

**Evaluation of Access and Utilization  
In the Children's Health Insurance Program:**

**New Hampshire Healthy Kids FY2003**

Conducted by Thomson Medstat  
in Partnership with the New Hampshire Healthy Kids Corporation and  
the New Hampshire Department of Health and Human Services

December 14, 2005

## Acknowledgements

This evaluation was funded by the **HNH***foundation* and overseen by the Q-CHIP Workgroup, whose members include the following:

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## **Acknowledgements**

The following staff from the Department of Health and Human Services, Office of Medicaid Business and Policy served as reviewers:

- Richard Kellogg, Acting Director
- Christine Shannon, Bureau Chief
- Andrew Chalsma, Administrator
- Valerie King, SCHIP Coordinator
- Ann Bennett, Program Assistant, Bureau of Health Care Research

# *Table of Contents*

Acknowledgements .....	2
Executive Summary.....	5
Background and Objectives.....	9
Overview of Methods.....	11
Enrollment.....	13
Demographics: Age /Gender.....	14
Demographics: Hospital Service Area.....	15
Length of Enrollment.....	16
Disenrollment.....	17
Visits to Primary Care Provider.....	18
Well Child Visits.....	20
Annual Dental Visit.....	22
Inpatient Use.....	23
Emergency Department Use.....	25
Chronic Care Management: Asthma.....	27
Mental Health Use and Cost.....	28
Notes.....	30

# Executive Summary

## Objectives and Background

This program evaluation focuses on access and utilization in the New Hampshire Healthy Kids children's health insurance programs during State Fiscal Years 2002 and 2003. The evaluation was performed by Thomson Medstat in partnership with the New Hampshire Healthy Kids Corporation (NHHK) and the New Hampshire Department of Health and Human Services (DHHS). The overall goal for the evaluation is to measure progress toward the State's objectives of increasing access to health services and improving health outcomes.

Based on analysis of detailed medical claims data from multiple sources, the evaluation reviews access and utilization in Healthy Kids Gold (Medicaid) and Healthy Kids Silver (State Children's Health Insurance Program or SCHIP). Healthy Kids Silver is a transitional program providing low-cost health insurance to children from age 1 through age 18 in families with income between 185% and 300% of the Federal Poverty Level (FPL).

Two groups of Healthy Kids Gold children with more serious health needs were *excluded* from the above study groups - Children with Severe Disabilities and Home Care for Children with Severe Disabilities. Information on the above groups was compiled separately and is included in the data tables that accompany the report.

During the period under study, Healthy Kids Gold included both the traditional Fee-For-Service program (HKG-FFS) and a voluntary Managed Care plan (HKG-MC). The Managed Care plan was discontinued in July 2003. Healthy Kids Silver (HKS) and HKG-MC are/were underwritten by Anthem Blue Cross Blue Shield with a separate dental plan from Northeast Delta Dental (NEDD). Anthem and NEDD provided claims and encounter data for the study. Claims data for the HKG-FFS program were processed by the Medicaid Management Information System (MMIS), the system of record, and available in an analytically ready database (the Medicaid Decision Support System, MDSS).

The study compares the Healthy Kids programs to each other and to accepted clinical guidelines and national Medicaid and commercial experience, where available. Many measures in the evaluation are taken from the Health Plan Employer Data and Information Set (HEDIS), a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. For these measures, comparisons are drawn to the average HEDIS results of Medicaid and commercial managed care plans nationwide in 2003, as reported by the National Committee on Quality Assurance (NCQA).

Results show that the Healthy Kids programs are generally doing well in managing common childhood and chronic diseases. However, opportunities for continued improvements are also evident, particularly in the HKG-FFS program. Summarized below are key findings in the following areas of measurement:

- Length of Enrollment / Disenrollment
- Visits to Primary Care Provider
- Well Child Visits
- Annual Dental Visit
- Hospital Utilization
- Ambulatory Sensitive Conditions
- Chronic Care Management - Asthma
- Use of Mental Health Services

# Executive Summary

## Key Findings

**Length of Enrollment / Disenrollment.** The Healthy Kids Silver program is designed to provide temporary coverage until a family secures other insurance. Close to 50% of Healthy Kids Silver enrollees leave the plan before the end of the year, compared to one-third of Healthy Kids Gold Fee-for-Service enrollees. Not all HKS disenrollees find private insurance coverage, and many children move back and forth between the Healthy Kids Gold and Healthy Kids Silver programs. Of children who disenrolled from HKS, only a small percentage (2-3%) re-enrolled in HKS in the same year. This contrasts with HKG-FFS, in which 26% of children who disenrolled were re-enrolled later in the year. This reflects the differing nature of the two programs -- HKG is the insurer of last resort, while HKS provides transitional coverage.

**Visits to Primary Care Provider.** Access to primary care is important for healthy childhood development and a key goal of expanding health insurance coverage. For the Healthy Kids program overall, 72% of continuously enrolled children visited a primary care provider during FY2003, up slightly from 70% in FY2002. Much higher percentages of children in Healthy Kids Silver and Healthy Kids Gold Managed Care visited a primary care provider during FY2003 (87% and 84%, respectively) than did children in Healthy Kids Gold FFS (69%). Results for HKS and HKG-MC exceeded the national Medicaid HEDIS average of 80% for children ages 2 to 6 (94% and 89% for HKS and HKG-MC, respectively), and also exceeded the national Medicaid HEDIS average of 80% for children ages 7 to 11 (86% and 82% for HKS and HKG-MC, respectively). In contrast, HKG-FFS fell short of the national Medicaid HEDIS experience at all ages at 68% for ages 3 – 6 and 61% for ages 7 – 11.

**Well Child Visits.** Regular preventive visits help detect problems before they affect a child's development or well being. In FY2003, 58% of continuously enrolled children ages 3 to 6 in HKG-FFS received the number of well visits expected for their age, based on guidelines published by the American Academy of Pediatrics. Rates of well child visits for this age group were higher for HKG-MC (69%) and HKS (76%), both of which exceeded the national HEDIS commercial average of 60%. For adolescents, who have the lowest rate of well child visits, the HKG-FFS rate of 35% was comparable to national Medicaid HEDIS results; the HKG-MC and HKS rates of 44% and 51% exceeded the national Medicaid (37%) and commercial (36%) HEDIS averages.

Achieving the total number of expected well child visits at a given age can be a high standard, because even a one-month slippage causes a visit to be counted as "missed." Particularly at the youngest ages, when multiple visits in a year are expected, it can be helpful to examine the percentage of continuously enrolled children who have the *minimum* number of expected visits, defined as one visit fewer than the most expected for a given age. Viewed in this way, 71% of all children between ages 1 to 2 in the Healthy Kids plans received the minimum number of expected well child visits in FY2003. In both years, HKS had a very high percentage of children, ages 1 – 2, with the minimum number of expected visits, at or near 90%.

**Annual Dental Visit.** Tooth decay is the most common childhood disease. Prevention and prompt treatment of tooth decay is important not only for oral health, but also for general physical and social well-being. In FY2003, 74% and 73% of continuously enrolled children ages 3 to 12 in the HKS and HKG-MC plans, respectively, received an annual dental visit, a level not only well above the national Medicaid HEDIS average but also above 90% of all plans reporting. HKS offers dental coverage through Northeast Delta Dental, as did HKG-MC for the period August 2001 through July 2003. The HKG-FFS program, which does not have such a dental plan, had a lower rate of annual

# Executive Summary

dental visits – 47% for children ages 3 to 12. However, the HKG-FFS annual dental visit rate for this age group exceeds the corresponding national Medicaid average, which in 2003 was 41% for children ages 4 to 6, 43% for children ages 7 to 10, and 40% for children ages 11 to 14.

**Hospital Utilization.** Overall, children age 1 or older in the Healthy Kids programs were admitted to the hospital at an annual rate of 20 per 1,000 members and visited the hospital Emergency Department at an annual rate of 444 per 1,000 members. For children age 1 or older, the rate of hospital admission in HKG-FFS was more than 40% higher than the rates in HKG-MC and HKS. Similarly, the rate of Emergency Department (ED) utilization in HKG-FFS was 49% above the HKG-MC rate and 32% above the HKS rate. Differences among plans are likely the result of many factors, including underlying illness prevalence and severity, which were not assessed in this study. In addition, both HKS and HKG-MC had a relatively small number of admissions each year (fewer than 200).

**Ambulatory Sensitive Conditions.** Across all Healthy Kids programs in FY2003, 22% of inpatient admissions and 30% of visits to the Emergency Department (ED) were for conditions for which hospital treatment can often be avoided with timely and effective ambulatory care. Such ambulatory sensitive conditions include Asthma, Bacterial Pneumonia, Gastroenteritis, Diabetes, and severe Ear, Nose, and Throat (ENT) Infections. One out of every five Emergency Department visits was for Severe ENT Infections. High rates of ED use for acute care illness that could have been handled by the primary care physician, or for chronic conditions that are exacerbated due to problems accessing primary care, can undermine continuity of care, jeopardize outcomes, and increase costs.

