits	2
Eligibility for the Medicaid Program	3
Medicaid Waiver Programs.....	4
Medicaid Funding Sources.....	4
Medicaid and the New Hampshire State Budget.....	4
Medicaid Organization and Spending within NH DHHS.....	5
Medicaid Spending by Type.....	5
<i>Medicaid Enrollment and Expenditures.....</i>	<i>6</i>
Medicaid Enrollment.....	6
Medicaid Expenditure: Provider Payments	9
Payments by Eligibility Category.....	10
Trends in Medicaid Service Spending	11
<i>Tracking Access, Quality and Outcomes.....</i>	<i>13</i>
Access	13
Use of Preventive Services.....	14
<i>Appendices.....</i>	<i>16</i>
Appendix 1: Medicaid Program Expansions Since 1984.....	17
Appendix 2. Recent New Hampshire Laws Relative to Medicaid.....	21
Appendix 3: Provider Payment Rate Changes in SFY 2007	22
Appendix 4a: NH Medicaid Expenditures by Service Categories, SFY 2007 Service Dates	23
Appendix 4b: NH Medicaid Expenditures by Service Categories, SFY 2007 Paid Dates	25
Appendix 5: NH Medicaid Per Member Per Month Expenditures by Service Categories for Eligibility Groups, SFY 2007 ...	27
Appendix 6: New Hampshire Medicaid Enrollment and Total Expenditures by New Hampshire Locations.....	28
<i>Glossary</i>	<i>34</i>
<i>Contributors.....</i>	<i>37</i>

New Hampshire Medicaid Overview

The Medicaid Program

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

The federal government and the states share responsibility for financing Medicaid. The federal government matches state Medicaid spending at rates that vary by state per capita income. For New Hampshire, the federal matching rate is currently set at 50 percent, which means the State receives one federal dollar for each state dollar it spends.

Just as the country has changed in many ways since 1965, Medicaid has evolved (utilizing state flexibility and guaranteed federal funding) in response to shifting economic and demographic conditions and changing needs. Medicaid has been transformed from providing medical assistance to individuals and families receiving cash assistance to a health and long-term care program for low income populations, including working families, elderly people, and individuals with diverse physical and mental disabilities. Appendix 1 contains a complete listing of program expansions to the NH Medicaid programs since 1984.

In the coming years, anticipated declining rates of employer-based health insurance, increasing numbers of uninsured, aging of the baby boomers, and rising health care costs will continue to affect the Medicaid program. Recent federal activity has presented new opportunities and challenges for states. The Medicare Modernization Act of 2003 (MMA) resulted in the transition of prescription drug coverage for low income seniors and individuals with disabilities covered by both programs (known as "duals") from Medicaid to Medicare. While this switch lowered Medicaid spending growth, states are now obligated to finance

a portion of this Medicare prescription coverage through payments back to the federal government. The Deficit Reduction Act of 2005 (DRA) imposed new requirements for states along with options in the areas of benefits, cost sharing and long-term care. The New Hampshire Department of Health and Human Services continues to evaluate these options and implement those that suit our needs and mission.

CMS has begun to propose new regulations and issue guidance, and is considering additional initiatives, in response to provisions enacted in the MMA and DRA. Areas affected include citizenship documentation requirements, cost sharing levels, case management services, Graduate Medical Education (GME) for medical residents, rehabilitation services, and outpatient hospital services. CMS is pursuing these actions to ensure the programmatic and fiscal integrity of Medicaid. States, beneficiaries, and providers have concerns about the possible negative consequences resulting from federal initiatives reducing the scope of services, limiting provider reimbursement, and shifting costs to the states. Congress is looking at imposing moratoriums on implementation of these actions while the impacts are examined further.

Given the proportion of states' budgets dedicated to Medicaid and the continued increase in federal spending, much attention has been focused on Medicaid reform. Across the country, states are exploring ways to control costs along with improving quality of care. Appendix 2 contains a list of efforts initiated by the NH Legislature towards costs and program management. Appendix 3 describes changes to Medicaid providers' rates initiated in 2007.

In September 2005, the federal Medicaid Commission released its initial report with recommendations for reducing the rate of spending growth in Medicaid over the next 5 years. Three recommendations having the greatest potential impact in New Hampshire include restricting the transfer of assets by beneficiaries in order to qualify for long-term care through Medicaid (reinforced laws recently passed in NH), permitting states to base their payments to drug companies on the average manufacturer price instead of the average wholesale price (federal directive to implement is on hold), and expanding the number of recipients who can be charged co-pays for prescription drugs, physician visits, and other services (considered by the NH Department of Health and Human Services (DHHS), but no action has been taken).

The Commission released its final report in December 2006. The report's objectives are to enhance both quality of care and Medicaid's long-term fiscal sus-

tainability, through long-term value of investments in quality improvement, increasing state flexibility, and changing how beneficiaries partner with the Medicaid program by encouraging patient responsibility for health care decisions and promoting and rewarding healthy behaviors. The range of recommendations aim to improve the health of beneficiaries through a more efficient Medicaid system that emphasizes prevention, provides long-term care services in the least restrictive appropriate environment, adopts interoperable forms of health information technology, coordinates care across providers and health care settings, and focuses on ensuring quality health care outcomes. The fate of these recommendations is being debated in various forums and will likely make an additional impression on Medicaid.

NH Medicaid Covered Services

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

- Comprehensive and preventive child health coverage for low income children up to the age of 21, following federal requirements of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program;
- Acute care coverage for some parents of covered children;

- A complex range of acute and long-term care services for the frail elderly, people with physical disabilities, and those with mental illness; and
- “Wraparound” coverage that supplements and fills gaps in the Medicare benefit for low income elders who are eligible for both Medicaid and Medicare, referred to as the “dually eligible” or “duals”.

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

NH Medicaid Coverage and Service Limits

Medicaid coverage depends on:

- the categories of services that are covered under the State plan;
- the applicable amount, duration and scope of limitations on otherwise covered benefits (such as visit limits and day limits); and

Table 1: New Hampshire Medicaid Covered Services

Federal Mandates

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

State Mandates

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

Optional Services

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

Table 2: New Hampshire Medicaid Limits on Covered Services**Service Limits on “Mandatory” Services**

- Inpatient hospital services (*must be medically necessary*)
- Outpatient hospital services, including emergency room services (*12 visits per year*)
- Physician services (*18 visits per year*)
- Diagnostic x-rays (*15 per year*)
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21 (*must be medically necessary*)
- Dental Services (*for persons age 21 and over, limited to treatment of acute pain or infection*)

Service Limits on “Optional” Services

- Prescription drugs (*Pharmacy Benefit Management (PBM) limits*)
- Psychotherapy (*12 visits per year*)
- Podiatrist Services (*12 visits per year*)
- Chiropractic Services (*6 visits per year*)
- Durable medical equipment (*prior authorization required*)
- Medical supplies (*prior authorization required*)
- Physical, occupational, speech therapy (*80 15-minute units per year*)
- Eyeglasses (*examine every year to determine need for glasses, 1 repair per year, replacement with ½ diopter change*)

- the standard of medical necessity that is used to determine whether otherwise covered services are medically appropriate for a particular individual in any specific case.

NH Medicaid has established service limits on a number of covered services including physician, laboratory and X-ray, and outpatient hospital services. Specific limits on service use are defined in Table 2.

Eligibility for the Medicaid Program

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

- *Categorical eligibility.* Federal law establishes many eligibility “categories,” and an individual will be determined eligible only if the detailed criteria are met for one of those categories. States are required to include certain “mandatory” eligibility groups; for example, all states must cover children and pregnant women with family incomes up to specified levels. Other eligibility pathways are optional and available only in those states that choose to cover them. Table 3 describes the eligibility groups covered by NH Medicaid.
- *Financial eligibility.* Medicaid is a means-tested program. To qualify for Medicaid, a person must have a low income expressed as a percentage of the Federal Poverty Level (FPL). CMS sets a minimum financial requirement, however states have some flexibility in extending eligibility beyond the minimum for each categorical group. In NH Medicaid, income levels vary from 300% of FPL for infants to 51% FPL for medically needy as shown in Figure 1.

Table 3: New Hampshire Medicaid Eligibility Categories

All state Medicaid programs must cover the following people (mandatory eligibility):

- Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI)*;
- 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 guidelines;
- Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level;
- Infants born to Medicaid-enrolled pregnant women; and
- Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program.

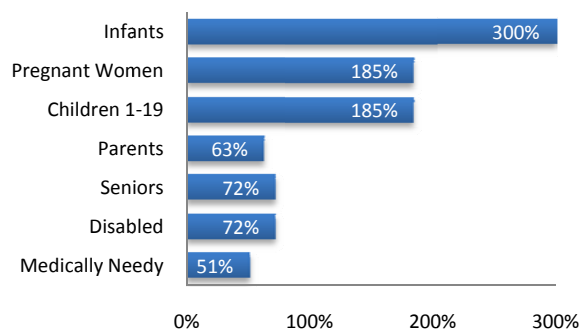
In addition, New Hampshire Medicaid has chosen to cover these optional groups:

- Low income elderly adults or adults with disabilities;
- Individuals eligible for Home and Community Based Services Waiver programs;
- Children and pregnant women up to 185% and parents up to 63% of the federal poverty level;
- Individuals determined to be “medically needy” due to low income and resources or 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; and
- 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 their Medicaid insurance coverage.

*SSI is a federal income assistance program for disabled, blind, or aged individuals independent of individuals' employment status. SSDI is an insurance program for those who have worked a specified amount of time and have lost their source of income due to a physical or mental impairment.

† 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.

Figure 1: New Hampshire Medicaid Eligibility by Percent of Poverty Level



Medicaid Waiver Programs

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

New Hampshire has several waiver programs in operation:

- Home Care for Children with Severe Disabilities (HC-CSD), commonly known as the Katie Beckett option: for severely disabled children up to age 19 whose medical disability qualifies them for institutional care but who are cared for at home.
- Home and Community Based Care for Acquired Brain Disorders (HCBC-ABD): services are available to individuals with traumatic brain injuries or neurological disorders who chose to remain in community settings in lieu of institutionalization.
- Home and Community Based Care for Developmentally Disabled (HCBC-DD): services are available to individuals with developmental disabilities and their families who chose to remain in community settings in lieu of institutionalization.

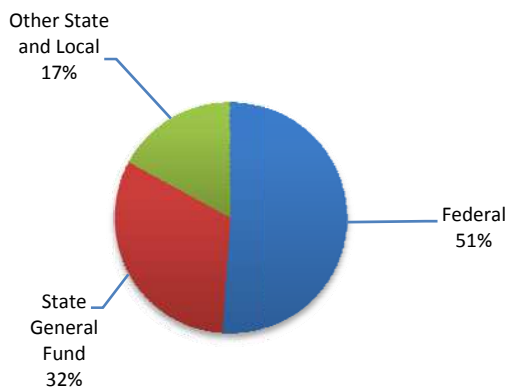
- Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI): services to provide options to eligible individuals who chose to remain in community settings in lieu of nursing home care.
- In Home Supports Waiver (IHS): services to provide in-home support to children with severe developmental disabilities, birth to age 21, living at home with their families.
- Medicaid Health Management Program (Disease Management): provides information, resources and disease management services for individuals with chronic illnesses such as asthma, diabetes, heart failure, coronary artery disease, chronic obstructive pulmonary disease, chronic kidney disease, and end-stage renal disease.

Medicaid Funding Sources

The NH Medicaid budget is comprised of federal, state general, and other state and local funds. The federal government covered just over 50% of New Hampshire’s \$1.22 billion dollars spent by the Medicaid program in State Fiscal Year (SFY) 2007.

Figure 2: New Hampshire Medicaid Funding Sources, SFY 2007

Total New Hampshire Medicaid Spending \$1.22 Billion



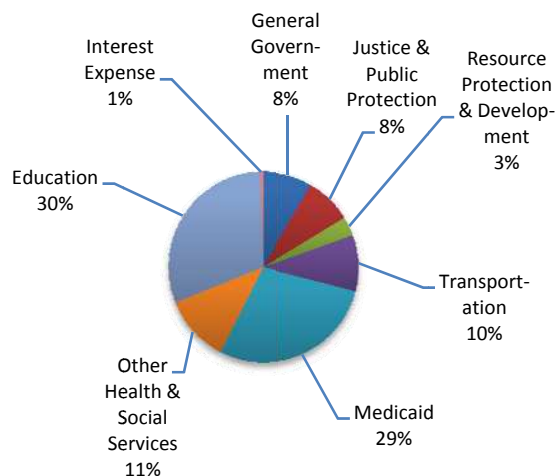
Source: NH DHHS, Office of Medicaid Business and Policy (OMBP)

Medicaid and the New Hampshire State Budget

In SFY 2007, Medicaid accounted for 28% of NH state budget expenses, second only to education. Note that for illustration purposes, the chart below separates Medicaid from the remainder of spending under the Health and Social Services budget category.

