State of New Hampshire

Department of Health and Human Services

Network Access Report

Appointment Availability Survey

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Overview

In March of 2014, New Hampshire's Governor Hassan signed into law a bill that created the New Hampshire Health Protection Program (NHHPP). The NHHPP provides eligible residents with health insurance coverage through the Affordable Care Act's provision to expand State Medicaid programs. Coverage for the eligible residents began in the State's fee-for-service Medicaid system, and enrollees were transitioned to the managed care organizations (MCOs) between September 2014, and December 2014. Since the NHHPP fee schedule included higher payment rates than the MCM Program, DHHS was interested in determining whether appointment accessibility is different based on the member's enrolled program. In order to evaluate whether differences in appointment availability exist, HSAG designed and conducted a secret shopper provider survey to compare the average length of time to the first available appointment for new members enrolled in the NHHPP or MCM Program. The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

Methodology

The eligible population included primary care providers (PCPs) who were actively enrolled in both of the New Hampshire Medicaid programs as of May 28, 2015. PCPs were defined as physicians whose primary specialty included family practice, general practice, internal medicine, or an advanced registered nurse practitioner. Using provider data received from DHHS, HSAG selected an eligible population of active, office-based PCPs with telephone numbers. HSAG then used Quest Analytics software to standardize the physicians' addresses and remove duplicated addresses for the same provider.

HSAG used a two-stage random sampling approach to generate the list of sampled provider locations. The sampled providers were surveyed by telephone and the information collected was used to evaluate the availability of appointments. HSAG then determined whether appointment availability varied based on Medicaid program and type of appointments—i.e., preventive (e.g., annual check-up) and routine/episodic (e.g., sore throat with congested nose).

Based on the eligible population, HSAG generated a random sample of PCPs. HSAG selected 412 unique provider locations and randomly assigned 50 percent of them to each appointment type (i.e., 206 cases for preventive appointments and 206 cases for routine/episodic appointments) to ensure a minimum margin of error of +/- 7.1 percent and 95 percent confidence level separately for preventive and for routine/episodic appointments. An additional 25 percent oversample (i.e., 104 PCPs) was included to accommodate invalid provider contact information for a final sample provider pool of 516 PCPs.

HSAG staff called each selected provider's office twice to determine the number of days required to obtain an appointment with the selected provider.[1] The only variables differing between the two calls were the program (i.e., NHHPP or MCM) with the MCO being defined as one of two MCOs (i.e., New Hampshire Healthy Families and Well Sense Health Plan).

Summary of Findings

Overall, the results of the study do not suggest the presence of any bias in the scheduling of appointments due to program enrollment (i.e., MCM versus NHHPP). Regardless of the appointment type (i.e., preventive or routine/episodic), differences in the ability to schedule appointments of their timing was negligible and not statistically significant.

In general, very few calls resulted in an appointment. Overall, only 85.0 percent of the attempted calls (i.e., 669 completed calls) resulted in reaching an office scheduling department. Of those 669 calls, only 12.0 percent (i.e., 80 calls) resulted in an appointment. Moreover, of the 80 appointments made, less than half of the appointments were made within the required timeframe (i.e., 45 percent) regardless of appointment type or program (i.e., 42.6 percent for MCM and 48.0 percent for NHHPP). As such, there is no evidence that appointment time varies based on program, and subsequently, differential payment structures. The primary reason callers were unable to make an appointment was due to providers not accepting new patients. To investigate this finding further, HSAG conducted 64 supplemental secret shopper calls as a member of a "commercial" health plan to confirm the finding regardless of the source of coverage. Results indicated no difference in the ability to schedule appointments between commercial enrollees and Medicaid enrollees. This finding suggests that the inability to make an appointment is a larger, New Hampshire issue, and not an issue limited to New Hampshire Medicaid.

Similarly, there was little difference in the availability of *preventive appointments* between MCM and NHHPP members. Of the 328 valid cases, only 63 calls ended with an appointment. In more than three-quarters of the calls (i.e., 80.8 percent), callers were unable to secure an appointment despite reaching the scheduling department. Of the 63 appointments, only 34.9 percent (i.e., 22 appointments) fell within the 30-day standard established for preventive visits. With regard to the availability of *routine/episodic appointments*, again, there was little difference between MCM and NHHPP members. Of the 341 valid cases, only 17 calls ended with an appointment. In 95.0 percent of the calls , callers were unable to secure an appointment despite reaching the scheduling department. However, unlike preventive visits, of the 17 routine/episodic appointments, only 82.4 percent (i.e., 14 appointments) fell within the 10-day standard established for this appointment type. The primary reason callers were unable to make an appointment was due to provider not accepting new patients as well as the physician offices requiring patients to complete additional steps before an appointment could be scheduled or being required to submit clinical information.