**Chronic Care Management - Asthma.** For long-term control of asthma, clinical guidelines emphasize maintenance treatment with inhaled anti-inflammatory medications. Compliance with appropriate maintenance medications has been found to reduce symptoms and hospital utilization and improve the quality of life. In the Healthy Kids Silver and Healthy Kids Gold MC plans, respectively, 85% and 80% of continuously enrolled children with persistent asthma received the recommended anti-inflammatory medications in FY2003. This performance exceeded results of 90% of Medicaid plans nationally as well as average results of commercial health plans. HKG-FFS had a lower percentage (62%) of persistent asthmatics on appropriate medications, a level equal to the national Medicaid HEDIS average.

**Use of Mental Health Services.** Treatment of mental health issues in children and adolescents is important to prevent school failure, substance abuse, problems with the criminal justice system, and suicide. In FY2003, approximately 7-8% of children enrolled in Healthy Kids at any time had at least one mental health service during the year (defined as any service with a mental health diagnosis or procedure). This is above the national commercial HEDIS average of 5%. A slightly higher percentage of HKG children received a mental health service than HKS. Among those with a mental health service, HKG-FFS children were almost twice as likely to be admitted inpatient as children in HKS and 65% more likely than children in HKG-MC. HKG-FFS children also had a longer average length of stay and were more likely to be readmitted.

## Implications and Recommendations

While program-wide improvements are possible in all areas to fully meet Healthy Kids objectives, the evaluation findings show a number of positive achievements. On most measures, the Healthy Kids programs are doing as well or better than Medicaid programs around the country. In a few areas, most notably primary care provider visits, well child visits, annual dental visits, and

# Executive Summary

appropriate medications for asthma, the HKS and HKG-MC plans compare very favorably to national experience.

By working in close partnership, NHHK and DHHS have demonstrated success in improving not only access to health insurance coverage, but also access to and utilization of healthcare services. The results of this study suggest several focus areas for further planning and evaluation to support continued improvements, as follows:

- *Leverage lessons learned from the managed care plans.* HKS and HKG-MC generally performed better on access and utilization measures than did the fee-for-service program. HKG-MC results may be biased slightly favorably because of the voluntary nature of the program. Voluntary managed care plans have been shown to be more likely to attract individuals who are healthier, lower cost, and more motivated to use preventive services.
- *Continue to emphasize the importance of primary care* -- in working with key stakeholders around the state to address provider shortages, in considering new plan designs for Healthy Kids Gold, in developing education programs for both providers and members. Findings support the State's consideration of new designs for the Medicaid program that would provide a "medical home" for enrollees in the FFS program through primary care case management or related managed care models.
- *Develop initiatives targeted to adolescents.* Findings indicate that access to preventive services is particularly low in adolescents, a critical developmental period, and support the State's recent development of an Adolescent Strategic Health Plan.
- *Expand on measures and comparisons in future studies.* This study was intended as a first step towards a more comprehensive approach to analyzing quality, outcomes, and cost in the Healthy Kids programs. Future studies can monitor progress on the access and utilization measures reported here and also expand into new areas of quality, cost, and outcomes measurement. In addition, the ongoing development of a comprehensive statewide database of health care insurance claims provides the opportunity for future comparisons of the Healthy Kids experience to commercial insurance experience in New Hampshire.

# Background and Objectives

## Background

The Healthy Kids Children's Health Insurance Program provides subsidized health insurance to children under the age of 19 through a partnership between the non-profit New Hampshire Healthy Kids Corporation (NHHK) and the New Hampshire Department of Health and Human Services (DHHS). Throughout this report, NHHK refers to the entity that administers the program and Healthy Kids to the program itself.

Healthy Kids includes a continuum of programs, based on varying levels of family income:

- Healthy Kids Gold – provides coverage at no cost to children in families at the lowest income levels.
- Healthy Kids Silver – offers low-cost health insurance at \$25 or \$45 per child per month. Co-payments of \$5 to \$50 apply to certain services. Total cost-sharing cannot exceed 5% of total family income. Coverage is underwritten by Anthem Blue Cross Blue Shield and Northeast Delta Dental.

The Healthy Kids programs are funded through a combination of sources -- federal government, state government, Healthy New Hampshire Foundation (**HNH**foundation), and family premiums. Additional support comes from in-kind contributions in the form of provider reimbursement discounts, and from other private grants.

New Hampshire has a history of taking practical steps to invest in and expand children's access to health insurance including the following:

- 1993 – Established NHHK to expand access to affordable health insurance coverage for uninsured children.
- 1994 – Expanded Medicaid (Healthy Kids Gold) eligibility, recognizing that the high cost of living and soaring cost of health insurance in New Hampshire requires broader access to publicly supported programs.
- 1998 – Secured enhanced federal funding and program flexibility to expand access through the premium-based State's Children's Health Insurance Program (SCHIP or Healthy Kids Silver).
- 1999 – Adopted best practices to improve continuous enrollment and retention, such as a joint mail-in application.
- 2002 – Invested in strategic opportunities to improve efficiency by centralizing Healthy Kids case management at NHHK.

To quantify progress toward program objectives, and to meet federal requirements for the assessment of quality of care in the SCHIP and Medicaid programs, NHHK contracted with Medstat for an evaluation of Quality in the Children's Health Insurance Program (Q-CHIP). The evaluation was funded by the **HNH**foundation and overseen by the Q-CHIP Workgroup, which is comprised of public officials, NHHK Board members and staff, and key stakeholders.

This Q-CHIP evaluation is based on medical claims and enrollment data and supplements a previous program evaluation based on telephone surveys with parents of children enrolled in or applying for Healthy Kids coverage.<sup>1</sup>

# Background and Objectives, continued

## Objectives

Specific objectives of the Q-CHIP evaluation are to:

- Provide an in-depth assessment of overall health care access and utilization in the Healthy Kids programs;
- Compare the experience of Healthy Kids Silver, Healthy Kids Gold fee-for-service (FFS) and managed care (MC) programs to each other and national benchmarks;
- Develop and implement performance measures that serve as a baseline for future program evaluations; and
- Establish and document methods that NHHK and DHHS staff can replicate in future evaluations.

## Key Program Characteristics

**Healthy Kids Gold** (HKG) provides coverage to infants up to age 1 at incomes up to 300% of the federal poverty level (FPL) and children from age 1 through age 18 in families with income up to 185% of FPL. During FY2002 and FY2003, coverage was provided through either the Medicaid fee-for-service program (FFS), or a voluntary managed care plan (MC) administered by Anthem Blue Cross and Blue Shield, with dental claims administered by Northeast Delta Dental (NEDD). The MC plan ended on 6/30/03.

**Healthy Kids Silver** (HKS) offers low cost insurance to children from age 1 through age 18 in families with income between 185% and 300% of FPL. To be eligible, children must be uninsured for 6 months unless good cause can be shown, such as a parent's involuntary job loss. Families pay premiums of \$25 or \$45 per child per month (\$20 and \$40, respectively, prior to January 2003), with capped family premiums of \$100 and \$135 per month, depending on income. Copayments of \$5 and \$10 apply to certain services, with total cost-sharing (premiums and copayments combined) not to exceed a maximum of 5% of the family's total income. Medical coverage is provided through a managed care plan administered by Anthem and dental coverage by Northeast Delta Dental.

# Overview of Methods

## Time Periods

Data were analyzed for services incurred in State Fiscal Years 2002 and 2003, defined as:

- FY2002: July 1, 2001–June 30, 2002
- FY2003: July 1, 2002–June 30, 2003

## Study Population

The analysis was performed on the following study groups:

- Healthy Kids Silver (HKS)
- Healthy Kids Gold Managed Care (HKG-MC)
- Healthy Kids Gold Fee For Service (HKG-FFS)
- Healthy Kids Gold (HKG – which includes both MC and FFS)
- Healthy Kids (HKS and HKG)

## Enrollees Excluded

Two groups of Healthy Kids Gold children were *excluded* from the above study groups:

- Children with Severe Disabilities
- Home Care for Children with Severe Disabilities

Information on the above groups was compiled separately and is included in the data tables for this study that are available on the NHHK website at [www.nhhealthykids.com](http://www.nhhealthykids.com).

## Development of Study Design

Medstat worked with the Q-CHIP Workgroup (listed in the Acknowledgement Section) to select and define measures for the evaluation focused on Healthy Kids program objectives. The study was designed to:

- Address issues that are important for a child population, adolescents as well as young children;
- Include a balanced set of measures – enrollment, access, and utilization;
- Build on and extend the Q-CHIP 2001-2002 evaluation;
- Create performance measures modeled after HEDIS, to facilitate comparisons to national experience; and
- Include measures likely to be chosen for the joint CMS/State Performance Measurement Partnership Project, e.g., Well-Child Visits.