Figure 3: New Hampshire State Budget Expenses, SFY 2007

Total New Hampshire State Budget \$4.3 Billion



Source: Schedule of Changes in Net Assets, Last Six Fiscal Years. State of New Hampshire Comprehensive Annual Financial Report for the Fiscal Year Ended June 30, 2007

Medicaid Organization and Spending within NH DHHS

In New Hampshire, the Medicaid Program is administered within the Department of Health and Human Services (DHHS). Functional responsibility for the many components of the program is coordinated among several organizational units within DHHS. These include the Office of Medicaid Business and Policy (OMBP - Medicaid Director, planning and policy, data and research, federal reporting, financial management), the Bureau of Behavioral Health (BBH - mental health), the Bureau of Developmental Services (BDS - developmental disabilities), and the Bureau of Elderly and Adult Services (BEAS - aged and long-term care). Each of these units has programmatic responsibility for the Medicaid services that fall under their respective jurisdiction as well as the funding for those services.

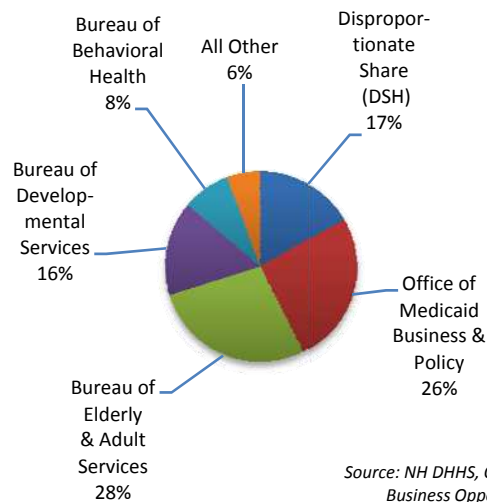
Spending by the NH Medicaid Program can be broken down into activities or Department organizational units. The Bureau of Elderly and Adult Services (BEAS) accounted for 28% of Medicaid spending. The Office of Medicaid Business and Policy (OMBP) accounted for 26% and Disproportionate Share Hospital (DSH) payments made to hospitals accounted for 17% of Medicaid expenditures.* Sixteen percent

* Certain hospitals are recognized by the State as serving a disproportionate share of low income and uninsured patients. These hospitals receive

of Medicaid spending was through the Bureau of Developmental Services (BDS), 8% by the Bureau of Behavioral Health (BBH), and 6% was for "Other" activities.

Figure 4: New Hampshire Medicaid Spending by Department, SFY 2007

Total NH Medicaid Spending \$1.22 Billion



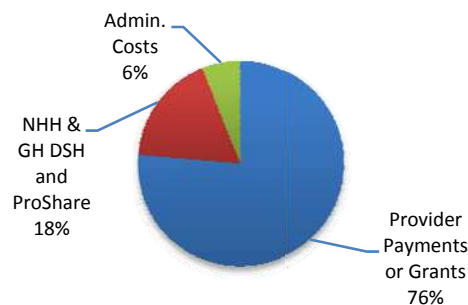
Source: NH DHHS, Office of Business Operations

Medicaid Spending by Type

There are three general types of Medicaid spending. The bulk of Medicaid expenditures (76%) are for services to beneficiaries (provider or grant payments). The second type of expenditures (18%) consists of Disproportionate Share payments to hospitals (certain general hospitals and NH Hospital) and ProShare payments to counties (covers the difference between actual NH Medicaid nursing home rates and the amount Medicare would reimburse). Administrative costs represent the smallest portion of expenditures (6%).

Figure 5: New Hampshire Medicaid Spending by Type, SFY 2007

Total NH Medicaid Spending \$1.22 Billion



Source: NH DHHS, Office of Business Operations

additional Medicaid payments for providing inpatient care to Medicaid enrollees.

Medicaid Enrollment and Expenditures

In state fiscal year 2007, New Hampshire Medicaid provided health insurance coverage to an average of 111,591 persons each month, serving more than 143,072 unique persons over the year.* The Medicaid program expended a total of \$1.22 billion in SFY 2007 of which \$869,776,290 (71%) were attributable to Medicaid provider payments. The difference in expenditures reported in the following tables from the total \$1.22 billion are from costs that are often in lump-sum payments and not necessarily attributable to individual enrollees. These costs include program administration, non-claim payments and settlements, rebates for prescription drugs, payments to CMS for prescription drugs for members who are also covered by Medicare, and payments for claims where services were provided in a period time other than SFY 2007, but were paid during the SFY 2007 time period.

Table 4 presents individuals enrolled and Medicaid expenditures for SFY 2007. Low income children represent 59% of NH Medicaid members yet only account for 23% of total program expenditures. Persons with disabilities (severely disabled children, physically and mentally disabled adults) represent 14% of the population and account for 41% of total program expenditures. Elderly adults, who rely on Medicaid for their long-term care needs, accounted for the largest percentage of payments. Elderly adults are 8% of the Medicaid population and account for 27% of total expenditures.

* Note average enrollment represents the average number of persons enrolled in the NH Medicaid program throughout SFY 2007 and not point in time statistics.

Table 4: Medicaid Enrollment[†] and Medical Provider Expenditures, SFY 2007

Eligibility Category [‡]	Enrolled at any time during SFY 2007		Medicaid Expenditures	
	Percent Enrolled		Percent of Cost	
Low income Child	84,801	59%	\$197,747,135	23%
Low income Adult	22,341	16%	\$ 67,918,308	8%
Severely Disabled Child	1,468	1%	\$29,029,077	3%
Disabled Physical	9,000	6%	\$159,115,307	18%
Disabled Mental	10,299	7%	\$175,895,186	20%
Elderly	11,689	8%	\$236,982,869	27%
QMB/SLMB	8,043	6%	\$3,006,191	0%
Total*	143,072	100%	\$869,776,299	

* NH Medicaid expenditures totaled \$1.22 billion in SFY 2007. The figures in this table cover payments to providers based on dates of service from July 1, 2006 through June 30, 2007. The figures in this table do not include expenditures for administration, cost settlements, rebates, and other types of non-claim payments.

Source: NH DHHS, OMBP

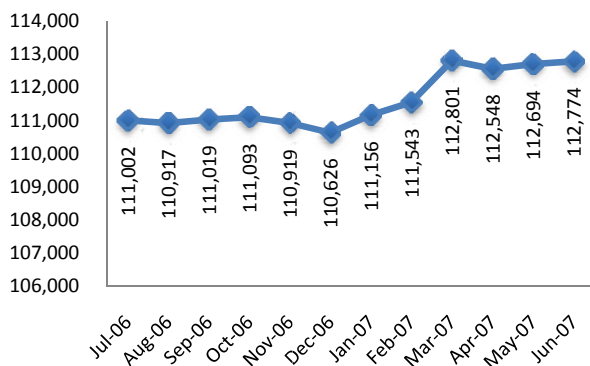
Medicaid Enrollment

Since 2002, Medicaid enrollment has continued to show a modest increase. In 2007, monthly enrollment in Medicaid trended upward from 111,002 to 112,774, an increase of 1.6%. Figure 6 provides the monthly enrollment for SFY 2007. In November and December there was a slight decline to 110,626 members, followed by a rapid increase to 112,801 in March then a leveling off for the remainder of the year. (New FPL guidelines are published the end of January accounting for the increased enrollment observed from February to March.)

[†] Enrollment figures in this table represent the number of persons enrolled at all during the fiscal year 2007, regardless of the length of time enrolled.

[‡] Members were assigned to an Eligibility Group based on their eligibility program type as of June 2007. Families eligible under the Temporary Assistance for Needy Families (TANF) and related programs were categorized as "low income" with age used to identify children (18 or less) and adults (greater than 18). Individuals in the elderly group were labeled by program even when age was less than 65. Similarly individuals in the disabled group were placed in "Disabled," even when their ages were greater than 65. Individuals who are eligible for Medicare and have low incomes may have their premiums, co-pays, co-insurance, and deductibles paid for by Medicaid and referred to as Qualified Medicare Beneficiary (QMB), or Specified Low income Medicare Beneficiary (SLMB).

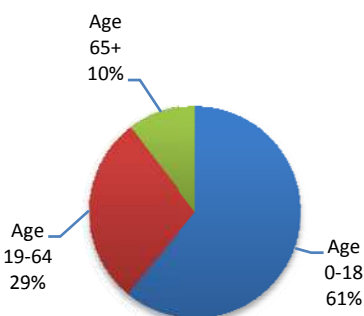
Figure 6: Monthly NH Medicaid Enrollment, SFY 2007



Source: NH DHHS, OMBP

Figure 7: NH Medicaid Enrollment by Age Categories, SFY 2007*

Total Enrollment in June of 2007 = 112,774

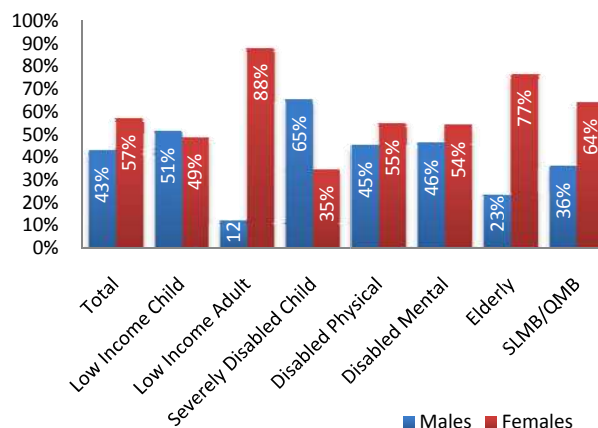


Source: NH DHHS, OMBP

In SFY 2007, children (members 18 years or less) made up 61% of the NH Medicaid population. As shown in Figure 7 members 19 to 64 represented 29% of members and the remaining 10% were members aged 65 plus. While children make up the majority of the Medicaid population, they account for only 26% of spending.

Females account for over half of Medicaid enrollees. Gender differences were observed in all eligibility categories with low income adults (88%) and the elderly (77%) being predominately females. Males made up a larger proportion of the low income child and severely disabled child groups.

Figure 8: NH Medicaid Enrollment by Gender and Eligibility Category, SFY2007



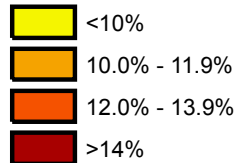
The percent of the population covered by NH Medicaid varies by Health Analysis Area (HAA)[†] from a low of 5% in the Derry area to a high of 16% in Berlin and Lancaster areas. Figure 9 displays the percent of population enrolled in NH Medicaid for each of the HAAs. While the percent of population is not among the highest, Manchester, Nashua and Concord areas had the largest actual number of Medicaid members. These three areas account for 41% of the total NH Medicaid population. Figure 9 displays the geographic breakdown within each HAA of Medicaid enrollees as a percentage of the population along with the distribution of Medicaid enrollees by eligibility group.

[†] Health Analysis Areas (HAA) are composed of zip codes that are close to each other geographically and share a common demography. These groupings were developed by NH DHHS as part of the NH CHIS project to provide a useful sub-division of the state for analysis of geographic variation. Groupings are based on hospital-care-seeking preference for commonly performed services.

* Percentage based on end of SFY 2007 data (June 2007).

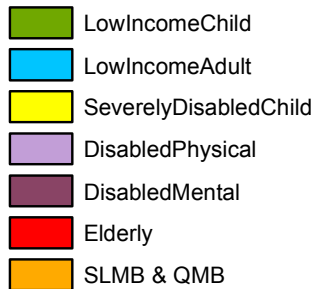
Figure 9: NH Medicaid Enrollment by Health Analysis Area State Fiscal Year 2007