[1] If an appointment was offered by the appointment scheduling staff for the sampled provider but at a different location, HSAG collected the appointment time, and included this information in its analysis. However, an appointment time offered for an alternate provider was not accepted.

Overview

In March of 2014, New Hampshire's Governor Hassan signed into law a bill that created the New Hampshire Health Protection Program (NHHPP). The NHHPP provides eligible residents with health insurance coverage through the Affordable Care Act's provision to expand State Medicaid programs. Residents began submitting applications to the NHHPP in July 2014, and the program commenced in August 2014. Coverage for the eligible residents began in the State's fee-for-service Medicaid system, and enrollees were transitioned to the managed care organizations (MCOs) in September 2014. The majority of the State's Medicaid population, the MCM population, was transitioned into MCOs in December 2014. The two Medicaid MCOs operating in the New Hampshire MCM Program are New Hampshire Healthy Families and Well Sense Health Plan.

Since the NHHPP fee schedule included higher payment rates than the MCM Program, DHHS was interested in determining whether appointment accessibility is different based on the member's enrolled program. In order to evaluate whether differences in appointment availability exist, HSAG designed and conducted a secret shopper provider survey to compare the average length of time to the first available appointment for new members enrolled in the NHHPP or MCM Program.

Methodology

HSAG conducted a secret shopper telephone survey of provider offices statewide to evaluate the average length of time needed for a Medicaid beneficiary to schedule an appointment and to be seen by a New Hampshire-licensed provider. A secret shopper is a person employed to pose as a client or patient in order to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

Eligible Population

The eligible population included primary care providers (PCPs) who were actively enrolled in both of the New Hampshire Medicaid programs as of May 28, 2015. PCPs were defined as physicians whose primary specialty included family practice, general practice, internal medicine, or an advanced registered nurse practitioner.[2]

[2] Specific criteria used to identify PCPs are as follows: PROVSPEC in ("001", "008", "011", "080") and PRVDR_LISTED_AS_PCP_IN_DIR_IND = "Y" and PRVDR_CLOSED_BY_MCO_DT = "12/31/9999" and PROVTYPE in ("020", "021", "022", "023", "033", "034"). In addition, PCP-type physicians and Advanced Registered Nurse Practitioners who practice in non-office settings (i.e., hospital-based providers, school-based providers, urgent care, etc.) were excluded, as well as pediatricians since the NHHPP is primarily a program for adults.

Data Collection

HSAG obtained provider information (i.e., practice location, telephone number, provider type, and specialty) from DHHS for all providers enrolled as of May 28, 2015, in one of the two MCOs.[3] Upon receipt of the data, HSAG selected an eligible population of active, office-based PCPs with telephone numbers. Unfortunately, due to limitations in the provider data collected for this study, HSAG was unable to identify either the provider's *panel status* or whether the provider was *accepting new patients.* HSAG used Quest Analytics software to standardize the physicians' addresses and remove duplicated addresses for the same provider.

Sample Selection

As noted earlier, PCPs with telephone numbers who were associated with both MCOs and programs[2] (i.e., NHHPP and MCM Program) were included in the secret shopper telephone survey. HSAG used a two-stage random sampling approach to generate the list of sampled provider locations. The sampled providers were surveyed by telephone and the information collected was used to evaluate the availability of appointments. HSAG then determined whether appointment availability varied based on Medicaid program and type of appointments—i.e., preventive (e.g., annual check-up) and routine/episodic (e.g., sore throat with congested nose). Specifically, HSAG determined whether appointment availability met the performance standards established in the MCOs' Amendment #5, Sections 19.3.4.2.3 and 19.3.4.2.4 of the MCM Agreement between DHHS and the MCOs[4].

Based on the eligible population, HSAG generated a random sample of PCPs. For each sampled provider associated with two or more locations, HSAG randomly selected one location. HSAG selected 412 unique provider locations and randomly assigned 50 percent of them to each appointment type (i.e., 206 cases for preventive appointments and 206 cases for routine/episodic appointments) to ensure a minimum margin of error of +/- 7.1 percent and 95 percent confidence level separately for preventive and for routine/episodic appointments. An additional 25 percent oversample (i.e., 104 PCPs) was included to accommodate invalid provider contact information for a final sample provider pool of 516 PCPs.