## HEDIS Comparisons

Some measures are modeled on The Health Plan Employer Data and Information Set (HEDIS), a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. For these measures, when available, comparisons are drawn to the average HEDIS results of Medicaid and/or commercial managed care plans nationwide in 2003, as reported by the National Committee on Quality Assurance (NCQA).

# Overview of Methods, continued

## Areas of Measurement

The report includes the following topical areas and measures:

### *Enrollment*

- Monthly / Annual Enrollment Counts
- Distribution of Length of Enrollment
- Disenrollment
- Transition among Healthy Kids Programs

### *Demographics*

- Age / Gender Distribution
- Geographic Distribution (by Hospital Service Area)

### *Use of Primary Care Services*

- Annual Visit (HEDIS)
- New Enrollees – Time to First Visit, defined as the time between enrollment in a program and date of first service

### *Use of Preventive Services*

- Well Child Visits (HEDIS)
- Annual Dental Visit (HEDIS)

### *Utilization*

- Inpatient Admissions
- Emergency Department
- Ambulatory Sensitive Conditions

### *Chronic Care Management: Asthma*

- Prevalence
- Severity
- Appropriate Medications (HEDIS)

### *Mental Health Use and Cost*

- Any
- Outpatient
- Inpatient

Detailed specifications for each of the measures are available on the NHHK website at [www.nhhealthykids.com](http://www.nhhealthykids.com). The data tables on the website also include descriptive information on prescription drug cost and use that is not summarized in this report.

## Key Measure Definitions

Several measurement definitions apply across multiple measures in the report, as follows:

***Enrollee Counts:*** Unless otherwise specified, enrollment counts represent the total unique (unduplicated) members for a given time period (month or year).

***Enrollee Age:*** Enrollee age is defined as the age on the last day of the reporting year. This ensures that each enrollee is counted in only one age group for the year.

***Continuous Enrollment:*** Several of the access and care management measures focus on continuously enrolled members, defined as children enrolled at the end of the year who had been continuously enrolled for the entire year, with no more than a one-month gap in coverage. Note that this method does not count children who were enrolled for 11 continuous months at the beginning of the year, but not in the last month.

## Data Sources

***Healthy Kids Gold:*** Claims and person-level eligibility data processed by the Medicaid Management Information System (MMIS), the system of record, and stored in an analytically ready database (the Medicaid Decision Support System, MDSS).

***Healthy Kids Silver:*** Claims data processed by Anthem and its subsidiary Matthew Thornton Health Plan and Northeast Delta Dental. Detailed person-level eligibility data processed through the New Heights eligibility system and stored in the MDSS.

***Healthy Kids Gold Managed Care:*** Claims data processed by Anthem and its subsidiary Matthew Thornton Health Plan, Northeast Delta Dental, and the MMIS (wrap-around FFS claims). Detailed person-level eligibility data processed through the MMIS and stored in the MDSS.

# Enrollment

**Background:** As specified in the Title XXI State Plan filed by New Hampshire, a key objective for the Healthy Kids program was to reduce by 50% the proportion of children under age 19 who are uninsured. This objective was achieved in 2001. Based on 2003 census data, New Hampshire had the third lowest rate of uninsured children in the nation, at 5.2%, and the lowest rate of uninsured low income children.<sup>2</sup>

Toward this objective, NHHK and DHHS have taken a number of steps over the years to streamline enrollment and maximize coordination between the Healthy Kids Gold and Silver programs. Most notably, the Healthy Kids programs use a joint, mail-in application and single system to determine eligibility.

In Fiscal Years 2002 and 2003, NHHK and DHHS took additional steps to increase coordination between programs, including:

- Centralizing enrollment processing and case management for all Healthy Kids programs at NHHK;
- Re-engineering the community-facilitated application process;
- Training community partners; and
- Encouraging pharmacies to accept temporary billing authorizations.

**Findings:** Between July 2001 and June 2003, enrollment in Healthy Kids Silver (HKS) grew by 60%, from 3,577 to 5,778. During the same period, enrollment in Healthy Kids Gold (HKG) grew by 25%, from 48,791 to 60,676.

Viewed on an annual basis, the Healthy Kids programs together served almost 80,000 children in FY2003, up 10% from FY2002.

**Figure 1 - Annual Enrollment  
(Unduplicated Counts)**

Plan	FY2002	FY2003	% Change
HKS	7,125	9,042	27%
HKG – MC	10,453	15,190	45%
HKG – FFS	63,745	67,188	5%
HK All	72,398	79,632	10%

Healthy Kids Gold MC experienced particularly rapid growth (45%) between years, as did the HKS program (27%). Some of the growth in the MC program may be attributable to the addition of a dental plan in August 2001.

It is important to recall that the Healthy Kids enrollment growth occurred during the national economic downturn. Other states experienced growth in their Medicaid and SCHIP populations during this period as well. Nationally:

- Medicaid enrollment grew 8% between June 2002 and June 2003.<sup>3</sup>
- SCHIP enrollment grew 4% from December 2002 to December 2003, down from previous years, as state budget shortfalls caused many states to take actions to slow the rate of health care spending.<sup>4</sup>

# Demographics: Age / Gender

## Age

Healthy Kids Silver (Figure 2) enrolls a slightly older mix of children than Healthy Kids Gold. Approximately two-thirds of HKS enrollees were between the ages of 7 and 18 at the end of FY2003, compared to only 57% of enrollees in the HKG-FFS program. The HKG-MC program had an age mix closer to HKS than HKG-FFS.

The difference in age distributions among the programs is explained in part by eligibility requirements. Children under the age of 1 qualify for HKG up to a family income of 300% of the federal poverty level.

The demographic data show that the Healthy Kids Silver program is an important source of services for adolescents. This is consistent with national SCHIP statistics.

Not shown in the graphs at the left are the children who turned 19 and “aged out” of coverage. Members who aged out in FY2003 accounted for 2.1%, 1.8% and 2.8% of HKS, HKG-MC, and HKG-FFS enrollees, respectively.

The age distributions by program were similar across fiscal years.

## Gender

Overall, boys slightly outnumber girls in the Healthy Kids programs, representing 52% of HKS enrollees and 51% of HKG enrollees.

Figure 2 - Age at End of FY2003:  
Healthy Kids Silver

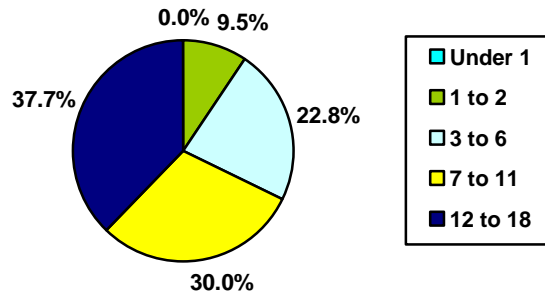


Figure 3 - Age at End of FY2003:  
Healthy Kids Gold - MC

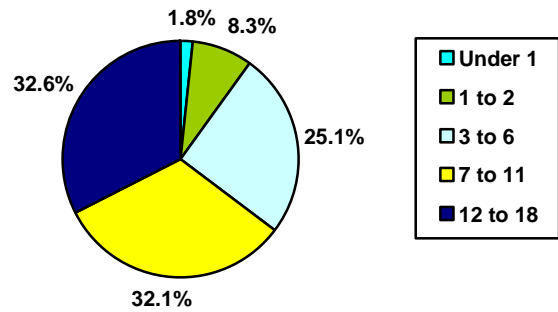
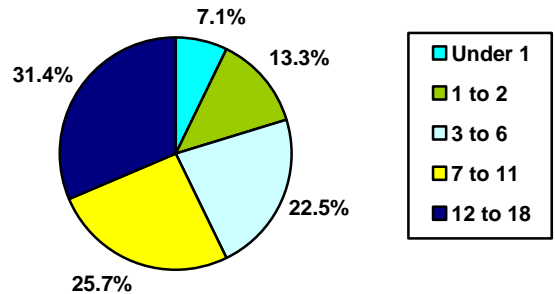


Figure 4 - Age at End of FY2003:  
Healthy Kids Gold - FFS



# Demographics: Hospital Service Area

Five Hospital Service Areas accounted for half of the HKG-FFS population in FY2003 - Manchester, Nashua, Concord, Exeter, and Rochester.

Compared to their representation in the HKG-FFS population:

- Concord, Derry, and Manchester were overrepresented in the HKG-MC Population. Laconia and Exeter were underrepresented.
- Concord, Derry, Peterborough and Wolfeboro were overrepresented in the HKS population. Keene, Manchester, and Nashua were underrepresented.