Medicaid Enrollees as a Percent of Total Population

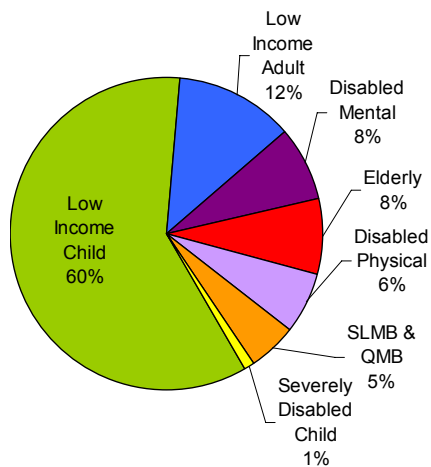


Eligibility Groups as a Percent of Medicaid Population

Size of Pie Represents Relative Number of Medicaid Enrollees

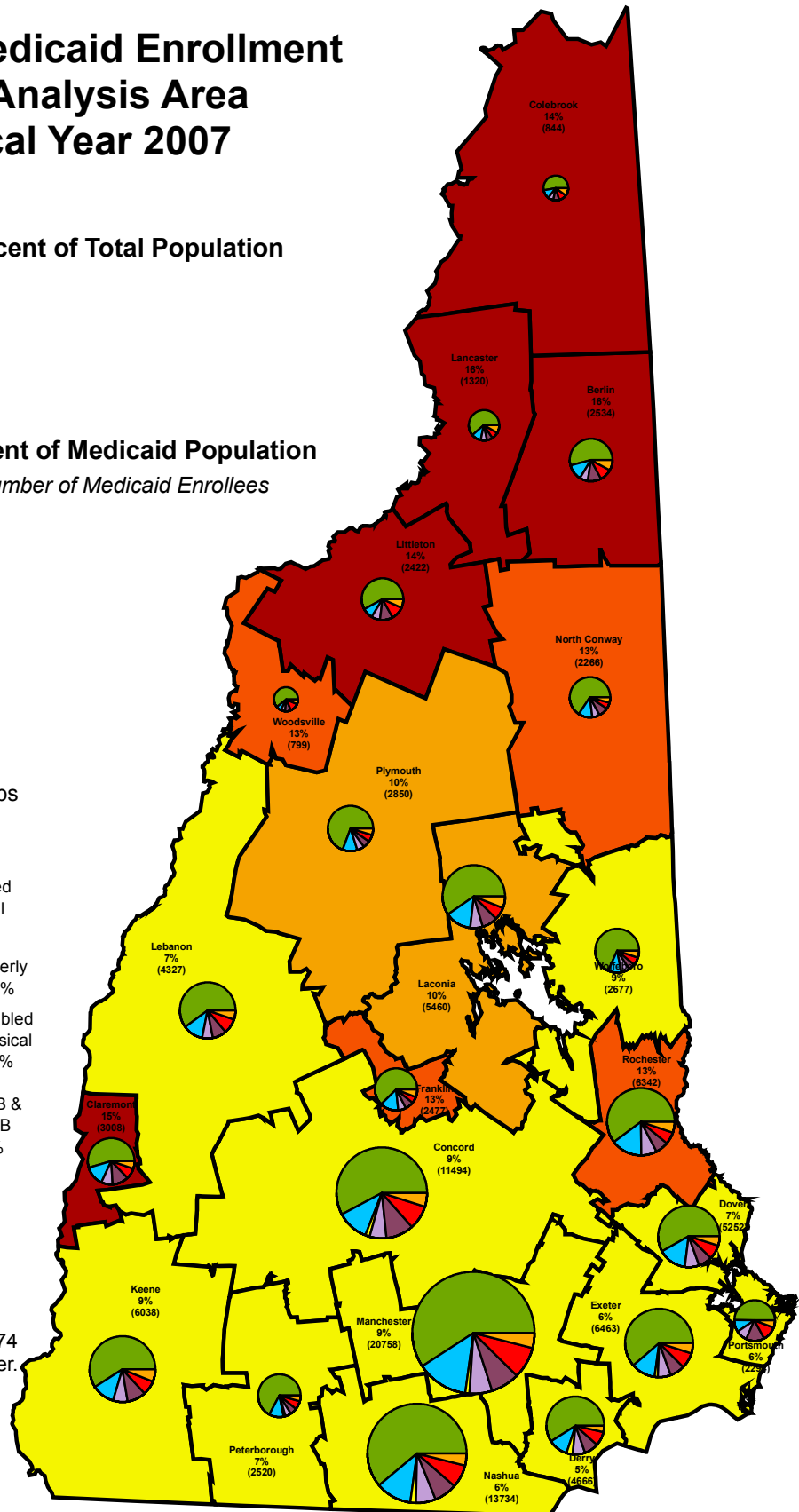


NH Enrollees by Eligibility Groups



Notes:

Data based on total enrollment of 112,774
Data does not include Healthy Kids Silver.
Health Analysis Areas defined by
resident's hospital preference, based on
non-specialty hospital services.
Data current as of 3/12/08.



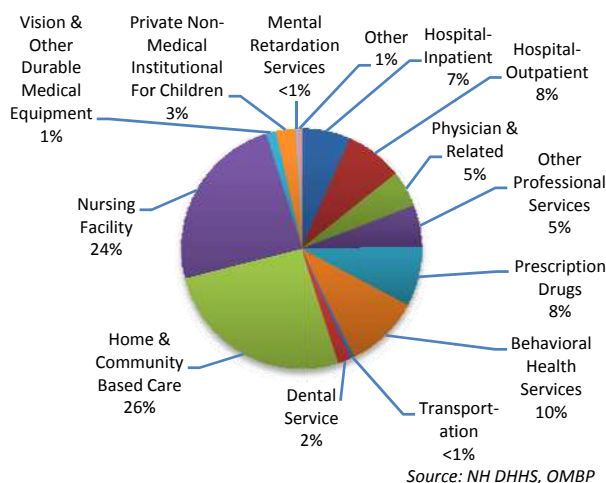
Source: NH DHHS, OMBP

Medicaid Expenditure: Provider Payments

In SFY 2007, the largest category of NH Medicaid spending was for long-term care services, including services provided at home and in institutions. As shown in Figure 10, approximately 53% of provider payments were associated with long-term care services. At over \$200 million dollars each, payments for home and community based care (HCBC) accounted for 26% of payments and nursing facilities another 24%. HCBC services for the developmentally impaired accounted for \$155 million (80%) of the total HCBC expenditures. Additionally, 3% of expenditures were for private non-medical treatment for children.

Acute care services including medical care and behavioral health accounted for 39% of NH Medicaid payments to providers. Hospital services contributed 14%, 8% for outpatient and 7% for inpatient services, and physician and other related services another 5%. Additionally, behavioral health services contributed another 10% of payments, other professional services† accounted for 6% of spending, while dental, vision, transportation, mental retardation, and other services‡ all accounted for 2% or less. Finally, prescription drugs accounted for 8% of payments.§ For a complete list of services and costs see Appendix Table 4.

Figure 10: Distribution of NH Medicaid Payments by Types of Service, SFY 2007



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

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

§ Expenditures for prescription drugs are not adjusted for rebates from manufacturers. In SFY 2007, pharmacy rebates totaled \$24.3million.

Table 5 provides expenditures and number of members using each service category. The most frequently used services were physician-related and prescription drugs. Over 97,000 members (68%) utilized physician-related services during SFY 2007 at an average yearly cost of \$440 per user. Prescription drugs were the next most frequently used services with over 87,000 members at an annual cost of \$805. Additionally, over half (53%) of members used outpatient services with an average payment of \$876. While long-term care services represent the highest cost areas they served a small proportion of members—HCBC served 11,724 (8%) members and nursing homes provided services to 7,136 members (5%). At least one service was used by 87% of members leaving 13% of members enrolled during the year with no service use.

Table 5: NH Medicaid Provider Claim Payments by Service Categories, SFY 2007

Service Category	Total Claim Payment	Service Users	Average Users as a Percent of Members	Average Paid Per User Per Year
Home & Community Based Care	\$225,892,462	11,724	8%	\$19,268
Nursing Facility	\$210,170,665	7,136	5%	\$29,452
Behavioral Health Services	\$86,880,800	22,826	16%	\$3,806
Prescription Drugs	\$70,133,412	87,075	61%	\$805
Hospital-Outpatient	\$66,577,331	75,971	53%	\$876
Hospital-Inpatient	\$57,251,212	16,314	11%	\$3,509
Other Professional Services	\$48,409,679	48,043	34%	\$1,007
Physician & Related	\$42,686,023	97,006	68%	\$440
Private Non-Medical Institutional For Children	\$22,846,207	1,259	1%	\$18,146
Dental Service	\$15,445,986	42,411	30%	\$364
Vision & Other Durable Medical Equipment	\$11,238,186	27,302	19%	\$412
Other	\$5,337,892	556	<1%	\$9,601
Transportation	\$4,438,083	9,415	7%	\$471
Mental Retardation Services	\$2,468,361	39	<1%	\$63,291
Total*	\$869,776,299	124,078	87%	\$7,009

* NH Medicaid expenditures totaled \$1.22 billion in SFY 2007. The figures in this table cover payments to providers based on dates of service from July 1, 2006 through June 30, 2007. The figures in this table do not include expenditures for administration, cost settlements, rebates, and other types of non-claim payments.

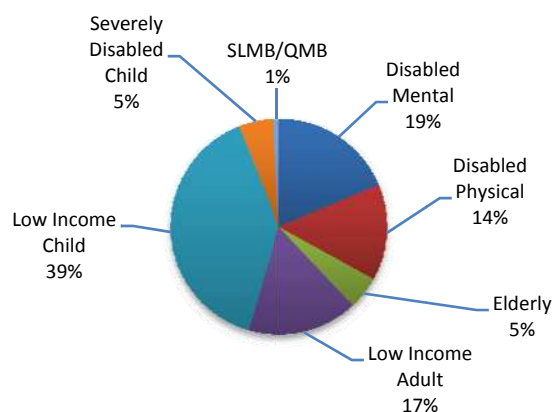
Source: NH DHHS, OMBP

Payments by Eligibility Category

Spending on acute care* services is driven by the health needs of children and members with disabilities. Children contribute 44% of spending on acute care services, with low income children accounting for 39% and severely disabled children an additional 5% (Figure 11). Members with disabilities account for another 33%, 19% for members with mental disabilities, and 14% for those with physical disabilities. Low income adults (17%), the elderly (5%) and QMB/SLMB (1%) account for the remainder.

Figure 11: NH Medicaid Spending for Acute Care Services by Eligibility Category, SFY 2007

Total Acute Care Spending \$338,265,192

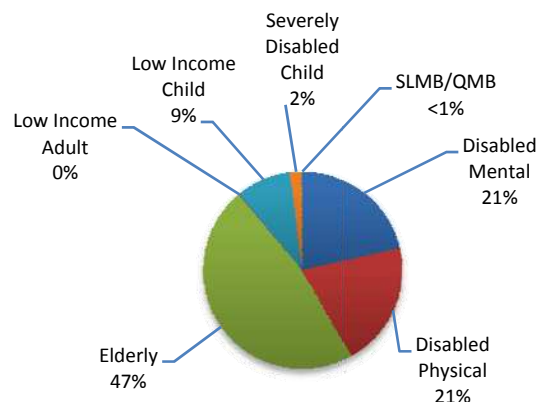


Source: NH DHHS, OMBP

In contrast spending on long-term care services† is driven by the elderly (47%) and members with disabilities (41%), 21% for those with mental disability and 20% for those with physical disability (Figure 12). Children using private non-medical institutions (PNMIs) account for the remaining spent for long term care.

Figure 12: NH Medicaid Spending for Long-Term Care Services by Eligibility Category, SFY 2007

Total Long Term Care Spending \$461,377,695



Source: NH DHHS, OMBP

Spending on prescription drugs is more broadly distributed; however, members with disabilities still constitute the largest proportion at 43%, 23% for those with physical disability and 20% for those with mental disability (Figure 13). The elderly account for 4% of prescription drug expenditures. Children contributed another 36%, 32% for low income children and 4% for children with severe disabilities. Low income adults accounted for the remaining 17%.

The Medicare prescription drug coverage (Part D) began on January 1, 2006 and now pays for drugs for the elderly and some people with disabilities.* In return for covering the drug costs for those who are receiving Medicaid and Medicare, all states are required to make State Phase Down Contributions back to Medicare. These “clawback” payments reflect the cost savings to Medicaid programs. In FY 2007, New Hampshire paid \$26,810,366 back to the federal government. These figures are not included here as Medicaid prescription drug payments.

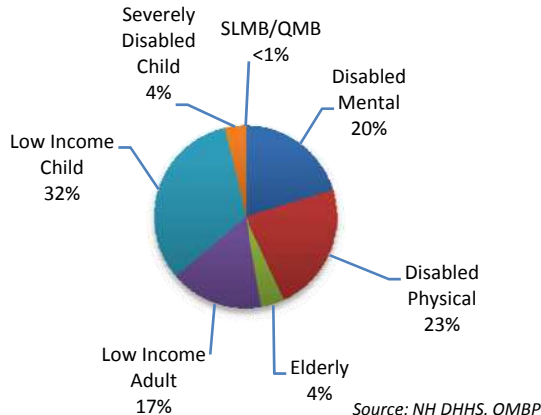
* Acute care includes behavioral health, inpatient and outpatient hospital, physician, other professional, dental, vision, DME, transportation and other services.