Telephone Survey of Providers' Offices

HSAG staff called each selected provider's office twice to determine the number of days required to obtain an appointment with the selected provider.[5] The only variables differing between the two calls were the program (i.e., NHHPP or MCM) with the MCO being defined as one of two MCOs (i.e., New Hampshire Healthy Families and Well Sense Health Plan). The program associated with the initial call was randomly assigned. The MCO associated with each provider was also randomly assigned, with 50 percent of the selected providers being assigned to each of the two MCOs. HSAG

[3] HSAG assumed that the provider network is functionally equivalent for the NHHPP and MCM Program.
[4] State of New Hampshire Department of Health and Human Services. (2014). *Amendment #5 to the Medicaid Care Management Contract.* Retrieved from http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: September 21, 2015.
[5] If an appointment was offered by the appointment scheduling staff for the sampled provider but at a different location, HSAG collected the appointment time, and included this information in its analysis. However, an appointment time offered for an alternate provider was not accepted.

staff made one phone call to each selected provider office during standard operating hours. If the secret shopper reached an answering service or voicemail during standard business hours, the secret shopper made a second attempt. If the caller was still unable to reach the appointment scheduling staff, the provider was noted as unavailable and replaced with an alternate provider. Also, in cases where the secret shopper was put on hold, the caller would wait on hold for five minutes before ending the call. The caller then made a second attempt at a different time. If the caller was still unable to reach the appointment scheduling staff, the provider was noted as unavailable and, again, would be replaced with an alternate provider. Appendix A contains the script HSAG used when calling the offices.[6]

Sampled providers were replaced with a provider from the oversample for the following scenarios:

- Phone number is not for the sampled provider
- Phone number is a non-working number
- Caller reaches voicemail and the voicemail identifies a different provider than the one selected
- Provider practice is located in a non-office setting (e.g., hospital-based, school-based clinic, urgent care, etc.)
- Provider is deceased or retired
- Provider is no longer employed by practice
- Provider is not a PCP
- Provider requires patient eligibility verification prior to scheduling an appointment
- Provider is not accepting insurance from NHHPP or MCM Program[6]
- Provider is not accepting insurance from MCOs[7]

[6] Temporary Medicaid IDs for use in the study were unavailable due to system constraints.
[7] Due to limitations in the provider data collected for this study, HSAG was unable to identify either the provider's *panel status* or whether the provider was *accepting new patients.*

The secret shopper results are divided into two sections to evaluate whether appointment availability differs by program/MCO and appointment types. The survey findings are first presented for preventive appointments followed by the results for routine/episodic appointments.

Preventive Appointments

The following section presents the results of telephone calls made to provider offices for preventive appointments. According to Amendment #5, the MCM Agreement between DHHS and the MCOs, these types of appointments are expected to be scheduled within 30 calendar days of the member's call. Table 1 presents the overall and program-specific results of the telephone calls to the sampled providers, including the original number of sampled cases, the number and percent of invalid sample cases, the number of invalid oversample cases, and the final number of sampled PCPs. (See Appendix C for a visual display of the telephone outcome surveys.)

Table 1—Secret Shopper Survey Response Rates For Preventive Appointments

Program	Original Cases			Replacement Cases			Final Sample Size[1]
	Initial Sample	Invalid Cases		Available	Invalid Cases		
		Number	Percent		Number	Percent	
MCM	206	61	29.6%	52	19	36.5%	178
NHHPP	206	79	38.3%	52	29	55.8%	150
Total	**412**	**140**	**34.0%**	**104**	**48**	**46.2%**	**328**

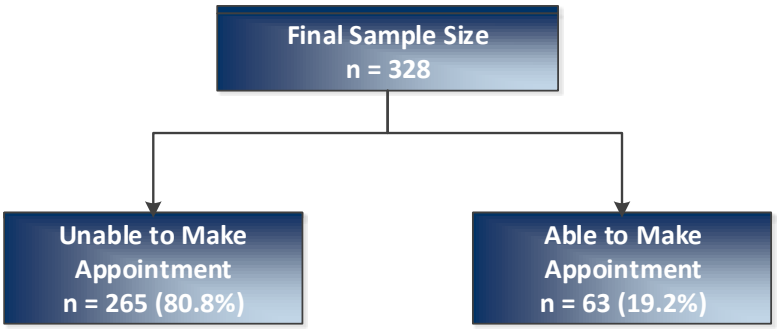
[1] Based on the exclusion of invalid sample cases, the final sample size led to a maximum margin of error of +/- 5.6 percent and 95 percent confidence level for preventive appointments. The margin of error at the program level varied slightly based on differences in the number of final sample cases—i.e., +/- 8.3 percent for the NHHPP and +/- 7.6 percent for the MCM.