The distribution of enrollees in HKS corresponds to the distribution of the uninsured in the state. According to the Endowment for Health, approximately 34% of uninsured families and individuals in New Hampshire live in the urban areas of Concord, Manchester, and Nashua.<sup>5</sup>

**Figure 5  
Distribution of Enrollees  
by Hospital Service Area (HSA)  
FY2003**

HSA	HKS	HKG MC	HKG FFS
BERLIN	2.3%	1.8%	2.3%
CLAREMONT	1.7%	3.3%	2.8%
COLEBROOK	0.3%	0.4%	0.8%
CONCORD	10.9%	12.3%	8.9%
CONWAY	3.5%	1.5%	2.4%
DERRY	7.5%	9.0%	4.9%
DOVER	4.1%	3.5%	4.9%
EXETER	8.6%	3.2%	7.0%
FRANKLIN	2.6%	2.3%	3.0%
HAVERHILL	0.9%	0.7%	0.9%
KEENE	3.6%	6.4%	5.0%
LACONIA	5.7%	2.6%	5.3%
LANCASTER	1.3%	0.8%	1.4%
LEBANON	2.7%	2.7%	2.6%
LITTLETON	3.0%	2.2%	2.4%
MANCHESTER	11.9%	17.8%	15.8%
NASHUA	9.7%	11.1%	12.0%
NEW LONDON	2.0%	2.6%	1.9%
PETERBOROUGH	4.0%	3.8%	2.9%
PLYMOUTH	2.4%	1.7%	2.0%
PORTSMOUTH	2.1%	1.4%	1.8%
ROCHESTER	4.8%	5.7%	5.9%
WOLFEBORO	4.3%	3.0%	2.8%
Total	100.0%	100.0%	100.0%

# Length of Enrollment

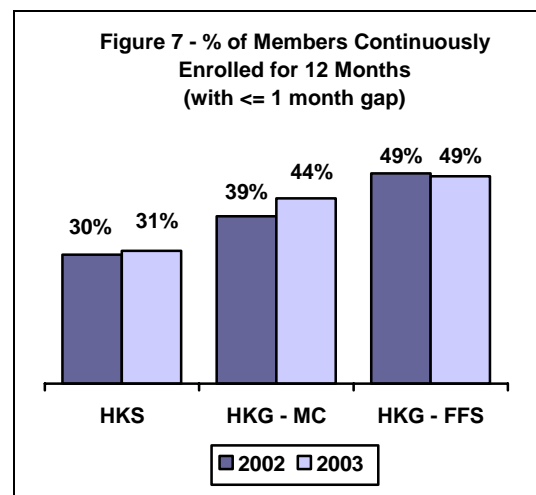
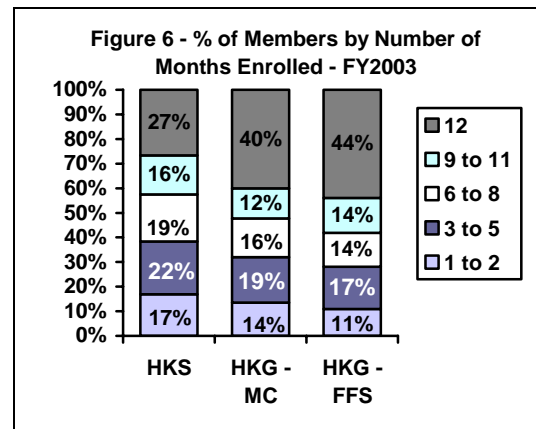
**Background:** HKS enrollment is more fluid than either Medicaid or private coverage. Nationally, between forty and fifty percent of SCHIP enrollees leave the program during a year.<sup>6</sup> Problems with access to care arise when families leave the program due to administrative barriers or lack of information and have not secured other insurance coverage.

**Findings:** The New Hampshire experience is consistent with national trends. Healthy Kids Silver children stay enrolled in the program for shorter periods of time than do children in Healthy Kids Gold.

Approximately 40% of HKS children were enrolled for less than 6 months during FY2003, and only 27% were enrolled for the entire year. In contrast, in the HKG-FFS program, only 28% of children were enrolled for less than 6 months, and 44% were enrolled for 12 months. These statistics reflect enrollment within discrete fiscal years, without looking back into the prior fiscal year.

In FY2003, just under one-third of Healthy Kids Silver members were continuously enrolled for the year, with a gap of one month or less (Figure 7), compared to 44% and 49% of Healthy Kids Gold members in the voluntary managed care and fee-for-service programs, respectively. The HKS findings are similar to those reported for SCHIP programs in other states.<sup>7</sup>

It is important to note that Anthem Blue Cross Blue Shield was guaranteed payment for the first six months of enrollment in HKG-MC. Even if a child was no longer eligible, Anthem would keep the child's name on the roster to receive payment, thus these results may be skewed.



# Disenrollment

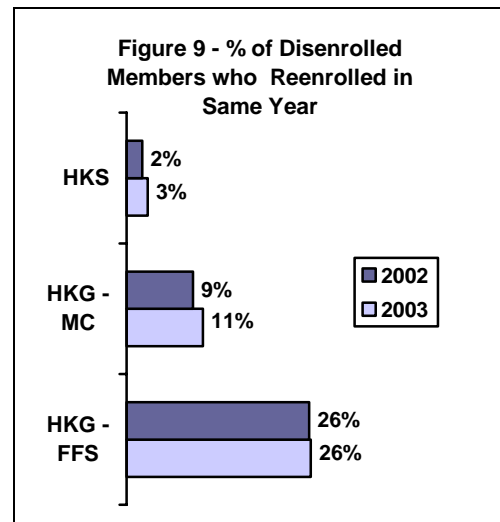
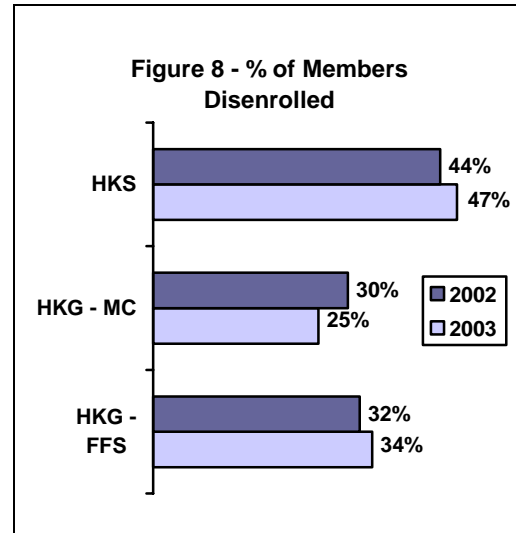
Viewed another way, close to half of all HKS members covered at the beginning of FY2003 disenrolled during that same year, compared to one-quarter of HKG-MC members and one-third of HKG-FFS members. Disenrollment increased slightly in FY2003 over FY2002 for both HKS and HKG-FFS (Figure 8).

Disenrollment differences among plans were greatest at the youngest ages. For HKS, FY2003 disenrollment was highest (55%) between the ages of 1 to 2 and declined with age to a low of 44% between the ages of 12 to 18. Healthy Kids Gold disenrollment was more stable across age ranges.

Of children who disenrolled from HKS, only a small percentage (2-3%) re-enrolled in HKS in the same year (Figure 9). This contrasts with HKG-FFS, in which 26% of children who disenrolled were re-enrolled later in the year. This reflects the differing nature of the two programs -- HKG is the insurer of last resort, while HKS provides transitional coverage. Survey data from the 2003 Healthy Kids Program Evaluation found that 58% of Silver enrollees who left the program did so because the family obtained other coverage, compared to 41% for Gold.<sup>8</sup>

The transitional nature of HKS coverage is evident in the number of children who participate in multiple Healthy Kids programs during the course of a year. In FY2003, 43% of all HKS members were also enrolled in HKG at some time during the year, either before or after their HKS enrollment. These transitions were most frequent among one-year olds, because those in families above 185% FPL are eligible to enroll in the premium-based HKS program from the HKG programs at that age.