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

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

Figure 13: NH Medicaid Spending for Prescription Drugs by Eligibility Category , SFY 2007

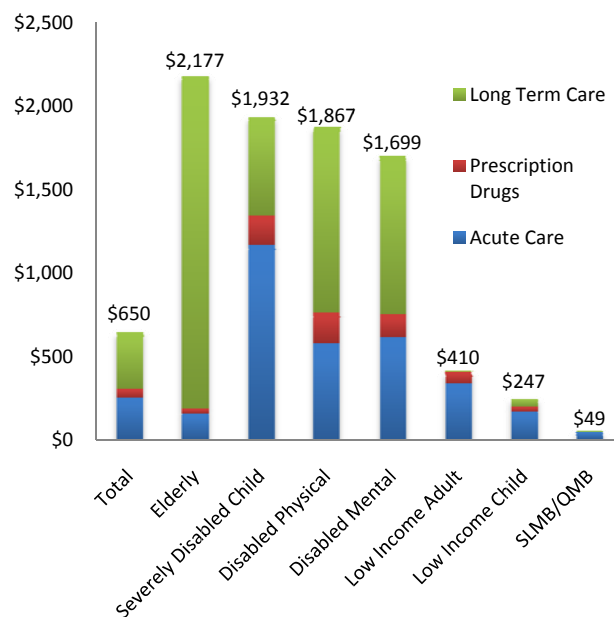
Total Prescription Drugs \$70,133,412



NH Medicaid spending varies widely by eligibility category. On average, NH Medicaid spent \$650 per member per month for services in SFY 2007. However, there is a ten-fold difference in spending per member per month (PMPM) by full benefit eligibility groups.[†] PMPM spending varies from \$247 PMPM for low income children to \$2,177 for the elderly. Figure 14 displays PMPM spending for members (SLMB/QMB per month spending is related to premium payments Medicaid pays for members to receive Medicare coverage, and if applicable, co-payments and deductibles.). Low income children and adults have the lowest PMPMs, largely driven by acute care spending. The children with severe disabilities' PMPM was \$1,932 driven by both acute and long-term care spending. Long-term care spending is the primary driver of PMPM spending for adults with disabilities and the elderly. Adults with physical disabilities PMPM was \$1,867, slightly higher than adults with mental disabilities at \$1,699. (For a complete listing of PMPM spending by service categories for each eligibility category see Appendix 5. A complete listing of Medicaid provider payments, enrollment and PMPMs by town is listed in Appendix 6.)

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

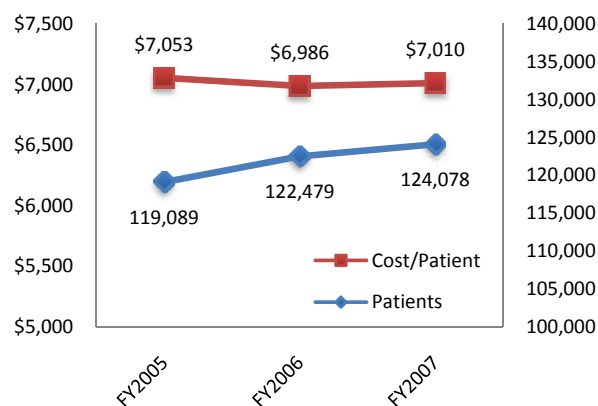
Figure 14: NH Medicaid per Member per Month Spending by Eligibility Groups, SFY 2007



Trends in Medicaid Service Spending

NH Medicaid services that drive most provider spending costs—long-term care, hospital inpatient and outpatient—have increased in both utilization and unit costs. Additionally total enrollment has increased. Overall total spending for NH Medicaid services increased 3.6% from 2005 to 2007, while per patient costs have decreased slightly by 0.6%. Cost trends are highlighted below (Appendix 4a contains a detailed listing of costs for services from SFY 2005 thru 2007).

Figure 14: NH Medicaid Costs per Patient and Number of Patients, per Member per Month Spending by Eligibility Groups, SFY 2005-2007



Long-Term Care Cost Trend: Home and community based care (HCBC) services increased, providing care to 19.1% more chronically ill and elderly and 7.8% more developmentally impaired members. Accordingly, HCBC costs for these two groups increased 45.9% and 12.9% respectively. Private non-medical institution (PNMI) services for children saw an increase in use of 3.1%, while costs increased 11.1%, with annual per patient costs increasing 7.8%. As a result of increased use of HCBC services, nursing home intermediate care level facility services decreased (2.3%) in number of members served, however, total payments increased 7.3% while costs per person increased 9.8%.

Hospital Cost Trend: The number of members using general hospital inpatient and outpatient services increased about 10% each. Hospital inpatient (16.3%) and outpatient (13.2%) costs also increased, resulting in a 5.7% increase per patient for inpatient services and 2.2% increase per patient for outpatient services.

Mental Health Center Cost Trend: Mental health centers served 8.4% more members in 2007 compared with 2005, while total costs rose 12.9%, but only 2.3% per patient.

Physician Services Cost Trend: Physicians served 7.2% more members in 2007 compared with 2005, while total costs rose 25.6%, or 17.3% per patient.

Pharmacy Cost Trend: While members using prescriptions drugs increased (3.4%), the total dollars spent decreased (20.0%) due to Medicare covering prescriptions for duals as of January 2006.

Dental Cost Trend: Members receiving dental services increased 14.1%, with an 11.9% increase in spending, but a 2% decline in per patient costs.

Tracking Access, Quality and Outcomes

The state of NH, through its Medicaid program, has made a significant impact on providing health insurance coverage to vulnerable populations, particularly low income children. In 2006, 23% of NH's families had incomes of \$30,000 or less. Eleven percent of NH's population remained uninsured in 2006, 5% less than the national rate of 16% uninsured*. Along with providing coverage, NH Medicaid must assure that members have access to health services and are provided quality care. The Office of Medicaid Business and Policies, New Hampshire Comprehensive Health Care Information System (NH CHIS) project has developed a series of metrics based on Health Care Effectiveness Data and Information Set (HEDIS) specifications to assist NH Medicaid with monitoring access, quality and outcomes of care. HEDIS measures can be compared to national HEDIS averages for Medicaid managed care programs compiled by the National Committee for Quality Assurance†. For this report, comparative data from the Medicaid HEDIS averages for 2006 are used.

Access

Primary care services are important to assuring access to appropriate medical care. Children and adolescents' access to primary care practitioners‡ is a NCQA HEDIS measure. NCQA HEDIS measures the percentage of children age 12 through 24 months old and 25 months through 6 years old, with at least one primary care practitioner visit during the current year (one year measure), and the percentage of children 7

* Source: Health Insurance Coverage of the Total Population, states (2005-2006), U.S. (2006) <http://www.statehealthfacts.kff.org/> (06/2007).

† NH CHIS quality metrics reported in this report are based on the NCQA HEDIS design specifications: HEDIS 2007, Technical Specifications, Volume 2. National Committee for Quality Assurance. 2006. www.ncqa.org. However, specifications for the NH CHIS quality metrics vary from those used to calculate the HEDIS National averages in that provider services billed under hospital outpatient services related to office or clinic based care are included, as are NH Medicaid codes for NH rural health centers, federally qualified health centers, and hospital-facility-based primary care clinics. Additionally, National metrics are based on calendar year reporting, while this report uses the State's fiscal year (7/1/06-6/30/07).

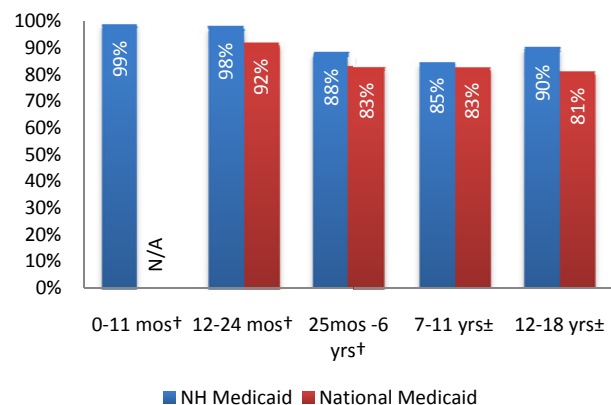
‡ Primary care include clinics, rural health centers, physicians with specialties Family/General Practice, General Internal Medicine, Pediatrics, Nurses and Physician Assistants. Additionally for the Adolescent Well Care measures, Obstetricians and Gynecologists are also considered.

through 11 years old and 12 through 19 years old with at least one visit during the current or prior year (two year measure). Measures of use of primary care services for children, adolescents, and adults have been developed by NH CHIS. NH CHIS has added a measure for infants through 11 months of age and the age group 12–19 years was modified to 12–18 years for consistency with the definition of children (0–18) used in all other NH CHIS reporting. All measures were based on children continuously enrolled during the year (zero or one month gap in coverage during study period); 60% of children were continuously enrolled in SFY 2007. The HEDIS access to primary care practitioners measure is not a measure of preventive service; the visits reported include both visits for preventive services and visits for medical illness and other problems.

In SFY 2007, 99 and 98% of children in their first eleven months and in their second year had at least one visit to a primary care provider. Eighty-five percent of children from age 25 months to six years had at least one primary care visit (Figure 14). There is no national HEDIS average for children in the first year, however, for other age groups NH Medicaid children were above the 2006 national HEDIS average for children.

For children age seven and older, the HEDIS measure criteria are at least one primary care visit in the past two years. Eighty-five percent of children age 7 to 11 had at least one primary care visit in the past two years, while 90% of children age 12 to 18 had at least one primary care visit. Similar to the younger children, these rates exceed the national averages of 83% and 81% respectively.

Figure 14: Percent of Children Receiving a Primary Care Visit During the Year by Age Group, SFY 2007



Source: NH DHHS, OMBP, NH CHIS

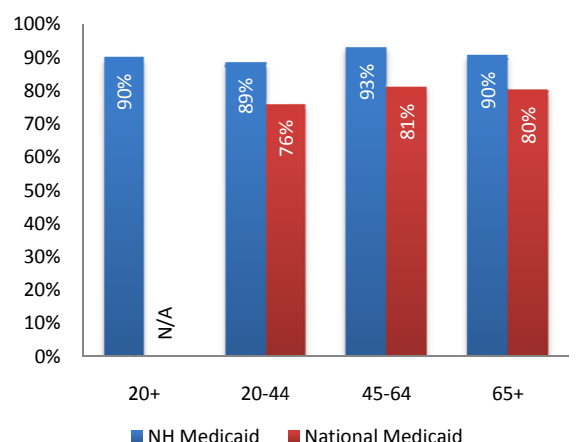
† Primary care visit in the past year.

± Primary care visit in the past two years.

Adult members also have better access to preventive health services than observed in the national averages, with 90% receiving a preventive service during SFY 2007. Members age 45 to 64 had the highest access rate with 93% accessing preventive health services followed closely by members age 65 and over at 90%. Adults age 20 to 44 had the lowest percentage of access at 89%—however, all age groups exceeded the 2006 national Medicaid audited NCQA HEDIS preventive health services rates (Figure 15). Adult members who are Medicaid-only* and have continuous eligibility are considered in this measure.

Figure 15: Adults' Access to Preventive/ Ambulatory Health Services by Age Group, SFY2007

Medicaid-Only Members



Source: NH DHHS, OMBP, NH CHIS

Use of Preventive Services

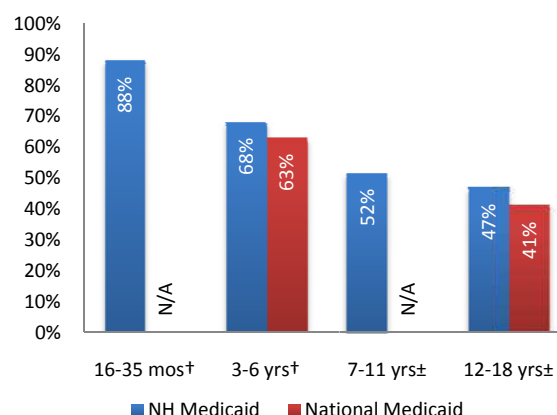
Use of preventive services such as well child visits, immunizations and routine screenings for children, adolescents and adults are designed to improve health status. Use of these services, particularly Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children is important to improving the overall health of NH Medicaid enrollees. Well-child visits are a NCQA HEDIS use of preventive service measure. These HEDIS measures are based on specific codes used to identify the visit as preventive in nature and, therefore, are distinguished from the access to primary care practitioner measure reported in the previous section. NCQA HEDIS reports a one-year measure for children age 3–6 years, a one-year measure for adolescent children age 12–19 years, and

* Due to incomplete claims experience, Medicaid members who are also covered by Medicare, referred to as dual eligibles, are not included in the calculation of HEDIS measures.

the distribution of visits during the first 15 months of life. A well-child measure for children age 16–35 months and children age 7–11 years was added, and the age 12–19 years measure was modified to 12–18 years for consistency with the definition of children used in NH CHIS reporting. All measures are based on continuously enrolled children during the year (zero or one month gap in coverage during study period).

Eighty-eight percent of children under the age of 3 in NH Medicaid received their scheduled well child visit in SFY 2007. Sixty-eight percent of children age 3 to 6 years and 52% of children age 7 to 11 years received their scheduled visits in the past two years, as did 47% of adolescents age 12 to 18 years. Two national averages exist on these measures, one for children aged 3 to 6 and one for adolescents. Both of these NH Medicaid age groups exceed the national averages (Figure 16). As with the access measure, only children continuously enrolled for the specified periods are included in these measures.

Figure 16: Percent of NH Medicaid Children With Well Child Visits by Age Group, SFY 2007



Source: NH DHHS, OMBP, NH CHIS

† Well child visit in the past year.