Among the 412 cases initially targeted for telephone outreach, 140 cases (i.e., 34.0 percent) were invalid and required replacement from the oversample. However, 48 replacement cases (i.e., 46.2 percent of replaced cases) were also invalid leading to a final sample size of 328 cases. With a range of 5.4 percentage points[8], the NHHPP and MCM Program had slight differences in the percentage of cases requiring a replacement with NHHPP providers requiring the greatest percentage of replacement (i.e., 20.9 percent). Program differences were largely attributed to the number of providers who indicated they did not participate in NHHPP despite being identified as an NHHPP provider in the State's data system. The majority of reasons for case replacement involved an incorrect/disconnected telephone number or providers who were no longer employed by the specific practice, followed by providers working in specialized care facilities (i.e., senior care and emergency room facilities). A list of all reasons for case replacement by program is detailed in Appendix B.

[8] Range is equal to the difference between MCM and NHHPP for [All Invalid Cases] / [All Outreach Calls]. MCM = [61 + 19] / [412+104], and NHHPP = [79 + 29] / [412 + 104].

Figure 1 shows a high-level visual representation of the different outcomes among the valid PCP cases for preventive appointments and key outcomes.

Figure 1—Preventive Appointment Outcome Map for Valid Cases



Overall, secret shoppers were only able to schedule preventive appointments with 19.2 percent of the providers (i.e., 63 cases). This finding suggests that one in every five new patients may require assistance from the MCOs to schedule a routine appointment with a PCP. The remaining tables in this section highlight detailed results by program for each of the key outcomes associated with the process map shown in Figure 1.

Table 2 presents the appointment status results overall and by program, including the number and percent of sampled PCPs in which callers were able or unable to schedule an appointment for preventive primary care.

Table 2—Number and Percent of Outreach Calls For Preventive Appointments

Program	Final Sample	Able to Schedule Appointment		Unable to Schedule Appointment	
		Number	Percent	Number	Percent
MCM	178	37	20.8%	141	79.2%
NHHPP	150	26	17.3%	124	82.7%
Total	**328**	**63**	**19.2%**	**265**	**80.8%**

As noted earlier, only about 20 percent (i.e., 63 or 19.2 percent) of the calls to providers to schedule a preventive visit led to an appointment. These results were consistent across both programs with individual performance was slightly lower, although not statistically significant, for the NHHPP (i.e., 17.3 percent) versus the MCM Program (i.e., 20.8 percent). The majority of reasons a caller was unable to schedule an appointment was related to a provider office indicating they were *not accepting new patients* (i.e., 55.8 percent overall, and 51.8 percent for MCM Program and 60.5 percent for the NHHPP). A list of all of the reasons callers were unable to schedule appointments by program is outlined in Appendix B.

Table 3 describes the minimum, maximum, and average calendar days to a preventive appointment as well as the percentage of calls that met the contractual requirement (i.e., an appointment within 30 calendar days).

Table 3—Average Time to Preventive Appointments								
		Calls with Appointment		Calendar Days to Appointment			Appointments in Compliance[1]	
Program	Final Sample	Number	Percent	Min	Max	Average	Number	Percent
MCM	178	37	20.8%	3	172	52.0	13	35.1%
NHHPP	150	26	17.3%	7	137	47.1	9	34.6%
Total	**328**	**63**	**19.2%**	3	172	50.0	**22**	**34.9%**

[1]Appointment standard = 30 calendar days.

Overall, only 19.2 percent (or 63) of the calls resulted in being able to schedule a preventive care appointment with a PCP. The average days to an appointment was 50 calendar days with wait times ranging from 3 days (MCM) to 172 days (MCM). On average, preventive appointments for MCM members were scheduled within 52 days whereas preventive appointments for members with the NHHPP had an average wait time of 47.1. Overall, only 34.9 percent of the preventive appointments could be scheduled within 30 calendar days of the outreach call with minimal differences noted between the NHHPP and MCM Program (i.e., 34.6 percent versus 35.1 percent, respectively). A slightly larger percentage of appointments (i.e., 35.1 percent) for MCM members were scheduled within 30 calendar days compared to NHHPP enrollees—i.e., 34.9 percent. The difference between the two programs was not statistically significant.

Routine/Episodic Appointments

The following section presents the results of telephone calls made to provider offices for routine/episodic (e.g., sore throat with congested nose) appointments. According to Amendment #5, the MCM Agreement between DHHS and the MCOs, these types of appointments are expected to be scheduled within 10 calendar days of the member's call. Table 4 presents the overall and program-specific results of the routine/episodic telephone calls to the sampled providers, including the original number of sampled cases, the number and percent of invalid sample cases, the number of invalid oversample cases, and the final number of sampled PCPs. (See Appendix C for a visual display of the telephone outcome surveys.)