However, transitions were also frequent at older ages. According to the 2003 Annual SCHIP Report to CMS, the most frequent reason for disenrollment from HKS is a decrease in income that results in eligibility for HKG.<sup>9</sup>



**Figure 10 - Healthy Kids Silver: Children Enrolled in Multiple HK Programs During FY2003**

Age Group	Number	Percent
1 to 2	567	66%
3 to 6	942	46%
7 to 11	1,081	40%
12 to 18	1,289	38%
All HKS	3,879	43%

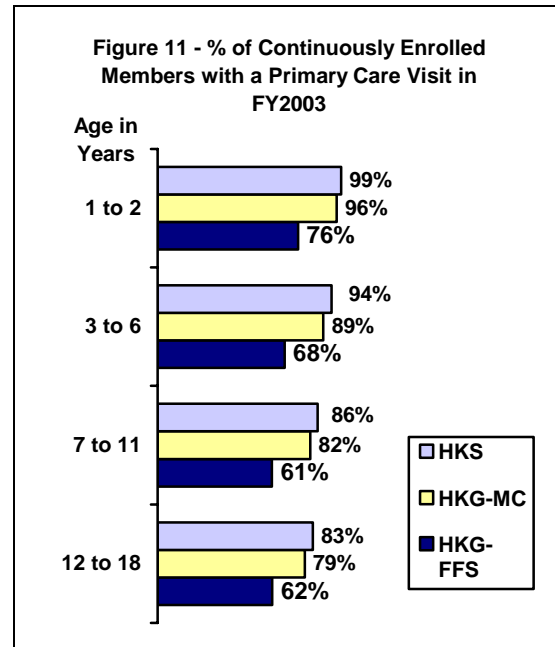
# Visits to Primary Care Provider

**Background:** A key goal for expanding health insurance coverage for children is to ensure access to primary care. Extensive research over the past 25 years has documented that the uninsured receive less preventive and therapeutic care. As a result, they have more advanced illness at the time they are diagnosed and suffer poorer health outcomes. Access to care is particularly important for healthy childhood development. Healthier children have lower medical costs and better school performance.<sup>10</sup>

**Findings:** For Healthy Kids overall, 72% of continuously enrolled children visited a primary care provider during FY2003, up slightly from 70% in FY2002.

HKS and HKG-MC had higher rates of primary care utilization than did HKG-FFS. Across all ages, 87% and 84% of HKS and HKG-MC continuously enrolled members, respectively, had a primary care visit in 2003, compared to 69% in HKG-FFS.

At the youngest ages (2 to 6), HKG-MC and HKS exceeded the average level of primary care visits reported by Medicaid and commercial managed care plans nationwide in 2003.<sup>11</sup> For adolescents, both HKG-MC and HKS achieved a level of primary care visits comparable to the national Medicaid managed care average. The HKG-FFS program shows significant room to improve primary care visits at all ages, but especially for older children and adolescents.



**Figure 12 - 2003 National HEDIS Average Children's Use of Primary Care Provider**

Medicaid	
25 mos- 6 years	80%
7 - 11	80%
Commercial	
25 mos- 6 years	87%
7 - 11	87%

*Note: age groups not directly comparable*

The higher use of primary care for HKG-MC over HKG-FFS is consistent with expectations, since managed care plans have an infrastructure and resources that emphasize primary care. In addition, the HKG-MC plan was a voluntary program. Families who opted to enroll in that program may have been more motivated to seek primary care, or better equipped to do so.

The slightly lower rate of annual primary care visits for 7-to-11 year-olds compared to the younger age groups stems from the fact that the primary care visit schedule for this age group only calls for a visit every other year, consistent with guidelines published by the American Academy of Pediatrics.

# Visits to Primary Care Provider

Among continuously enrolled children ages 2 and up who visited a primary care provider in FY2003, the average number of visits was 3.5 across all plans (Figure 13).

A final measure of primary care access is the time frame within which children are first seen by a primary care provider following enrollment. In FY2003, children in both HKS and HKG-MC saw a primary care provider within two months of enrollment, slightly sooner than children in HKG-FFS (Figure 14). HKG-MC improved dramatically between years on this measure, whereas the other plans showed more consistent time frames across years (this may be a data artifact, although Medstat is unaware of any specific data issues that would explain this finding).

Differences among plans in the time to first visit is a function of enrollee age, illness severity, differences in provider networks, and other factors. Given the younger average age in HKG-FFS and expected greater illness burden in this group, enrollees in this plan might have been expected to require visits sooner, on average, than enrollees in the other plans.

**Figure 13 - Average Primary Care Visits by Continuously Enrolled Members with Visits – FY2003**

Age Group	HKS	HKG - MC	HKG - FFS	HK ALL
Under 1	n/a	6.0	11.6	11.5
1 to 2	5.5	7.2	6.9	6.9
3 to 6	3.7	3.5	3.8	3.7
7 to 11	2.9	3.0	3.1	3.1
12 to 18	2.8	3.1	3.3	3.2
All Ages 2+	3.2	3.3	3.5	3.5
All Ages	3.2	2.6	5.2	4.7

**Figure 14 - New Enrollees: Average # Months Between Enrollment and 1st Visit**

Plan	FY2002	FY2003
HKS	1.7	1.8
HKG - MC	3.5	1.6
HKG - FFS	2.3	2.3
HK ALL	2.3	2.3

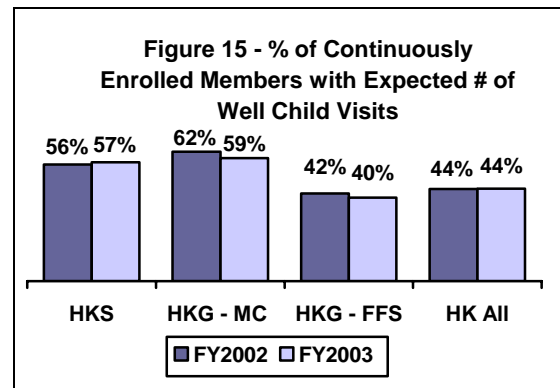
# Well Child Visits

**Background:** Well child visits are central to children's health services. Regular preventive visits help detect problems before they affect a child's development or well being. Children who receive well child visits on schedule are half as likely to incur hospital services (inpatient or Emergency Department) and 30% more likely to be immunized.<sup>12</sup> The American Academy of Pediatrics (AAP) has published widely accepted guidelines that recommend a total of 27 well child visits during infancy, childhood, and adolescence.<sup>13</sup>

**Findings:** Across all plans in FY2003, 44% of continuously enrolled Healthy Kids children received the number of visits expected for their age according to AAP guidelines (Figure 15). The rate of well child visits in that year ranged from a low of 40% in HKG-FFS to a high of 59% in HKG-MC.

Findings varied by age:

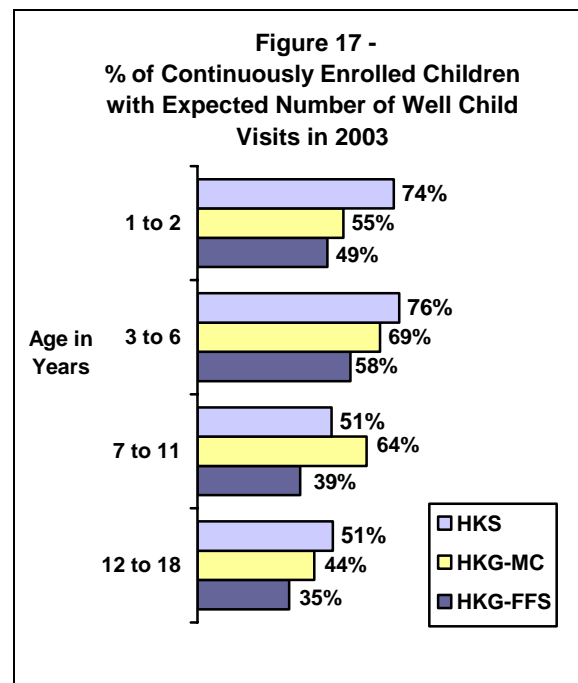
- Ages 3 to 6, when annual visits are expected, the Healthy Kids experience in all plans meets or exceeds the comparable Medicaid HEDIS national average of 58%. The HKS and HKG-MC rates at 76% and 69% respectively, were above HKG-FFS at 58%.
- Ages 7 to 11, a visit is expected every two years. This measure focuses on children continuously enrolled in FY2003 and looks back across both FY2003 and FY2002 for a visit; as such, it is affected by disenrollment in the prior year, which particularly impacts the Healthy Kids Silver rate (51% HKS compared to 64% for HKG-MC).
- Adolescents have the lowest rate of well child visits (Figure 17). For this group, the HKG-FFS rate (35%) is comparable to HKS (51%) and HKG-MC (44%); both are above national Medicaid and commercial average HEDIS results.



**Figure 16 - 2003 HEDIS National Average Well Child Visits**

Category	Age Group	Average (%)
Medicaid	3-6 yrs	58%
	12-21 yrs	37%
Commercial	3-6 yrs	60%
	12-21 yrs	36%

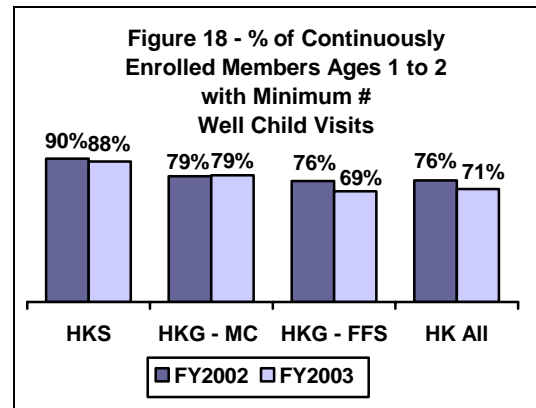
*Note: age groups not directly comparable*



# Well Child Visits, continued

Achieving the total number of expected well child visits at a given age can be a high standard, because even a one-month slippage causes a visit to be counted as “missed.” Particularly at the youngest ages, when multiple visits in a year are expected, it can be helpful to examine the percentage of continuously enrolled children who have the *minimum* number of expected visits, defined as one visit fewer than the most expected for a given age.