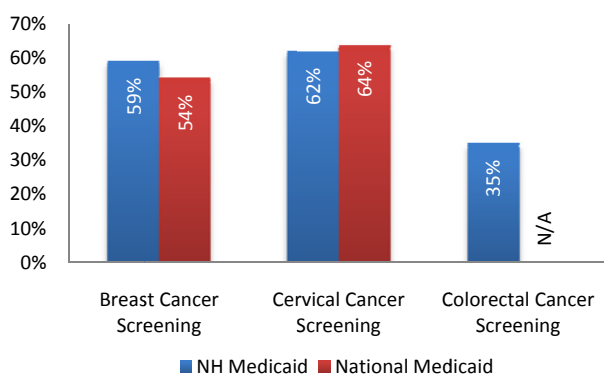
± Well child visit in the past two years.

Adult screenings for breast cancer and cervical cancer were consistent with National NCQA rates. Over half (59%) of female Medicaid-only members received a breast cancer screening and 62% received a cervical cancer screening. 2006 National NCQA average screening rates were 54% for breast cancer and 64% for cervical cancer (Figure 17). Screening provides women with earlier detection of breast cancer, allowing for more treatment options and better chance of survival. Women age 40 to 69 (N=2,927) are considered for this measure. As with breast cancer, early detection of cervical cancer is key to treatment and

survival. Women 21 to 64 are considered for this measure (N=9,483).

Colorectal cancer (CRC) is the second leading cause of cancer-related death in the United States. Unlike other screening tests that only detect disease, some methods can detect premalignant polyps and guide their removal, which may prevent the development of cancer. Colorectal screenings occurred in 35% of members. This measure assesses whether Medicaid-only adults 50-80 years of age (N=2,193) with continuous enrollment had the appropriate screening for CRC.

Figure 17: Adult Medicaid-Only Members with Preventive Screenings, SFY2007

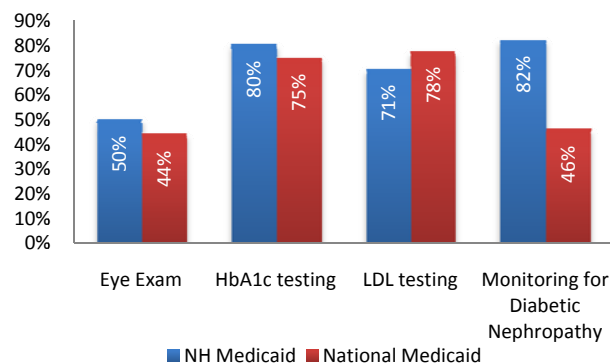


Source: NH DHHS, OMBP, NH CHIS

Diabetes accounts for nearly 20% of deaths in all persons over the age of 25. Diabetes is one of the most costly and highly preventable diseases. Complications, such as amputations, blindness, and kidney failure can be prevented with early detection. Adult Medicaid-only members with diabetes received comprehensive diabetic care at rates that were higher than that observed in the national NCQA reporting* (Figure 18). A high rate of monitoring for diabetic nephropathy was indicated: 82% of diabetics received this test in 2007 (changes to the measure definition did not allow for a national comparison). Glycosylated hemoglobin (HbA1c) testing at 80% was higher than the national average of 75%. Similarly, 50% of members with diabetes received an eye examination, higher than the nationally reported 44%. Only low-density lipoprotein (LDL) cholesterol testing at 71% was lower than the national average of 78%.

Figure 18: Comprehensive Diabetes Care New Hampshire, SFY2007

Diabetic Medicaid-Only Members



Source: NH DHHS, OMBP, NH CHIS

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

Appendices

<i>Appendix 1: Medicaid Program Expansions Since 1984</i>	<i>17</i>
<i>Appendix 2: Recent New Hampshire Laws Relative to Medicaid</i>	<i>21</i>
<i>Appendix 3: Provider Payment Rate Changes in SFY 2007</i>	<i>22</i>
<i>Appendix 4a: NH Medicaid Expenditures by Service Categories, SFY 2007 Service Dates</i>	<i>23</i>
<i>Appendix 4b: NH Medicaid Expenditures by Service Categories, SFY 2007 Paid Dates</i>	<i>25</i>
<i>Appendix 5: NH Medicaid Per Member Per Month Expenditures by Service Categories for Eligibility Groups, SFY 2007</i>	<i>27</i>
<i>Appendix 6: New Hampshire Medicaid Enrollment and Total Expenditures by New Hampshire Locations</i>	<i>28</i>

Appendix 1: Medicaid Program Expansions Since 1984

Implementation Date	Program Expansion	Reason
10/1/84	Establishment of a mandatory group of qualified pregnant women and children under age 5 whose coverage was to be phased in over a 5 year period and a mandatory eligibility group of newborn children of Medicaid-eligible women.	Federal Mandate – Deficit Reduction Act of 1984 (DEFRA 84)
7/1/86	Amended the qualified pregnant women eligibility group by requiring States to provide Medicaid to any pregnant woman who met the AFDC income and resource requirements regardless of family structure.	Federal Mandate – Consolidated Omnibus Reconciliation Act of 1985 (COBRA 85)
7/1/87	Individuals who are approved under the provisions of Section 1916 of the SSA and who are eligible for Medicaid the month prior to such approval, remain automatically eligible for Medicaid until SSA changes their status.	Federal Mandate – Employment Opportunities for Disabled Americans Act (EODAA)
1/1/89	New coverage group - children with severe disabilities	State Mandate (RSA 167:3-c VI)
1/2/89	Payment of co-insurance, deductibles and Medicare premiums for qualified Medicare beneficiaries (QMB)	Federal Mandate Medicare Catastrophic Coverage Act of 1988 (MCCA)
5/31/89	Change In & Out spend down period from six months to one month. Result is smaller spend downs that are easier for clients to meet	State Initiative - settlement re: Bishop v. Mongan
7/1/89	Medical Assistance (MA) for pregnant women and infants under one year of age with income at 75% of the FPL	Federal Mandate MCCA
7/3/89	New coverage group - home care for children with severe disabilities (Katie Beckett)	State Mandate (RSA 167:3-c IV)
9/30/89	Protection of income and resources of the spouse of an institutionalized individual.	Federal Mandate MCCA
10/1/89	Elimination of eligibility penalty for property transfers of less than fair market value - for MAO cases.	Federal Mandate MCCA, Family Support Act of 1988 (FSA)
1/1/90	Use SSI income and resource methodology for QMB cases	Federal Mandate (OBRA 89)
1/1/90	Cover services provided by Federally Qualified Health Centers (FQHCs)	Federal Mandate (OBRA 90)
4/1/90	Allow old medical expenses as deductions in determining eligibility for In & Out medical assistance	Federal Mandate - existing (compliance issue)
4/1/90	Increase in income limit for pregnant women and children under the age of six to 133% FPL	Federal Mandate (OBRA 89)
4/1/90	Twelve month extended medical assistance for AFDC cases that lose eligibility due to employment	Federal Mandate (FSA)
7/1/90	Buy-in of Medicare Part A premium for working disabled with income under 200% FPL	Federal Mandate (OBRA 90)
10/1/91	New coverage group, AFDC unemployed parent	Federal Mandate: 45 CFR 233.101, Social Security Act, Section 407
1/1/91	Medical assistance for one year to a child born to a woman who is eligible for and receiving MA at the time of birth if the child continues to live with the mother and the mother remains eligible or would remain eligible for MA if still pregnant	Federal Mandate (OBRA 90)
1/1/91	Provide medical assistance to children under the age of 22 who are residing in designated receiving facilities	State initiative - to enhance state dollars by obtaining 50% federal financial participation
4/1/91	Reduction in VA benefits to a maximum of \$90 for individuals in nursing homes who have no dependents	Federal Mandate (OBRA 90)

Implementation Date	Program Expansion	Reason
7/1/91	Coverage of children born after 9/30/83 with income up to 100% federal poverty level. To be phased in up to age 19	Federal Mandate (OBRA 90)
10/21/91	Exclude SSA income and resource accounts set up under Plan for Achieving Self Support	State initiative - out of court settlement with NH Legal Assistance
5/11/92	Resource offset for life insurance. Adult categories of financial and medical assistance	State initiative - Favreau v. Department of Human Services Consent Decree
7/1/92	Increase income limit for poverty level pregnant women and children under age one from 133% federal poverty level to 150% federal poverty level	State Mandate (SB 319)
12/1/92	Allow a one month - six month option for In & Out spend down cases	State Initiative (to avoid litigation)
1/1/93	Payment of Medicare Part B premiums for specified low income Medicare beneficiaries (SLMBs)	Federal Mandate (OBRA 90)
8/10/93	Certain trusts established for the benefit of disabled individuals are exempt resources for Medicaid eligibility determinations.	Federal Mandate (OBRA 93)
12/1/93	Use SSI earned income disregards for APTD applicants and recipients. Use SSI definition of disability to determine medical eligibility for APTD applicants and recipients	State Mandate (HB-2-FN)
1/1/94	Increase income limits for poverty level groups (pregnant women, children born after 9/30/83) to 170% federal poverty level, initial processing of MA cases through clinics expanded	State Mandate (SB 209)
7/1/94	Use of shortened application form, presumptive eligibility for poverty level pregnant women who apply through prenatal clinics	State Initiative
7/1/94	Increase income limits for poverty level groups to 185% of the federal poverty level. Also expand coverage of children to through age 18	State Mandate (SB 774)
1/1/95	Increase income limits for specified low income Medicare beneficiaries to 120% federal poverty level	Federal Mandate (OBRA 90)
5/1/96	Conversion from "full-month" Medicaid coverage (if the individual is eligible at anytime during the month, the individual is eligible for the whole month) to date specific eligibility.	State Initiative
2/1/97	Welfare Reform - For TANF-related MA: except for PL cases, change employment expense disregard from \$90/mo to 20% of gross income; exclude one vehicle per household; elimination of the equity value of life insurance as a resource; and elimination of the "3 of the last 6 month" criterion for EMA eligibility any time financial assistance closes due to increased earned income.	State Initiative
1/1/98	Payment of Medicare Part B premiums for specified low income Medicare beneficiaries whose income is higher than 120% of the Federal poverty level but less than or equal to 135% of the Federal poverty level and who are not receiving MA.	Federal Mandate (Balanced Budget Act of 1997)
1/1/98	Partial payment of Medicare Part B Premiums for specified low income Medicare beneficiaries whose income is higher than 135% of the Federal poverty level but less than or equal to 175% of the Federal poverty level and who are not receiving MA.	Federal Mandate (Balanced Budget Act of 1997)

Implementation Date	Program Expansion	Reason
1/1/98	Increase in the nursing facility income cap to \$1,250. The change in income limit effected nursing facility eligibility and eligibility for all home and community-based care programs.	Mandated by the language in the HCBC-ECI waiver, which stated that the income limit for the HCBC-ECI was a certain percentage of the State Supplementary Income maximum payment level.
5/1/98	Increase the income limit for infants under age one who are not covered by other health insurance and whose family income is higher than 185% of the Federal poverty level but less than or equal to 300% of the Federal poverty level.	State Initiative
7/1/99	Increase in the substantial gainful activity (SGA) income criterion from \$500 to \$700 per month. The State is required to use SSI earned income disregards for APTD applicants and recipients.	State Mandate (Chp. 225, NH laws of 1999; and 20 CFR 404.1574(b)(2), (3), and (4), and 416.974(b)(2), (3), and (4))
8/1/99	Increase in the monthly personal needs allowance from \$40 to \$50 for residents of nursing facilities, community residences and residential care facilities.	State Mandate (RSA 167:27-a)
8/1/99	Increase in the NHEP/FAP maximum shelter allowance from \$243 to \$268 subsequently changed the NHEP/FAP SON as well as the PIL for group sizes 2 or more by \$25.	State Initiative
4/1/00	Increase in the NHEP/FAP maximum shelter allowance subsequently changed the NHEP/FAP SON by \$25.	State Initiative
8/1/00	Allow 50% earned income disregard for TANF cat needy; increase cat needy resource limit to \$2000	State Initiative
8/1/00	Extend 12 month EMA to TANF cat needy cases closed due to increased income or hours of employment	State Initiative
10/1/00	Revised earned income computation for OAA, QMB, SLMB, SLMB135, SLMB175, and QWDI to use the SSI methodology. Eliminated the employment expense disregard for all adult eligibility determinations.	State Initiative
1/1/01	Formula established to automatically increase the significant gainful activity (SGA) level annually. As a result of the formula, the SGA level was increased from \$700 to \$740.	Federal Mandate (20 CFR 416.974 (b)(2)(ii)(B))
1/1/01	Removed language, which made spouses legally liable for their spouses and parents legally liable for their children in determining Medicaid eligibility. Federal mandates still apply.	State Mandate (RSA 167:3-b)
3/1/01	New coverage group - Women diagnosed with breast or cervical cancer (or a pre-cancerous condition) by the Breast and Cervical Cancer Prevention program.	State Initiative
2/1/02	New Coverage group - Medicaid for Employed Adults with Disabilities - MEAD	State Mandate (RSA 167:6; TWWIIA)
4/03 – 6/03	State Medicaid matching rates raised by 2.95 % from 4/03 thru 6/04 as temporary federal fiscal relief for the states due to a economic downturn, to counteract declines in state revenue collections at the same time Medicaid program were facing increased enrollments.	Federal Mandate (Jobs and Growth Tax Relief Reconciliation Act of 2003)
2003	Established new Medicare Part D prescription drug program. Medicaid drug coverage for dual eligibles, those who qualify for both Medicaid and Medicare, transferred to Medicare as of Jan. 1, 2006. States are required to make monthly “claw-back” payments to Medicare, reflecting savings in Medicaid drug expenditures.	Federal Mandate Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
2004	Implemented Preferred Drug List (PDL) and supplemental rebate program for Medicaid prescription drug program.	State Initiative