Table 4—Secret Shopper Survey Response Rates For Routine/Episodic Appointments							
	Original Cases			Replacement Cases			Final Sample Size[1]
Program	Initial Sample	Invalid Cases		Available	Invalid Cases		
		Number	Percent		Number	Percent	
MCM	206	56	27.2%	52	12	23.1%	190
NHHPP	206	82	39.8%	52	25	48.1%	151
Total	**412**	**138**	**33.5%**	**104**	**37**	**35.6%**	**341**

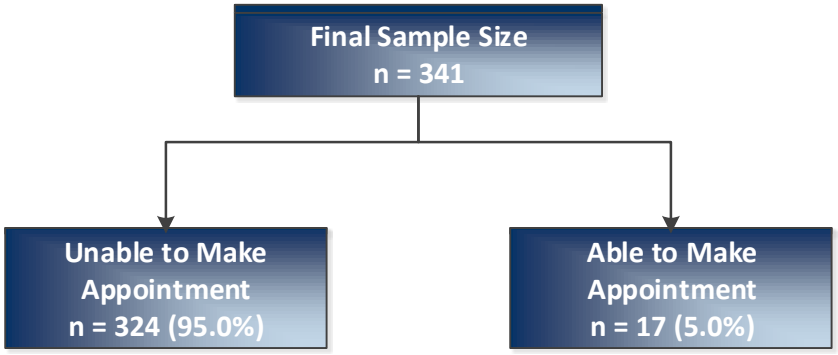
[1]Based on the exclusion of invalid sample cases, the final sample size led to a maximum margin of error of +/- 5.5 percent and 95 percent confidence level for routine/episodic appointments. The margin of error at the program level varied slightly based on differences in the number of final sample cases—i.e., +/- 8.3 percent for the NHHPP and +/- 7.4 percent for the MCM.

Among the 412 cases selected for telephone outreach, 138 cases (i.e., 33.5 percent) were invalid and required replacement from the oversample. However, many of the replacement cases (i.e., 37 cases, 35.6 percent of replaced cases) were also invalid leading to a final sample size of 341 cases.

With a range of 7.5 percentage points[9], the NHHPP and MCM Program had slight differences in the percentage of cases requiring a replacement with NHHPP providers requiring the greatest percentage of replacement (i.e., 20.7 percent). The majority of reasons for case replacement involved providers who were no longer employed by the specific practice and incorrect/disconnected phone numbers, followed by providers working in specialized care facilities (i.e., senior care and emergency room facilities). A list of all reasons for case replacement by program are detailed in Appendix B. Program differences were largely attributed to the number of providers who indicated they did not participate in NHHPP despite being identified as an NHHPP provider in the State's data system.

Figure 2 shows a high-level visual representation of the different outcomes among the valid PCP cases for routine/ episodic appointments and key outcomes.

Figure 2—Routine/Episodic Appointment Outcome Map for Valid Cases



Overall, secret shoppers were only able to schedule routine/episodic appointments with 5.0 percent of the providers (i.e., 17 cases). This finding suggests that more than nine in every ten new patients may require assistance from the MCOs to schedule a routine/episodic appointment with a PCP. This percentage is considerably lower than was identified for preventive visits. The remaining tables in this section highlight detailed results by program for each of the key outcomes associated with the process map shown in Figure 2.

Table 5 presents the appointment status results overall and by program, including the number and percent of sampled PCPs in which callers were able or unable to schedule an appointment for routine/episodic care.

[9] Range is equal to the difference between MCM and NHHPP for [All Invalid Cases] / [All Outreach Calls]. MCM = [56 + 12] / [412+104], and NHHPP = [82 + 25] / [412 + 104].

Table 5—Number and Percent of Outreach Calls for Routine/Episodic Appointments					
Program	Final Sample	Able to Schedule Appointment		Unable to Schedule Appointment	
		Number	Percent	Number	Percent
MCM	190	10	5.3%	180	94.7%
NHHPP	151	7	4.6%	144	95.4%
Total	**341**	**17**	**5.0%**	**324**	**95.0%**

As noted earlier, only 5 percent (or 17) of the calls to providers to schedule a routine/episodic visit led to an appointment. These results were consistent across both programs with individual performance slightly lower, although not significantly, for NHHPP (i.e., 4.6 percent) versus the MCM Program (i.e., 5.3 percent). The majority of reasons a caller was unable to schedule an appointment was related to a provider office indicating they were *not accepting new patients* (i.e., 41.0 percent overall, and 40.0 percent for MCM Program and 42.4 percent for the NHHPP). A list of all of the reasons callers were unable to schedule appointments by program is outlined in Appendix B. Table 6 describes the minimum, maximum, and average calendar days to a routine/episodic appointment as well as the percentage of calls that met the contractual requirement (i.e., an appointment within 10 calendar days).