Viewed in this way, 71% of all children ages 1 to 2 in the Healthy Kids plans received the minimum number of expected well child visits in FY2003. This was down slightly from FY2002, due to a decline in well child visits in the HKG-FFS plan. In both years, HKS had a very high percentage of children with the minimum number of expected visits, at or near 90%.



# Annual Dental Visit

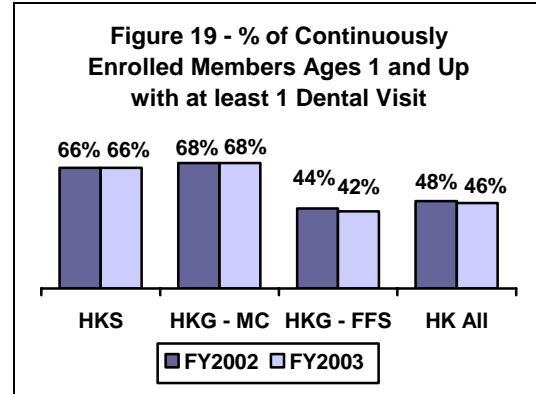
**Background:** Tooth decay is the most common childhood disease, and oral infections are increasingly implicated in serious systemic illness in childhood and later life. Prevention and prompt treatment of tooth decay is important not only for oral health, but also for general physical and social well-being.

Medicaid programs have historically been challenged in their efforts to provide access to dental care, because low reimbursement rates, which have since changed, and Medicaid-specific administrative processes discourage provider participation.<sup>14</sup> New Hampshire Medicaid has increased its reimbursement rates, but faces underlying dentist shortages – 20% of the state’s population lives in areas designated as Dental Health Professional Shortage areas.<sup>15</sup>

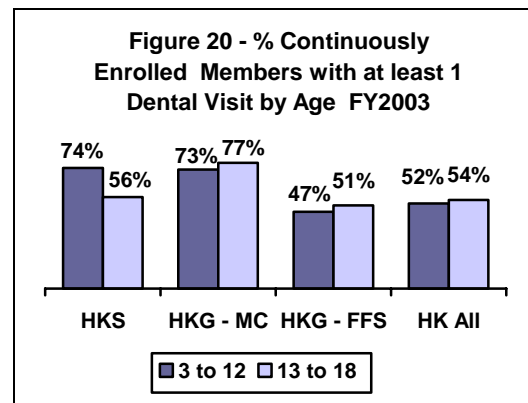
**Findings:** Across all Healthy Kids programs, 46% of continuously enrolled children ages 1 and up had at least one dental visit in FY2003. There was significant variation across plans (Figure 19).

In HKS and HKG-MC, approximately two-thirds of continuously enrolled children had at least one dental visit. This level exceeds the 90<sup>th</sup> percentile of national Medicaid HEDIS results. HKS offers dental coverage through Northeast Delta Dental, as did HKG-MC for the period August 2001 through June 2003.

In HKG-FFS, 42% of continuously enrolled children age 1 and up had at least one dental visit in FY2003. While this leaves significant room for improvement, it is important to note that children of all ages in New Hampshire had higher rates of using dental services than the national Medicaid experience.<sup>16</sup>



Note: Dental Option for HKG–MC was only available from August 2001 – July 2003.



**Figure 21 - 2003 Medicaid HEDIS Average Annual Dental Visit**

4-6 yrs	41%
7-10 yrs	43%
11-14 yrs	40%
15-18 yrs	34%
<i>Note: age groups not directly comparable</i>	

HKS and HKG-MC showed very comparable levels of dental access for children ages 3 to 12. HKS did not fare as well among adolescents in FY2003 (Figure 20).

# Inpatient Use

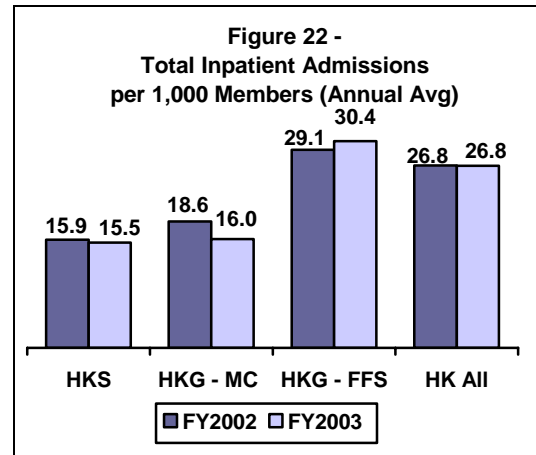
**Background:** Access to good primary care can help avoid costly hospitalizations. To measure the frequency of avoidable hospital admissions, researchers have focused on Ambulatory Sensitive Conditions (ASCs), clinical conditions for which hospitalization can potentially be avoided if ambulatory care is provided in a timely and effective manner.<sup>17</sup> Examples of ASCs include asthma, bacterial pneumonia, gastroenteritis, and diabetes.

Young children, minority and low income children, and children on Medicaid have a higher percentage of hospital admissions for Ambulatory Sensitive Conditions (ASCs). One study found that 26% of all admissions for Medicaid patients were for ASCs, twice the level of the privately insured.<sup>18</sup> Admissions for ASCs can be reduced through compliance with well child visits in the first two years of life.<sup>19</sup>

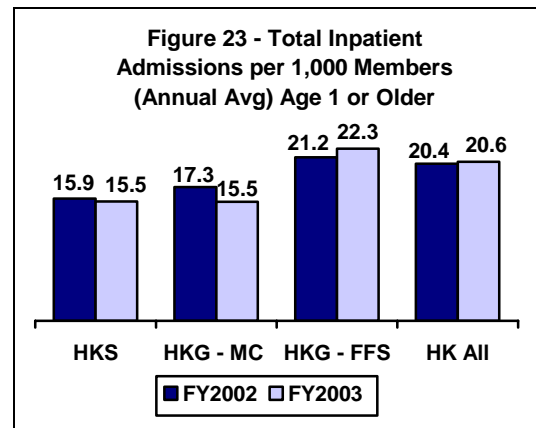
**Findings:** The frequency of Ambulatory Sensitive Conditions needs to be examined in the context of the overall admission rate. Across all Healthy Kids plans (Figure 22), the rate of admission was approximately 27 per 1,000 (annual average, not unduplicated) members in both FY2002 and FY2003.

HKG-FFS had the highest overall admission rate, in part because of the high rate of admission for children less than one year old. After excluding children under the age of 1 (Figure 23), the HKG-FFS admission rate was 22.3 per 1,000 members in FY2003. This was more than 40% higher than HKG-MC or HKS.

Differences among plans are likely the result of many factors, including underlying illness prevalence and severity, which were not assessed here. In addition, both HKS and HKG-MC had a relatively small number of admissions each year (HKS fewer than 100 and HKG-MC fewer than 200).



Note: Number of admissions each year was <100 for HKS and <200 for HKG-MC



## *Inpatient Use, continued*

For Healthy Kids overall, 22% of inpatient admissions in FY2003 were for Ambulatory Sensitive Conditions (ASCs), up from 17% in FY2002 (Figure 24). The recent findings are consistent with data from other states, which show 20-30% of inpatient admissions and Emergency Department visits for Medicaid and SCHIP populations are for ASCs.<sup>20</sup>

HKS and HKG-MC both had higher percentages of ASC admissions than did HKG-FFS, which may have proportionally more admissions for serious illnesses because of its high concentration of newborns and young infants.

Asthma was the most frequent Ambulatory Sensitive Condition overall and in the HKG plans. In FY2003, the leading ASC for HKS was Diabetes with ketoacidosis or coma, which accounted for 16% of total HKS admissions in that year.