Implementation Date	Program Expansion	Reason
2004	Developed and implemented Medicaid Decision Support System (MDSS).	State Initiative
3/ 2005	Implemented Medicaid Health Management Program to provide high quality, cost-effective disease management care for Medicaid participants with chronic illnesses.	State Initiative
5/2005	Secretary of HHS appoints advisory Medicaid Commission to recommend ways to modernize Medicaid. The Commission is charged with preparing a report on cost savings and another report on longer-term sustainability recommendations.	Federal Initiative
7/2005	Medicaid will provide wraparound coverage for the several classes of drugs excluded from Medicare Part D coverage.	State Initiative (Chp. 294:2, NH Laws of 2005)
7/2005	Enactment of care management pilot program to support the efficient and effective delivery of primary and specialty care services focused on prevention and each client having a medical home.	State Initiative (Chp. 177:123, NH Laws of 2005)
8/2005	Medicaid Commission releases first report, with recommendations to reduce Medicaid spending growth by \$11 billion over the next five years while working toward longer-term program changes to better serve beneficiaries.	Federal Initiative
2005-2006	Developed and implemented plan for preparation and start-up of Medicare Part D prescription drug program, covering all education, outreach and systems activities to transition all duals eligibles (had both Medicaid and Medicare) to new program.	State Initiative – see MMA above
2/2006	Federal provisions to reduce the rate of federal and state Medicaid spending growth through new flexibility on Medicaid premiums, cost sharing and benefits, along with tighter controls on asset transfers to qualify for long-term care.	Federal Initiative & Mandate - Deficit Reduction Act of 2005 (DRA)
11/2006	Medicaid Commission releases second report, with recommendations for long-term Medicaid reforms. Focused on improving health of beneficiaries through a more efficient Medicaid system.	Federal Initiative

Appendix 2. Recent New Hampshire Laws Relative to Medicaid

The following recently enacted New Hampshire laws impacted NH Medicaid activities during SFY 2007.

- Established a committee to study NH Medicaid reimbursement rates for pharmacy providers with support from DHHS. (Chp. 73, NH Laws of 2005, extended by Chps. 155, 252 and 253, NH Laws of 2006).
- Authorized DHHS to establish and implement a care management pilot program that supports the efficient and effective delivery of primary and specialty care services focused on prevention and each client having a medical home. (Chp. 177:123, NH Laws of 2005).
- Through package of legislation, strengthened provisions encouraging elders needing long term care to choose home and community-based care, tightened Medicaid eligibility for long term care by increasing the “look-back” period for non-qualifying asset transfers from three to five years, added financial incentives to encourage purchase of long term care insurance, and clarified provisions enabling recovery of Medicaid payments from a long term care recipient’s estate. (Chp. 177:159-182, NH Laws of 2005).
- Appropriated funds and authorized DHHS to make payments to the federal Centers for Medicare and Medicaid Services required under the Medicare Part D state phased-down contribution, known as “clawback.” (Chp. 1, NH Laws of 2006).
- Appropriated funds and authorized DHHS to provide supplemental assistance for the purchase of prescription drugs to persons eligible for both NH Medicaid and Medicare who were having difficulty during the required transition to Medicare Part D coverage. (Chp. 2, NH Laws of 2006).
- Authorized reimbursement under special circumstances for parents who provide personal care to a minor child with special health care needs residing at home. (Chp. 132, NH Laws of 2006).
- Made changes to the consideration of assets for long-term care, as required by the federal Deficit Reduction Act. Clarified the treatment of assets in cases of undue hardship and how investments in annuities were treated. Also provided that qualifying long-term care insurance policies would be disregarded as assets. (Chp. 278, NH Laws of 2006).
- Required Fiscal Committee approval before DHHS could provide additional funds to the Healthy Kids Silver Program during FY 2007 and required a biennial contract (after July 1, 2007) for the administration of the state children’s health insurance program. (Chp. 299, NH Laws of 2006).

Appendix 3: Provider Payment Rate Changes in SFY 2007

Rate Description	Change
Home Care Rate Increase	Increased rate by 4.6%
Wheelchair Transportation	Increased rate by 4.6%
Vaccine Codes	Increase from old rates of \$47.50 - \$87.16 to the new rates of \$111.61 - \$113.79

Appendix 4a: NH Medicaid Expenditures by Service Categories, SFY 2007 Service Dates

Note: Sorted by SFY 2007 Total Cost

Category of Service	FY 2005			FY 2006			FY 2007			Percent Change 2005 to 2007		
	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient
Intermediate Care Facility Nursing Home	6,570	\$179,290,021	\$27,289.20	6,459	\$184,654,835	\$28,588.77	6,419	\$192,405,238	\$29,974.33	-2.3%	7.3%	9.8%
Home & Community Based Care, Developmentally Impaired	3,261	\$137,213,538	\$42,077.14	3,388	\$145,900,409	\$43,063.88	3,514	\$154,957,332	\$44,097.13	7.8%	12.9%	4.8%
Mental Health Center	16,819	\$75,027,414	\$4,460.87	17,556	\$78,557,028	\$4,474.65	18,224	\$83,128,982	\$4,561.51	8.4%	10.8%	2.3%
Dispense Prescribed Drugs	91,644	\$133,299,203	\$1,454.53	92,931	\$103,520,144	\$1,113.95	87,075	\$70,133,412	\$805.44	-5.0%	-47.4%	-44.6%
Outpatient Hospital, General	68,573	\$58,816,193	\$857.72	74,279	\$59,794,752	\$805.00	75,970	\$66,574,057	\$876.32	10.8%	13.2%	2.2%
Inpatient Hospital, General	14,544	\$46,481,442	\$3,195.92	15,612	\$51,132,598	\$3,275.21	16,011	\$54,065,977	\$3,376.80	10.1%	16.3%	5.7%
Physicians Services	90,329	\$33,571,404	\$371.66	94,033	\$38,537,681	\$409.83	96,796	\$42,181,488	\$435.78	7.2%	25.6%	17.3%
Home & Community Based Care, Elderly & Chronically Ill	2,744	\$26,427,923	\$9,631.17	2,940	\$31,338,417	\$10,659.33	3,269	\$38,546,944	\$11,791.66	19.1%	45.9%	22.4%
Clinic Services	8,716	\$29,799,466	\$3,418.94	8,924	\$32,124,574	\$3,599.80	8,745	\$31,956,840	\$3,654.30	0.3%	7.2%	6.9%
Private Non-Medical Institutional For Children	1,221	\$20,556,999	\$16,836.20	1,299	\$23,783,088	\$18,308.77	1,259	\$22,846,207	\$18,146.31	3.1%	11.1%	7.8%
Dental Service	37,157	\$13,809,131	\$371.64	40,575	\$15,096,272	\$372.06	42,411	\$15,445,986	\$364.20	14.1%	11.9%	-2.0%
Rural Health Clinic	20,609	\$9,439,626	\$458.03	21,419	\$10,391,648	\$485.16	21,817	\$10,789,841	\$494.56	5.9%	14.3%	8.0%
Furnished Medical Supplies Or Durable Medical Equipment	14,068	\$9,023,258	\$641.40	12,176	\$9,205,383	\$756.03	12,801	\$10,191,935	\$796.18	-9.0%	13.0%	24.1%
Skilled Nursing Facility Nursing Home	2,635	\$6,845,358	\$2,597.86	2,790	\$8,329,811	\$2,985.60	2,778	\$8,782,242	\$3,161.35	5.4%	28.3%	21.7%
Day Habilitation Center	2,090	\$6,154,523	\$2,944.75	2,196	\$6,811,367	\$3,101.72	2,400	\$7,716,872	\$3,215.36	14.8%	25.4%	9.2%
Home Health Services	2,865	\$7,267,681	\$2,536.71	2,960	\$6,861,904	\$2,318.21	2,836	\$7,087,274	\$2,499.04	-1.0%	-2.5%	-1.5%
Private Duty Nursing	133	\$5,856,445	\$44,033.42	132	\$6,107,447	\$46,268.54	122	\$6,960,712	\$57,055.02	-8.3%	18.9%	29.6%
Personal Care	204	\$4,800,056	\$23,529.69	178	\$4,781,274	\$26,861.09	176	\$5,246,505	\$29,809.69	-13.7%	9.3%	26.7%
SNF Nursing Home Atypical Care	45	\$4,187,814	\$93,062.52	54	\$4,938,802	\$91,459.31	56	\$4,675,267	\$83,486.91	24.4%	11.6%	-10.3%
Placement Services	150	\$3,061,783	\$20,411.89	164	\$3,490,657	\$21,284.49	196	\$4,155,045	\$21,199.21	30.7%	35.7%	3.9%
ICF Nursing Home Atypical Care	88	\$4,197,702	\$47,701.16	88	\$4,384,897	\$49,828.37	74	\$3,926,226	\$53,057.10	-15.9%	-6.5%	11.2%
Psychology	5,798	\$3,717,032	\$641.09	5,687	\$3,808,023	\$669.60	5,890	\$3,631,132	\$616.49	1.6%	-2.3%	-3.8%
Inpatient Psychiatric Facility Services Under Age 22	377	\$3,000,560	\$7,959.05	302	\$2,980,306	\$9,868.56	354	\$3,185,235	\$8,997.84	-6.1%	6.2%	13.1%
Wheelchair Van	2,832	\$2,491,184	\$879.66	2,802	\$2,563,651	\$914.94	2,651	\$2,869,407	\$1,082.39	-6.4%	15.2%	23.0%
ICF Services For The Mentally Retarded	30	\$2,402,656	\$80,088.54	35	\$2,383,396	\$68,097.02	39	\$2,468,361	\$63,291.31	30.0%	2.7%	-21.0%
Intensive Home And Community Services	93	\$812,778	\$8,739.55	136	\$1,528,719	\$11,240.58	186	\$2,315,238	\$12,447.51	100.0%	184.9%	42.4%
Home Based Therapy	586	\$1,900,442	\$3,243.08	514	\$1,701,161	\$3,309.65	585	\$2,176,328	\$3,720.22	-0.2%	14.5%	14.7%
Medical Services Clinic	1,482	\$1,026,403	\$692.58	1,607	\$1,462,656	\$910.18	1,789	\$2,043,178	\$1,142.08	20.7%	99.1%	64.9%
Ambulance Service	6,555	\$1,422,179	\$216.96	7,377	\$1,692,182	\$229.39	7,976	\$1,568,675	\$196.67	21.7%	10.3%	-9.4%
Laboratory (Pathology)	17,041	\$1,123,751	\$65.94	17,788	\$1,093,191	\$61.46	17,368	\$1,294,690	\$74.54	1.9%	15.2%	13.0%

	FY 2005			FY 2006			FY 2007			Percent Change 2005 to 2007		
Category of Service	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient	Patients	Total Cost of Coverage	Cost Per Patient
Child Health Support Service	455	\$1,148,714	\$2,524.65	385	\$1,147,643	\$2,980.89	378	\$1,182,847	\$3,129.22	-16.9%	3.0%	23.9%
Optometric Services Eyeglasses	21,907	\$1,479,112	\$67.52	23,035	\$1,659,324	\$72.03	17,180	\$1,046,251	\$60.90	-21.6%	-29.3%	-9.8%
Physical Therapy	1,400	\$754,639	\$539.03	1,497	\$835,560	\$558.16	1,665	\$902,721	\$542.17	18.9%	19.6%	0.6%
Adult Medical Day Care	296	\$1,176,962	\$3,976.22	242	\$1,025,187	\$4,236.31	185	\$885,258	\$4,785.18	-37.5%	-24.8%	20.3%
Family Planning Services	1,839	\$639,246	\$347.60	1,736	\$499,142	\$287.52	1,785	\$537,555	\$301.15	-2.9%	-15.9%	-13.4%
Advanced Registered Nurse Practitioner	1,884	\$362,229	\$192.27	1,666	\$332,577	\$199.63	2,053	\$435,885	\$212.32	9.0%	20.3%	10.4%
I/P Hospital Swing Beds, Snf	90	\$474,080	\$5,267.56	97	\$309,516	\$3,190.88	76	\$367,149	\$4,830.90	-15.6%	-22.6%	-8.3%
X-Ray Services	795	\$57,139	\$71.87	968	\$68,275	\$70.53	2,328	\$283,783	\$121.90	192.8%	396.7%	69.6%
Occupational Therapy	342	\$212,840	\$622.34	368	\$233,119	\$633.48	423	\$217,564	\$514.34	23.7%	2.2%	-17.4%
Podiatrist Services	2,585	\$159,439	\$61.68	2,977	\$175,539	\$58.96	3,320	\$194,892	\$58.70	28.4%	22.2%	-4.8%
Crisis Intervention	6	\$192,349	\$32,058.24	7	\$191,518	\$27,359.70	11	\$120,686	\$10,971.43	83.3%	-37.3%	-65.8%
Speech Therapy	109	\$70,901	\$650.47	115	\$83,399	\$725.21	133	\$92,320	\$694.14	22.0%	30.2%	6.7%
Certified Midwife (Non-Nurse)	56	\$49,873	\$890.59	71	\$60,399	\$850.69	80	\$68,650	\$858.13	42.9%	37.7%	-3.6%
Chiropractic	861	\$61,798	\$71.78	882	\$58,928	\$66.81	970	\$62,136	\$64.06	12.7%	0.5%	-10.8%
Audiology Services	709	\$38,075	\$53.70	767	\$40,568	\$52.89	669	\$34,160	\$51.06	-5.6%	-10.3%	-4.9%
I/P Hospital Swing Beds, lcf	8	\$37,841	\$4,730.09	11	\$19,411	\$1,764.62	11	\$14,544	\$1,322.15	37.5%	-61.6%	-72.0%
Outpatient Hospital, Mental	11	\$2,860	\$259.99	3	\$2,169	\$723.06	13	\$3,275	\$251.90	18.2%	14.5%	-3.1%
Disability Determination Service	3	-\$245	-\$81.67	-	\$0	\$0.00	-	\$0	\$0.00	-100.0%	-100.0%	-100.0%
TOTAL*	119,089	\$839,941,816	\$7,053.06	122,479	\$855,698,545	\$6,986.49	124,078	\$869,776,299	\$7,009.92	4.2%	3.6%	-0.6%