Table 6—Average Time to Routine/Episodic Appointments								
Program	Final Sample	Calls with Appointment		Calendar Days to Appointment			Appointments in Compliance[1]	
		Number	Percent	Min	Max	Average	Number	Percent
MCM	190	10	5.3%	0	14	4.8	7	70.0%
NHHPP	151	7	4.6%	0	10	3.0	7	100%
Total	**341**	**17**	**5.0%**	**0**	**14**	**4.1**	**14**	**82.4%**

[1]Appointment standard = 10 calendar days.

Overall, only 5.0 percent (or 17) of the calls resulted in being able to schedule a routine/episodic appointment. The average days to an appointment was 4.1 calendar days with wait times ranging from same-day appointments (i.e., MCM and NHHPP, each) to 14 days (i.e., MCM). On average, routine/episodic appointments for MCM members were scheduled within 4.8 days whereas routine/episodic appointments for members with NHHPP had an average wait time of 3.0 days. Overall, 82.4 percent of the routine/episodic appointments could be scheduled within 10 days of the outreach call with some differences noted between the NHHPP and MCM Program performance (i.e., 100 percent versus 70.0 percent, respectively). However, due to the small number of calls that ended with an appointment, caution should be used when interpreting these differences.

Conclusions

Overall, the results of the study do not suggest the presence of any bias in the scheduling of appointments due to program enrollment (i.e., MCM versus NHHPP). Regardless of the appointment type (i.e., preventive or routine/episodic), differences in the ability to schedule appointments was negligible and not statistically significant.

In general, very few calls resulted in an appointment. Table 7 presents the overall study results by program and by appointment type.

Table 7—Overall Study Results by Program and Appointment Type

Program	Preventive			Routine/Episodic			Total Appts.[4]
	Total Calls[1]	Appts.	Compliant[2]	Total Calls[1]	Appts.	Compliant[3]	
MCM	178	37 (20.8%)	13 (35.1%)	190	10 (5.3%)	7 (70.0%)	47 (12.8%)
NHHPP	150	26 (17.3%)	9 (34.6%)	151	7 (4.6%)	7 (100%)	33 (11.0%)
Total	**328**	**63 (19.2%)**	**22 (34.9%)**	**341**	**17 (5.0%)**	**14 (82.4%)**	**80 (12.0%)**

[1] A total sample of 412 cases was selected for each program, stratified by type of appointment (i.e., 206 preventive cases and 206 routine/episodic cases).
[2] Appointment standard = 30 calendar days.
[3] Appointment standard = 10 calendar days.
[4] Total Appointments = total number of preventive and routine/episodic appointments divided by the total number of preventive and routine/episodic calls made. This number provides an overall estimate of access to services.

In reviewing the overall study results presented in this report, the following conclusions can be drawn:

- Overall, only 85.0 percent of the attempted calls (i.e., [1032 total attempted calls[10]] – [363 invalid calls] = [669 completed calls]) resulted in reaching the scheduling department. Of those 669 calls, only 12.0 percent (i.e., 80 calls) resulted in an appointment. Moreover, of the 80 appointments made, less than half of the appointments (i.e., [22 + 14 compliant appointments] / [63 + 17 appointments]) were made within the required timeframe (i.e., 45 percent) regardless of appointment type or program (i.e., 42.6 percent for MCM and 48.0 percent for NHHPP).
- Similar to the overall findings, there was little difference in the availability of *preventive appointments* between MCM and NHHPP members.
    - Of the 328 valid cases, only 63 calls ended with an appointment. In more than three-quarters of the calls (i.e., 80.8 percent), callers were unable to secure an appointment despite reaching the scheduling department. The primary reason callers were unable to make an appointment was due to the provider not accepting new patients as well as being unable to reach the appointment staff or being required to submit clinical information.

[10] Attempted calls includes both sample and oversample cases.

- Of the 63 appointments, only 34.9 percent (i.e., 22 appointments) fell within the 30-day standard established for preventive visits.
- No substantial differences were noted between the MCM and NHHPP populations.

- Similar to the overall findings, there was little difference in the availability of *routine/episodic appointments* between MCM and NHHPP members.
  - Of the 341 valid cases, only 17 calls ended with an appointment. In 95.0 percent of the calls , callers were unable to secure an appointment despite reaching the scheduling department. The primary reason callers were unable to make an appointment was due to provider not accepting new patients as well as the physician offices requiring patients to complete additional steps before and appointment could be scheduled or being required to submit clinical information. Again, these results suggest the potential for limited capacity of provider practices.
  - Unlike preventive visits, of the 17 routine/episodic appointments, only 82.4 percent (i.e., 14 appointments) fell within the 10-day standard established for this appointment type.