<b>Figure 24 - Inpatient Admissions for Ambulatory Sensitive Conditions All Healthy Kids</b>		
	<b>% of Admissions</b>	
	<b>FY2002 Total=1,519</b>	<b>FY2003 Total=1,691</b>
<b>Condition</b>		
Asthma	3.1%	4.7%
Bacterial Pneumonia	3.6%	3.9%
Dehydration Volume Depletion	1.9%	3.9%
Kidney/Urine Infection	2.4%	2.4%
All Other ASC	6.2%	7.2%
All	17.2%	22.1%

# Emergency Department Use

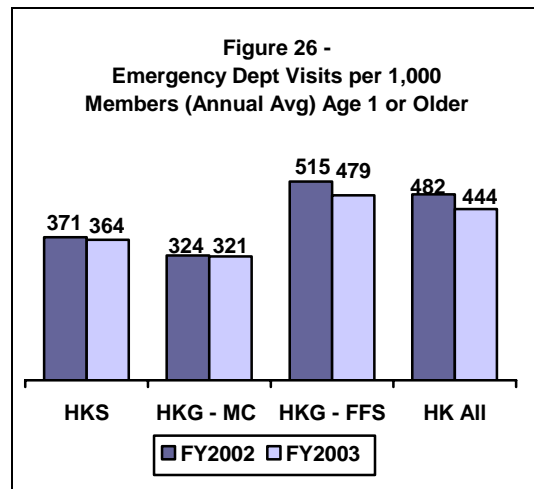
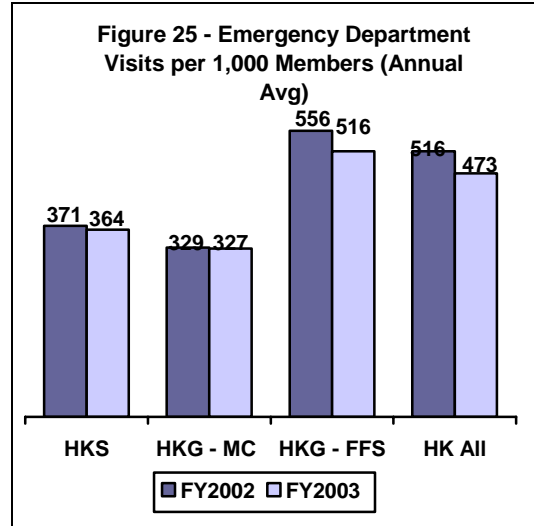
**Background:** Reliance on the hospital Emergency Department (ED) for routine treatment increase health care costs and can undermine continuity of care (the process by which the patient and a physician are cooperatively involved in ongoing health care management). High levels of ED utilization for non-urgent care can also signal potential issues with access to primary care.

Non-urgent care is medical care given for an acute onset of symptoms which are not emergent or urgent in nature, and which do not result in a hospital admission. Examples include cold symptoms, sore throat, and nasal congestion. Nationally, Medicaid has a higher percentage of ED visits for non-urgent care than other payers.<sup>21</sup>

The same factors that result in avoidable admissions for Ambulatory Sensitive Conditions (ASCs) coupled with lack of flexible provider hours in the evenings and on weekends, can lead to preventable visits to the Emergency Department.<sup>22</sup>

**Findings:** Across all Healthy Kids plans, the rate of ED use in FY2002 (Figure 25) was 516 per 1,000 members (annual average, not unduplicated), above the 2002 national ED rate for children under age 15 of 397 per 1,000.<sup>23</sup> The HKS rate of ED use in FY2002 was 371 per 1,000, below the national average. HKG-MC was lowest of all plans at 329 per 1,000.

HKG-FFS had the highest ED use of the three Healthy Kids programs. Even after excluding children under the age of 1 (Figure 26), who have a high rate of ED use, the FY2003 HKG-FFS ED rate was 479 per 1,000, 32% above HKS and 49% above HKG-MC.



# Emergency Department Use, continued

For Healthy Kids overall, 30% of Emergency Department Visits in FY2003 were for Ambulatory Sensitive Conditions (Figure 27), up from 27% in FY2002.

Severe ENT Infections accounted for one of every five ED Visits across all plans. Otitis media (middle ear infections) alone accounted for 13% of all ED visits in FY2003 (Figure 28).

More than 500 children across plans visited the ER more than once during the year for otitis media. Repeat visits accounted for one-third of all otitis media ED visits in HKG-FFS and one-fifth in HGK-MC. Repeat visits were much less common in the HKS plan.

Figure 27 - ED Visits for Ambulatory Sensitive Conditions (ASC) All Healthy Kids		
Condition	% of ED Visits	
	FY2002 Total = 29,128	FY2003 Total = 29,828
Severe ENT Infections	19.0%	20.6%
Diabetes C	2.2%	2.1%
Asthma	1.7%	2.1%
Gastroenteritis	1.4%	1.9%
Bacterial Pneumonia	1.0%	1.1%
All Other ASC	1.6%	2.0%
All	26.9%	29.7%

Figure 28 - ED Visits for Otitis Media FY2003		
Plan	% of All ED Visits	% of All ED Visits for Otitis Media by Members with Multiple ED Visits
HKS	8%	9%
HKG - MC	10%	20%
HKG - FFS	14%	33%
All HK	13%	n/a

# Chronic Care Management: Asthma

**Background:** Asthma is the most common chronic disease in children and a leading cause of missed school days, emergency room visits, and hospitalizations. Low-income, minority, and inner city children are at-risk for higher morbidity and mortality.<sup>24</sup> The U.S. Healthy People 2010 and Healthy New Hampshire 2010 have both targeted reductions in the rate of hospitalization for asthma.

For individuals with persistent asthma, clinical guidelines emphasize treatment with inhaled anti-inflammatory medications for long-term control. Compliance with appropriate maintenance medications has been found to reduce symptoms and hospital utilization and improve the quality of life.

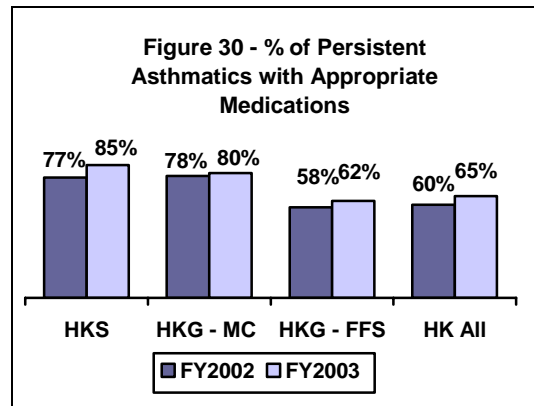
**Findings:** For the Healthy Kids programs overall, 7.6% of children had asthma in FY2003. HKG-MC had a lower prevalence of childhood asthma than did HKS or HKG-FFS. This is not unexpected, given that voluntary managed care plans often attract a healthier patient mix. HKG-FFS had the most severe patient mix of the three plans and HKS the least severe, consistent with the established relationship between asthma and socioeconomic status.

Of children with persistent asthma, 85% and 80%, respectively, of those in the HKS and HKG-MC plans were receiving appropriate medications in FY2003 (Figure 30). This performance compares very favorably to national Medicaid (exceeding the 90<sup>th</sup> percentile), to commercial HEDIS average results,<sup>25</sup> and the experience of other SCHIP programs (e.g., Florida).<sup>26</sup>

HKG-FFS had a lower percentage (62%) of persistent asthmatics on appropriate medications, a level consistent with the national Medicaid HEDIS average.

**Figure 29 - Asthma Prevalence (Age 2+) and Severity – FY2003**

Plan	Asthmatics per 100 Continuously Enrolled Members	% of Asthmatics w/ Persistent Asthma
HKS	8.3	53%
HKG – MC	6.8	62%
HKG – FFS	7.7	92%
HK All	7.6	85%



**Figure 31 - 2003 HEDIS Average Asthma Medication Use<sup>27</sup>**

<b>Medicaid</b>	
Ages 5 – 9	62%
Ages 10 – 17	62%
<b>Commercial</b>	
Ages 5 – 9	72%
Ages 10 – 17	68%

*Note: age groups not directly comparable*

# Mental Health Use and Cost

**Background:** Untreated mental health issues in children and adolescents can lead to school failure, substance abuse, problems with the criminal justice system, and suicide. Only 20% of children with mental disorders receive the treatment they need.<sup>28</sup>

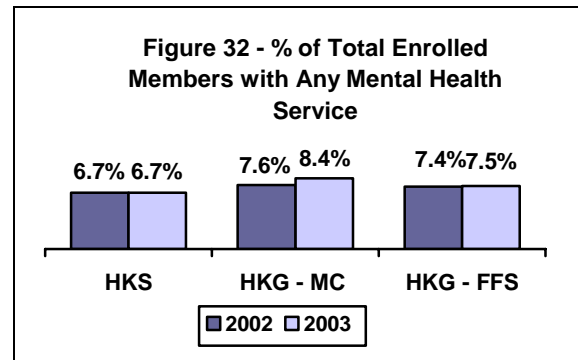
Nationally, about 5% of children and adolescents access mental health services in a given year, with Medicaid enrollees accessing mental health services at higher rates than the privately insured.<sup>29</sup> A national benchmarking study found that 10% of Medicaid children had a mental health service during the year.<sup>30</sup> States that included in this measure any mental health services delivered by primary care providers reported rates of 9% to 14%.