*Difference from \$1.22 Billion for SFY 2007 due to provider spending for services with dates of services (7/1/2006-6/30/2007); does not reflect administrative, cost settlements, rebates or other off-claim payments

Appendix 4b: NH Medicaid Expenditures by Service Categories, SFY 2007 Paid Dates

Category of Service	Total Cost of Coverage
Intermediate Care Facility Nursing Home	\$192,302,606
Home & Community Based Care, Developmentally Impaired	\$155,564,269
Mental Health Center	\$83,151,821
Dispense Prescribed Drugs	\$69,329,665
Nursing Facility Supplemental	\$67,453,660
Outpatient Hospital, General	\$66,863,869
Inpatient Hospital, General	\$57,792,442
Physicians Services	\$42,991,462
Home & Community Based Care, Elderly & Chronically Ill	\$37,813,208
Clinic Services	\$36,330,262
Private Non-Medical Institutional for Children	\$23,314,396
Dental Service	\$15,575,670
Rural Health Clinic	\$10,706,699
Furnished Medical Supplies or Durable Medical Equipment	\$10,543,649
Skilled Nursing Facility Nursing Home	\$9,164,695
Day Habilitation Center	\$7,630,454
Home Health Services	\$7,079,910
Private Duty Nursing	\$7,039,430
Personal Care	\$5,157,234
SNF Nursing Home Atypical Care	\$4,558,607
ICF Nursing Home Atypical Care	\$4,158,106
Placement Services	\$4,007,326
Psychology	\$3,733,559
Inpatient Psychiatric Facility Services Under Age 22	\$3,515,346
Wheelchair Van	\$2,910,803
ICF Services for the Mentally Retarded	\$2,459,649
Intensive Home and Community Services	\$2,261,225
Home Based Therapy	\$2,094,593
Medical Services Clinic	\$1,870,580
Ambulance Service	\$1,525,878
Laboratory (Pathology)	\$1,370,512
Child Health Support Service	\$1,149,576
Optometric Services Eyeglasses	\$1,081,188
Physical Therapy	\$940,361
Adult Medical Day Care	\$898,862
Family Planning Services	\$567,974
Advanced Registered Nurse Practitioners	\$421,202
I/P Hospital Swing Beds, SNF	\$319,377
Occupational Therapy	\$230,997
X-Ray Services	\$218,086
Podiatrist Services	\$203,226
Crisis Intervention	\$113,140
Speech Therapy	\$90,828
Certified Midwife (Non-Nurse)	\$74,349
Chiropractic	\$61,469
Inpatient Hospital, Mental	\$46,116
I/P Hospital Swing Beds, ICF	\$37,791
Audiology Services	\$35,559
Outpatient Hospital, Mental	\$3,019

Category of Service	Total Cost of Coverage
Subtotal - Provider Payments	\$946,764,704
Third Party Liability Carrier Refund Non-Claim Specific	-\$562,430
Insurance Premium Carrier System Payout	\$443,453
Provider Recoupment Non-Claim Specific	-\$368,086
Provider Recoupment Manual Adjustment	\$0
Provider Refund Non-Claim Specific	-\$2,924,992
Provider Refund Claim Specific	-\$98,974
Provider Return	\$0
Provider System Payout Non-Claim Specific	\$4,942,675
Recipient Refund Non-Claim Specific	-\$1,943,229
Subtotal - Non-claim Payments	-\$511,582
TOTAL*	\$946,253,122

* Total NH Medicaid expenditures totaled \$1.22 billion in SFY 2007. The figures in this table cover payments to providers and cost settlements, rebates, and other types of non-claim payments, based on payment dates from July 1, 2006 through June 30, 2007. The figures in this table do not include expenditures for administration.

Appendix 5: NH Medicaid Per Member Per Month Expenditures by Service Categories for Eligibility Groups, SFY 2007

Category of Service Groups	Total Medicaid Enrollment	Low income Adult	Low income Child	Severely Disabled Child	Disabled Mental	Disabled Physical	Elderly
HCBC	\$168.69	\$4.19	\$19.96	\$585.64	\$866.93	\$902.00	\$310.27
Nursing Facility	\$156.95	\$0.10	\$1.09	\$4.29	\$81.84	\$199.98	\$1,686.53
Prescription Drugs	\$52.37	\$70.15	\$28.53	\$173.94	\$136.88	\$188.36	\$26.40
Behavioral Health	\$64.88	\$25.02	\$36.60	\$157.06	\$396.51	\$67.89	\$38.34
Hospital Outpatient	\$49.72	\$112.05	\$26.24	\$47.69	\$73.53	\$162.48	\$33.26
Hospital Inpatient	\$42.75	\$74.61	\$23.93	\$60.77	\$65.58	\$159.91	\$35.50
Other Professional	\$36.15	\$42.20	\$29.08	\$764.32	\$21.91	\$46.33	\$3.63
Physician & Related	\$31.88	\$70.86	\$23.42	\$18.93	\$31.74	\$71.38	\$17.82
PNMI for Children	\$17.06	\$0.00	\$27.92	\$1.47	\$3.64	\$1.55	\$0.00
Dental Service	\$11.53	\$5.16	\$17.09	\$8.69	\$4.21	\$3.29	\$0.44
Vision & DME	\$8.39	\$4.07	\$3.81	\$105.70	\$10.15	\$43.30	\$9.31
Other	\$3.99	\$0.00	\$6.39	\$0.33	\$1.60	\$0.66	\$0.00
Transportation	\$3.31	\$1.93	\$0.58	\$1.93	\$4.20	\$16.68	\$15.81
Intermediate Care Facility - MR	\$1.84	\$0.00	\$2.77	\$1.31	\$0.00	\$2.79	\$0.00
Total	\$649.53	\$410.34	\$247.40	\$1,932.05	\$1,698.72	\$1,866.61	\$2,177.31

Appendix 6: New Hampshire Medicaid Enrollment and Total Expenditures by New Hampshire Locations

Location	Member Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Acworth	503	42	\$234,973	\$467.14
Alstead	2,314	193	\$1,264,397	\$546.41
Alton	3,858	322	\$1,856,050	\$481.09
Alton Bay	903	75	\$440,269	\$487.56
Amherst	2,988	249	\$2,326,938	\$778.76
Andover	1,425	119	\$480,919	\$337.49
Antrim	3,328	277	\$1,439,883	\$432.66
Ashland	2,903	242	\$1,226,125	\$422.36
Ashuelot	976	81	\$305,564	\$313.08
Atkinson	2,634	220	\$7,014,043	\$2,662.89
Auburn	2,464	205	\$1,762,372	\$715.25
Barnstead	1,342	112	\$580,012	\$432.20
Barrington	6,353	529	\$3,573,565	\$562.50
Bartlett	683	57	\$400,964	\$587.06
Bath	1,139	95	\$440,837	\$387.04
Bedford	6,850	571	\$9,142,227	\$1,334.63
Belmont	9,349	779	\$4,074,086	\$435.78
Bennington	1,306	109	\$644,145	\$493.22
Berlin	25,525	2,127	\$17,585,310	\$688.94
Bethlehem	3,382	282	\$1,914,407	\$566.06
Bow	3,783	315	\$9,144,268	\$2,417.20
Bradford	1,754	146	\$826,461	\$471.19
Bretton Woods	10	1	\$4,805	\$480.51
Bristol	6,816	568	\$2,956,629	\$433.78
Brookline	1,808	151	\$968,589	\$535.72
Campton	5,899	492	\$3,383,489	\$573.57
Canaan	2,947	246	\$1,502,217	\$509.74
Candia	2,278	190	\$1,506,834	\$661.47
Canterbury	1,375	115	\$784,065	\$570.23
Center Barnstead	3,440	287	\$1,112,195	\$323.31
Center Conway	3,649	304	\$5,057,153	\$1,385.90
Center Harbor	1,715	143	\$976,847	\$569.59
Center Ossipee	4,775	398	\$1,852,587	\$387.98
Center Sandwich	652	54	\$213,475	\$327.42
Center Strafford	99	8	\$24,927	\$251.79
Center Tuftonboro	1,256	105	\$388,381	\$309.22
Charlestown	7,457	621	\$4,035,728	\$541.20
Chester	2,136	178	\$1,215,209	\$568.92
Chesterfield	663	55	\$139,840	\$210.92
Chichester	952	79	\$493,625	\$518.51
Chocorua	1,053	88	\$310,272	\$294.65
Claremont	28,489	2,374	\$22,468,483	\$788.67

Location	Member Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Colebrook	6,147	512	\$4,058,112	\$660.18
Concord	64,568	5,381	\$75,791,363	\$1,173.82
Contoocook	2,366	197	\$1,166,624	\$493.08
Conway	8,010	668	\$3,498,390	\$436.75
Cornish	379	32	\$151,839	\$400.63
Cornish Flat	344	29	\$85,780	\$249.36
Danbury	1,676	140	\$753,380	\$449.51
Danville	2,375	198	\$946,684	\$398.60
Deerfield	2,872	239	\$1,317,088	\$458.60
Derry	27,706	2,309	\$14,741,911	\$532.08
Dover	30,698	2,558	\$22,240,928	\$724.51
Drewsville	223	19	\$117,436	\$526.62
Dublin	1,064	89	\$355,356	\$333.98
Dunbarton	1,332	111	\$877,095	\$658.48
Durham	3,304	275	\$1,666,593	\$504.42
East Andover	253	21	\$318,015	\$1,256.98
East Derry	208	17	\$100,011	\$480.82
East Hampstead	1,348	112	\$822,890	\$610.45
East Kingston	1,448	121	\$441,560	\$304.94
East Wakefield	1,818	152	\$459,697	\$252.86
Eaton Center	134	11	\$77,409	\$577.68
Effingham	1,670	139	\$970,554	\$581.17
Elkins	201	17	\$108,294	\$538.78
Enfield	3,290	274	\$2,094,992	\$636.78
Enfield Center	195	16	\$150,742	\$773.03
Epping	5,335	445	\$2,125,572	\$398.42
Epsom	5,089	424	\$3,554,459	\$698.46
Errol	335	28	\$119,300	\$356.12
Etna	129	11	\$180,878	\$1,402.16
Exeter	12,773	1,064	\$12,706,058	\$994.76
Farmington	11,772	981	\$4,549,358	\$386.46
Fitzwilliam	2,274	190	\$1,106,446	\$486.56
Francestown	732	61	\$477,109	\$651.79
Franconia	1,104	92	\$1,066,872	\$966.37
Franklin	18,648	1,554	\$9,383,004	\$503.16
Freedom	1,104	92	\$486,043	\$440.26
Fremont	1,846	154	\$1,326,350	\$718.50
Georges Mills	314	26	\$162,431	\$517.29
Gilford	5,129	427	\$2,864,519	\$558.49
Gilmanton	2,057	171	\$1,171,678	\$569.61
Gilmanton Iron Works	1,306	109	\$443,619	\$339.68
Gilsum	657	55	\$286,030	\$435.36
Glen	1,288	107	\$651,043	\$505.47
Glenclyff	918	77	\$6,129,205	\$6,676.69
Goffstown	8,122	677	\$7,587,008	\$934.13
Gorham	3,834	320	\$1,557,254	\$406.17