In order to validate the accuracy of the study results, HSAG conducted a supplemental survey of providers that reported not accepting new patients. Specifically, HSAG secret shoppers re-contacted provider offices posing as commercial insurance members of Anthem State Employee's Insurance[11] to determine whether Medicaid status had been a factor in providers' responses. Using the same script as the original study, callers attempted to schedule appointments as commercial members. Of the 64 completed calls, only 1 (1.7 percent) resulted in a scheduled appointment. Moreover, 76.6 percent of the calls were unsuccessful due to the providers not accepting new patients, further corroborating the findings. Although some research has noted differences in the acceptance of new patients based on payment source[12], these findings suggest access to providers is a statewide issue, and not an issue exclusive to New Hampshire Medicaid.

Study Limitations

Although the current study does not reveal any impact of differential provider payments on the availability of appointments, the secret shopper survey has identified several potential barriers that affect the study. Among the potential areas are the accuracy of New Hampshire's Medicaid provider data and the availability of providers to accept enrollees in the MCM Program and NHHPP.

Of the 516 total preventive outreach calls, only 328 valid cases were identified. This finding suggests that approximately one-third (i.e., 36.4 percent) of the provider contact information proved to be inaccurate or outdated, and was ultimately excluded from the study. Regardless of the program, the primary drivers for exclusions were related to inaccurate provider information and classification. Similarly, out of the 516 total routine/episodic outreach calls, only 341 valid cases were identified. Again, this finding suggests that approximately one-third (i.e., 33.9 percent) of the provider contact information proved to be inaccurate or outdated, and was ultimately excluded from the study. Similar to preventive appointments, the primary driver for routine/episodic appointment

[11] Please note that Anthem State Employee's Insurance was selected to ensure the widest possible network.
[12] Hing, E. (2015, August 14). *QuickStats: Percentage of Office-Based Primary Care Physicians Not Accepting New Patients, by Source of Payment - United States, 2013*. (Centers for Disease Control and Prevention) Retrieved October 27, 2015, from Morbidity and Mortality Weekly Report (MMWR): http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6431a10.htm?s_cid=mm6431a10_e

exclusions were related to inaccurate provider information and classification. As a supplemental investigation, HSAG researched the automated provider directories of providers previously identified as *not accepting new patients*. Of the 18 providers reviewed, the automated directories confirmed that 7 (38.9 percent) of the providers were not accepting new patients while 11 (61.1 percent) of the providers indicated they were accepting new patients. Based on these results, nearly two-thirds provided responses during the telephone survey that did not match the automated directory. Due to the daily variation that occurs in providers' panels, it is not possible to say whether this is a data source issue or a discrepancy due to timing. However, future studies will need to limit the selection of providers to those that are active and accepting new patients.

Appendix A—Provider Survey Script

1. Determine whether sample case is associated with the NHHPP or MCM Program (i.e., New Hampshire Healthy Families and Well Sense Health Plan).

2. Call the office and document the name of the appointment scheduling staff member.

3. "Hello, does Dr. <<Insert Dr.'s Last Name>> take <<Insert MCO Name>>[13]?" (If YES, GO TO Item #4; if NO, then SKIP TO Item #9)

4. "Does Dr. <<Insert Dr.'s Last Name>> take <<Insert Program Name>>[14]?" (If YES, then GO TO #Item 5; if NO, then SKIP TO Item #9)

5. If *Appointment Type* = Preventive, GO TO Item #7; if *Appointment Type* = Routine/Episodic, GO TO Item #6.

6. "I have a sore throat and a congested nose. When is the earliest appointment date with Dr. <<Insert Dr.'s Last Name>>?"

7. "I need an annual check-up. When is the earliest appointment date with Dr. <<Insert Dr.'s Last Name>>?"

8. If able to schedule an appointment, record the date noted by the scheduler but do not schedule the appointment. (GO TO #9)

9. "Thank you."

[13] Fifty percent of the calls referred to New Hampshire Healthy Families and fifty percent referred to Well Sense Health Plan.
[14] Each provider was called twice; one call for NHHPP and one call for the MCM Program.

Appendix B—Appointment Availability Detail Results

Detailed Preventive Appointment Results

Table 8—Reasons for Replacement of Providers for Preventive Appointments						
Reasons for Replacement[1]	Total		MCM		NHHPP	
	Number	Percent	Number	Percent	Number	Percent
Incorrect/disconnected phone number	42	30.0%	21	34.4%	21	26.6%
Doctor not employed by practice	23	16.4%	11	18.0%	12	15.2%
Non-office setting	21	15.0%	11	18.0%	10	12.7%
Does not accept MCO	19	13.6%	9	14.8%	10	12.7%
Does not accept program	17	12.1%	1	1.6%	16	20.3%
Not a PCP	9	6.4%	5	8.2%	4	5.1%
Doctor is dead or retired	6	4.3%	3	4.9%	3	3.8%
Requires eligibility verification	3	2.1%	0	0.0%	3	3.8%

[1] Although the same provider was contacted for each program (i.e., MCM versus NHHPP), differences in the number of invalid cases requiring replacement occurred since the calls were made separately leading to different program results. For example, one of the two calls to the same PCP may have resulted in contact with the scheduling staff while the other call did not.