**Findings:** Approximately 7-8% of children enrolled in Healthy Kids at any time in FY2003 had at least one mental health service during the year (defined as any service with a mental health diagnosis or procedure). A slightly higher percentage of HKG children received a mental health service than HKS (Figure 32).

Among those with a mental health service, HKG-FFS children were almost twice as likely to be admitted inpatient as children in HKS and 65% more likely than children in HKG-MC. HKG-FFS children also had a longer average length of stay and were more likely to be readmitted (Figure 33).

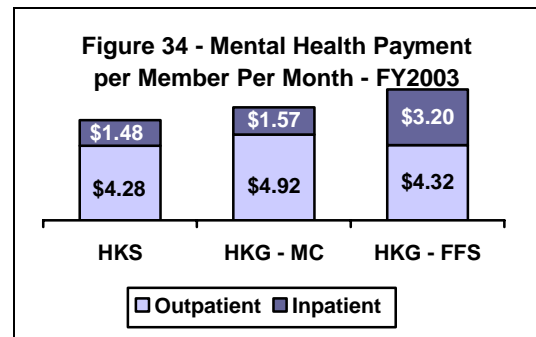
As a result of these utilization differences, 43% of HKG-FFS mental health expenditures were for inpatient care in FY2003, compared to approximately 25% in HKS and HKG-MC. HKG-FFS' outpatient payments PMPM were similar to HKS and HKG-MC, but HKG-FFS had much higher inpatient payments PMPM (Figure 34).

Across all Healthy Kids plans, the leading reasons for hospital admission were Depressive Disorder NEC and Depressive Psychosis (Unspecified).



**Figure 33 - Mental Health Admissions FY2003**

Plan	% of Members w/ MH Services Who are Admitted	Average Length of Stay
HKS	2.8%	7.11
HKG - MC	3.2%	6.74
HKG - FFS	5.3%	10.57



**Figure 35 - Top 5 Inpatient Mental Health Diagnoses All Healthy Kids – FY2003**

Condition	Number of Admits
Depressive Disorder NEC	58
Depressive Psychosis – Unspec	43
Oppositional Disorder	35
Prolonged Postpartum Stress*	21
Manic Depressive NOS	20

\*This appears to be a claims coding error

# Mental Health Use and Cost, continued

A higher percentage of HKS and HKG-MC children incurred outpatient mental health visits than HKG-FFS children (Figure 36). This suggests better access in these programs. Among children with visits, HKG-FFS children had more visits, on average. HKS and HKG-MC members were eligible for up to 20 visits per year as authorized by the Behavioral Health Network. However, HKG-MC members can receive additional services using their Medicaid card if approved by DHHS.

In the outpatient setting, Attention Deficit with Hyperactivity (ADHD) was the top mental health diagnosis in all plans. Prolonged Postpartum Stress was also frequent in HKG-FFS. This could be a claims coding error, but not necessarily so.

Note that the data summarized above do not include admissions or outpatient visits for substance abuse. Across all Healthy Kids plans, there were a total of eleven admissions and 324 outpatient visits for substance abuse in FY2003.

**Figure 36 - Outpatient Mental Health Visits  
FY2003**

	% of Enrolled Members w/ Outpatient MH Visits	Average # Visits
HKS	6.7%	7.12
HKG - MC	7.9%	6.99
HKG - FFS	6.0%	8.75

**Figure 37 - Top 5 Outpatient Mental Health Diagnoses  
All Healthy Kids – FY2003**

Condition	Total Visits
Attention Deficit w/Hyperactivity	7,090
Prolonged Postpartum Stress*	5,066
Adjust Reaction-Emotion/Conduct	4,619
Oppositional Disorder	4,544
Adj. Reaction – Mixed Emotions	3,749

\*This may be a claims coding error.

# Notes

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<sup>1</sup> RKM Research and Communications, Inc. *The 2003 New Hampshire Healthy Kids Program Evaluation*, June, 2004.

<sup>2</sup> Hoffman, C., Carbaugh, A., and Cook, A. *Health Insurance Coverage in America: 2003 Data Update*. Washington: Kaiser Commission on Medicaid and the Uninsured, November, 2004.

<sup>3</sup> Ellis, E. and Smith, V.K. *Medicaid Enrollment in 50 States: June 2003 Data Update*. Washington: Kaiser Commission on Medicaid and the Uninsured, January, 2004.

<sup>4</sup> Smith, V.K. and Rousseau, D. M. *SCHIP Program Enrollment: December 2003 Update*. Washington: Kaiser Commission on Medicaid and the Uninsured, July, 2004.

<sup>5</sup> Josephs, L. *Issue Brief: Geographic Barriers to Accessing Health 2002, Endowment for Health*, [www.endowmentforhealth.org](http://www.endowmentforhealth.org), December 27, 2002.

<sup>6</sup> Smith, V.K. and Rousseau, D. M. *SCHIP Program Enrollment: December 2002 Update*. Washington: Kaiser Commission on Medicaid and the Uninsured, July, 2003.

<sup>7</sup> Schenkman, B. et al., *Florida Annual SCHIP Report to CMS, FFY2002*.

<sup>8</sup> See RKM Research and Communications above.

<sup>9</sup> New Hampshire Department of Health and Human Services, Annual SCHIP Report to CMS, FFY2003.

<sup>10</sup> Hadley, J. *Sicker and Poorer: The Consequences of Being Uninsured, Executive Summary*. Prepared for the Kaiser Commission on Medicaid and the Uninsured, February, 2003.

<sup>11</sup> National Committee for Quality Assurance (NCQA).

<sup>12</sup> Chung, P.J. and Schuster, M.A. Access and Quality in Child Health Service: Voltage Drops, *Health Affairs*, 23(5), 77-87, September/October 2004.

<sup>13</sup> American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care, *Pediatrics*, 105(3), March 3, 2000, 645-646.

<sup>14</sup> Nagy, E. *Dental Care for Medicaid-Enrolled Children*. Washington: American Public Human Services Association, July, 2000.

<sup>15</sup> Wood, B., Bean, G., Baber, K., Bujino, L., Laflamme, D., and Kiely, M. *Supporting New Hampshire Youth, Moving Toward a Healthier Future*. Concord: New Hampshire Department of Health and Human Services, Division of Public Health Services, Maternal and Child Health Section, March, 2005.

<sup>16</sup> See NCQA above.

<sup>17</sup> See for example:  
Weissman, J.S., Gatsonis, C. and Epstein, A.M. Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland, *Journal of the American Medical Association*, 1992, 268, 2388-2394.

Pappas, G., Hadden, W., Kazak, L.J., and Fisher, G. Potentially Avoidable Hospitalizations: Inequalities in Rates between US Socioeconomic Groups, *American Journal of Public Health*, 1997, 87, 811-816.

<sup>18</sup> Parker, J.D. and Schoendorf, K.C. Variation in Hospital Discharges for Ambulatory-Care Sensitive Conditions Among Children, *Pediatrics*, October 2000, 106(4), 942-948.

# Notes

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<sup>19</sup> Hakim, R.B. and Bye, B. V. Effects of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries, *Pediatrics*, July 2001, 108(1), 90-97.

<sup>20</sup> *Quality of Care Measures: A Chart Book for the Florida KidCare Program*, University of Florida, Institute for Child Health Policy, October, 2004.

<sup>21</sup> McCaig, L.F., and Burt, C.W. National Ambulatory Medical Care Survey: 2002 Emergency Department Summary. *Advance Data from Vital and Health Statistics*, No. 340, March 18, 2004.

<sup>22</sup> Oster, A. and Bindman, B. Emergency Department Visits for Ambulatory Care Sensitive Conditions: Insights into Preventable Hospitalizations, *Medical Care*, 2003; 1(2): 198-207.

<sup>23</sup> See McCaig and Burt, above.

<sup>24</sup> Centers for Disease Control, National Center for Environmental Health, *Asthma's Impact on Children and Adolescents*, [www.cdc.gov/asthma/children.htm](http://www.cdc.gov/asthma/children.htm).

<sup>25</sup> See NCQA, *The State of Health Care Quality*, above.

<sup>26</sup> See *Quality of Care Measures: A Chart Book for the Florida KidCare Program* above,

<sup>27</sup> See NCQA, *The State of Health Care Quality: 2004*, above

<sup>28</sup> National Mental Health Association. A Public Health Crisis: Children and Adolescents With Mental Disorders, *Congressional Briefings Call for Early Identification, Evaluation, and Treatment of Children's Mental Disorder*, [www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=688](http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=688), News Release, May 12, 2005.

<sup>29</sup> Howell, E. M., Buck, J. A., and Teich, J. L. Mental Health Benefits Under SCHIP, *Health Affairs*, November/December 2000, 19(6), 291-297.

<sup>30</sup> Dougherty Management Associates, *Children's Mental Health Benchmarking Project: Fourth Year Report*, Funded by Annie E. Casey Foundation, January, 2005.