Location	Member Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Goshen	1,100	92	\$600,383	\$545.80
Grafton	1,612	134	\$615,587	\$381.88
Grantham	786	66	\$412,044	\$524.23
Greenfield	1,149	96	\$1,797,958	\$1,564.80
Greenland	1,214	101	\$660,169	\$543.80
Greenville	3,211	268	\$952,574	\$296.66
Groveton	4,718	393	\$2,160,006	\$457.82
Guild	307	26	\$199,773	\$650.72
Hampstead	2,183	182	\$1,696,771	\$777.27
Hampton	9,775	815	\$7,275,389	\$744.29
Hampton Falls	720	60	\$321,004	\$445.84
Hancock	922	77	\$537,143	\$582.58
Hanover	882	74	\$1,165,499	\$1,321.43
Harrisville	541	45	\$283,275	\$523.61
Haverhill	847	71	\$549,573	\$648.85
Hebron	1,034	86	\$218,593	\$211.40
Henniker	3,238	270	\$1,674,914	\$517.27
Hill	1,240	103	\$418,641	\$337.61
Hillsboro	10,393	866	\$5,390,687	\$518.68
Hinsdale	5,451	454	\$2,081,850	\$381.92
Holderness	1,361	113	\$584,079	\$429.15
Hollis	1,898	158	\$1,655,304	\$872.13
Hooksett	7,680	640	\$4,900,123	\$638.04
Hudson	14,940	1,245	\$7,548,860	\$505.28
Intervale	1,150	96	\$507,925	\$441.67
Jackson	280	23	\$177,695	\$634.63
Jaffrey	6,378	532	\$3,416,485	\$535.67
Jefferson	1,476	123	\$1,153,509	\$781.51
Kearsarge	217	18	\$35,160	\$162.03
Keene	27,024	2,252	\$28,603,955	\$1,058.46
Kingston	3,775	315	\$1,704,002	\$451.39
Laconia	31,115	2,593	\$22,872,219	\$735.09
Lancaster	6,635	553	\$4,424,435	\$666.83
Lebanon	8,518	710	\$7,629,769	\$895.72
Lempster	1,400	117	\$466,831	\$333.45
Lincoln	1,807	151	\$618,495	\$342.28
Lisbon	4,142	345	\$1,728,586	\$417.33
Litchfield	4,377	365	\$2,651,386	\$605.75
Littleton	12,038	1,003	\$7,987,106	\$663.49
Lochmere	342	29	\$119,656	\$349.87
Londonderry	11,430	953	\$6,009,199	\$525.74
Loudon	3,997	333	\$2,197,794	\$549.86
Lyme	427	36	\$522,335	\$1,223.27
Lyndeborough	986	82	\$400,781	\$406.47
Madbury	624	52	\$240,825	\$385.94
Madison	1,487	124	\$907,876	\$610.54

Location	Member Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Manchester	194,392	16,199	\$106,801,112	\$549.41
Marlborough	2,256	188	\$942,063	\$417.58
Marlow	779	65	\$547,748	\$703.14
Meadows	4	0	\$0	\$0.00
Melvin Village	333	28	\$321,145	\$964.40
Meredith	6,400	533	\$3,138,943	\$490.46
Meriden	104	9	\$47,911	\$460.68
Merrimack	10,845	904	\$7,258,602	\$669.30
Milan	1,569	131	\$883,006	\$562.78
Milford	12,400	1,033	\$6,966,634	\$561.83
Milton	5,509	459	\$1,982,811	\$359.92
Milton Mills	808	67	\$378,851	\$468.87
Mirror Lake	303	25	\$79,477	\$262.30
Monroe	749	62	\$244,521	\$326.46
Mont Vernon	1,154	96	\$670,729	\$581.22
Moultonborough	2,471	206	\$691,900	\$280.01
Mount Washington	12	1	\$4,968	\$413.99
Nashua	101,627	8,469	\$58,934,244	\$579.91
Nelson	995	83	\$297,153	\$298.65
New Boston	2,556	213	\$2,162,111	\$845.90
New Castle	131	11	\$154,954	\$1,182.85
New Durham	2,434	203	\$925,971	\$380.43
New Hampton	1,814	151	\$816,955	\$450.36
New Ipswich	4,321	360	\$1,913,269	\$442.78
New London	1,390	116	\$1,453,156	\$1,045.44
Newbury	1,155	96	\$426,940	\$369.64
Newfields	534	45	\$561,361	\$1,051.24
Newmarket	6,870	573	\$3,405,141	\$495.65
Newport	13,397	1,116	\$7,985,497	\$596.07
Newton	2,152	179	\$765,030	\$355.50
Newton Junction	154	13	\$34,448	\$223.69
North Conway	6,064	505	\$3,274,544	\$540.00
North Hampton	1,844	154	\$1,112,145	\$603.12
North Haverhill	2,463	205	\$2,485,437	\$1,009.11
North Salem	430	36	\$104,449	\$242.91
North Sandwich	187	16	\$91,855	\$491.21
North Stratford	2,977	248	\$1,202,120	\$403.80
North Sutton	282	24	\$133,791	\$474.44
North Walpole	1,116	93	\$346,595	\$310.57
North Woodstock	1,306	109	\$546,952	\$418.80
Northwood	3,570	298	\$2,259,010	\$632.78
Nottingham	2,019	168	\$986,993	\$488.85
Orford	934	78	\$629,775	\$674.28
Ossipee	2,718	227	\$1,724,411	\$634.44
Other	25,300	2,108	\$28,877,745	\$1,141.41
Pelham	4,550	379	\$2,441,550	\$536.60

Location	Member Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Peterborough	5,447	454	\$3,724,946	\$683.85
Piermont	709	59	\$345,172	\$486.84
Pike	641	53	\$227,669	\$355.18
Pittsburg	1,344	112	\$416,823	\$310.14
Pittsfield	6,859	572	\$2,820,108	\$411.15
Plainfield	747	62	\$636,296	\$851.80
Plaistow	3,823	319	\$2,110,673	\$552.10
Plymouth	7,020	585	\$4,904,649	\$698.67
Portsmouth	21,321	1,777	\$22,754,466	\$1,067.23
Randolph	117	10	\$85,696	\$732.45
Raymond	9,525	794	\$4,108,035	\$431.29
Rindge	3,664	305	\$1,855,489	\$506.41
Rochester	49,900	4,158	\$23,982,413	\$480.61
Rollinsford	2,014	168	\$1,017,767	\$505.35
Rumney	3,397	283	\$2,008,691	\$591.31
Rye	1,605	134	\$1,291,969	\$804.97
Rye Beach	169	14	\$138,282	\$818.24
Salem	15,239	1,270	\$8,755,502	\$574.55
Salisbury	640	53	\$242,667	\$379.17
Sanbornton	1,887	157	\$938,139	\$497.16
Sanbornville	4,942	412	\$1,531,676	\$309.93
Sandown	3,288	274	\$2,090,136	\$635.69
Seabrook	11,519	960	\$4,170,000	\$362.01
Silver Lake	727	61	\$295,203	\$406.06
Somersworth	19,860	1,655	\$8,214,777	\$413.63
South Acworth	190	16	\$140,422	\$739.06
South Newbury	20	2	\$24,742	\$1,237.10
South Sutton	148	12	\$12,806	\$86.53
South Tamworth	184	15	\$7,891	\$42.89
Spofford	938	78	\$596,778	\$636.22
Springfield	786	66	\$414,183	\$526.95
Stinson Lake	45	4	\$13,966	\$310.35
Stoddard	574	48	\$206,984	\$360.60
Strafford	2,184	182	\$1,167,645	\$534.64
Stratham	2,287	191	\$1,514,231	\$662.10
Sugar Hill	169	14	\$38,931	\$230.36
Sullivan	816	68	\$253,598	\$310.78
Sunapee	2,190	183	\$1,222,677	\$558.30
Suncook	13,268	1,106	\$6,471,303	\$487.74
Swanzey	5,739	478	\$2,600,849	\$453.19
Tamworth	2,136	178	\$890,976	\$417.12
Temple	847	71	\$442,085	\$521.94
Tilton	10,185	849	\$5,685,764	\$558.25
Troy	3,208	267	\$1,096,289	\$341.74
Twin Mountain	789	66	\$230,402	\$292.02
Union	2,856	238	\$1,207,897	\$422.93

Location	Member Months	Average Enrollment	Expenditures	Per Member Per Month Payment
Walpole	1,304	109	\$825,148	\$632.78
Warner	2,717	226	\$1,167,194	\$429.59
Warren	1,198	100	\$590,294	\$492.73
Washington	1,031	86	\$417,898	\$405.33
Waterville Valley	133	11	\$28,052	\$210.91
Weare	5,765	480	\$3,007,127	\$521.62
Wentworth	883	74	\$440,116	\$498.43
West Chesterfield	719	60	\$222,506	\$309.47
West Lebanon	3,627	302	\$2,415,809	\$666.06
West Nottingham	144	12	\$168,625	\$1,171.01
West Ossipee	1,984	165	\$752,039	\$379.05
West Peterborough	309	26	\$167,803	\$543.05
West Stewartstown	2,153	179	\$3,127,056	\$1,452.42
West Swanzey	1,836	153	\$869,991	\$473.85
Westmoreland	967	81	\$1,020,457	\$1,055.28
Whitefield	7,371	614	\$13,270,510	\$1,800.37
Wilmot	764	64	\$435,432	\$569.94
Wilton	2,858	238	\$1,293,447	\$452.57
Winchester	9,130	761	\$5,149,831	\$564.06
Windham	3,639	303	\$3,108,189	\$854.13
Winnisquam	701	58	\$333,697	\$476.03
Wolfeboro	4,316	360	\$2,619,914	\$607.02
Wolfeboro Falls	1,918	160	\$779,655	\$406.49
Wonalancet	58	5	\$7,064	\$121.79
Woodstock	351	29	\$115,648	\$329.48
Total	1,339,092	111,591	\$869,776,299	\$649.53

Glossary

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

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

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

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

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

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

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

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

Federal Financial Participation (FFP) – The term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates. FFP for administrative expenditures also varies in its rate, depending upon the type of administrative costs. See FMAP.

Federal Medical Assistance Percentage (FMAP) – The term for the federal matching rate – i.e. the share of the costs of Medicaid services or administration that the federal government bears. FMAP varies depending upon a state’s per capita income.

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

Federally Qualified Health Center (FQHC) – States are required to include services provided by FQHCs in their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers as well as by “look alike” clinics that meet requirements for federal funding but do not actually receive federal grant funds.

Fee-For-Service – A method of paying for medical services under which doctors and hospitals are paid for

each service they provide. Bills are either paid by the patient who then submits them to the insurance company or are submitted by the provider to the patient's insurance carrier for reimbursement.

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

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

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

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

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

Medically Needy - A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses. These individuals meet Medicaid's categorical requirements- i.e., they are children or parents or aged or individuals with disabilities- but their income is too high to enable them to qualify for “categorically needy” coverage. Instead, they qualify for coverage by “spending down” – i.e., reducing their income by their medical expenses. States that elect to cover the “medically needy” do not have to offer the same benefit package to them as they offer to the “categorically needy.” See Categorically Needy, Spend-down.

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

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

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

Qualified Medicare Beneficiary (QMB) – A Medicare recipient with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is at or below 100% of the federal poverty line (FPL) and whose countable resources do not exceed \$4000. QMBs are eligible to have Medicaid pay all of their Medicare cost-sharing requirements, including monthly premiums for Part B coverage, help with Part D cost sharing requirements, and all required deductibles and coinsurance (up to Medicaid payment amounts).

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

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

reduced to a state-specified level, the individual qualifies for Medicaid benefits for the remainder of the period. See Medically Needy.

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

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

State Plan Amendment (SPA) – A state that wishes to change its Medicaid eligibility criteria, covered benefits, or provider reimbursement rates must amend its state Medicaid plan. Similarly, states must conform their Medicaid plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment to CMS for approval.

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

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

Waivers – When requested by a state, the Secretary of HHS may waive certain requirements or limitations of the federal Medicaid statute, allowing the state to receive

federal Medicaid matching funds, which would not otherwise be available. One example is Section 1915(c) waivers for home- and community-based services, which allow states to offer special services to beneficiaries at risk of institutionalization in a nursing facility or mental health facility. Another example is Section 1115 demonstration waivers, which allow states to cover certain categories of individuals or services (or both), which would not be covered otherwise.

Contributors

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

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

- Andrew Chalsma, Chief, Bureau of Data and Systems Management
- Christine Shannon, Chief, Bureau of Health Care Research
- Kathleen Dunn, Medicaid Director
- Don Hunter, Program Planner
- Janet Horne, GIS Specialist

Muskie School of Public Service, University of Southern Maine:

- Catherine McGuire, Director of Health Data Resources and Senior Policy Analyst

Maine Health Information Center:

- Rebecca Symes, Senior Analyst
- Natasha Ranger, Senior Programmer Analyst
- Lynn Walkiewicz, Programmer Analyst



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

129 Pleasant Street-Annex, Concord, NH 03301-3857
603-271-8166 • 1-800-852-3345, Ext. 8166 • TDD Access: 1-800-735-2964
www.dhhs.state.nh.us/dhhs/ombp