Table 9 highlights the reasons for being unable to schedule a preventive appointment with a provider. Of the 265 cases in which an appointment could not be scheduled, 148 of the unscheduled appointments (i.e., 55.8 percent) were due to the provider no longer accepting new patients followed by 39 cases (i.e., 14.7 percent) where the caller was unable to reach the appointment scheduling staff. These reasons were consistently cited for both programs accounting for close to three-quarters of the incomplete appointments for the NHHPP and MCM Programs (i.e., 73.4 percent and 68.1 percent, respectively). Of the incomplete appointments, more than half of the calls cited providers not accepting new patients for both programs. None of the proportionate values for the other reasons substantively differed between the programs.**Error! Reference source not found.**

Table 9—Reasons Associated with Callers being Unable to Schedule Preventive Appointments[1]						
Reasons for Incomplete Appointments	Total		MCM		NHHPP	
	Number	Percent	Number	Percent	Number	Percent
Not accepting new patients[2]	148	55.8%	73	51.8%	75	60.5%
Unable to reach the appointment scheduling staff	39	14.7%	23	16.3%	16	12.9%
New patient process[3]	36	13.6%	18	12.8%	18	14.5%
Requires medical record review	29	10.9%	19	13.5%	10	8.1%
Panel review[4]	13	4.9%	5	3.5%	8	6.5%
Accepts patients but with limits[5]	7	2.6%	5	3.5%	2	1.6%

Table 9—Reasons Associated with Callers being Unable to Schedule Preventive Appointments[1]						
Reasons for Incomplete Appointments	Total		MCM		NHHPP	
	Number	Percent	Number	Percent	Number	Percent
Leaving practice	6	2.3%	3	2.1%	3	2.4%
Cannot answer insurance questions	5	1.9%	4	2.8%	1	0.8%
Other	3	1.1%	3	2.1%	0	0.0%

[1] The total for all reasons is greater than the number of outreach calls ending in no appointment since one negative outcome may be associated with multiple reasons. As such, the percent calculations are based on the number of calls that did not end in an appointment (i.e., MCM 141 and NHHPP 124).

[2] HSAG conducted two supplemental investigations to ensure the accuracy of its findings. First, HSAG conducted 64 calls as "commercial" health plan members to confirm offices were not accepting new patients independent of Medicaid status. Results indicated no differences between commercial health plan and Medicaid enrollees. Additionally, HSAG identified confirmed the providers' *new patient status* against health plan online directories. In approximately 60 percent of the cases, the *new patient status* was verified suggesting that the source provider data contained insufficient or inaccurate information to correctly identify provider actively accepting patients. Future studies will adjust for this limitation.

[3] The *New patient process* refers to physician offices that require patients to complete additional steps before an appointment can be scheduled (e.g., register with the office, complete new patient paperwork, participate in new patient interview, etc.).

[4] A *Panel review* refers to provider offices that require the patient to supply clinical information for review by a panel of physicians. If accepted following the panel review process, the patient is assigned to an appropriate provider and scheduled for an appointment.

[5] The *Accepts patients but with limitations* reason refers to physician offices that limit their patient panel—i.e., children only. Since the population for this study is limited to adults, these calls led to no appointments.

Detailed Routine/Episodic Appointment Results

Table 10—Reasons for Replacement of Providers for Routine/Episodic Appointments						
Reasons for Replacement[1]	Total		MCM		NHHPP	
	Number	Percent	Number	Percent	Number	Percent
Doctor not employed by practice	37	26.8%	20	35.7%	17	20.7%
Incorrect/disconnected phone number	37	26.8%	19	33.9%	18	22.0%
Does not accept program	30	21.7%	1	1.8%	29	35.4%
Non-office setting	14	10.1%	6	10.7%	8	9.8%
Does not accept MCO	9	6.5%	3	5.4%	6	7.3%
Not a PCP	6	4.3%	4	7.1%	2	2.4%
Doctor is dead or retired	3	2.2%	2	3.6%	1	1.2%
Requires eligibility verification	2	1.4%	1	1.8%	1	1.2%

[1] Although the same provider was contacted for each program (i.e., MCM versus NHHPP), differences in the number of invalid cases requiring replacement occurred since the calls were made separately leading to different program results. For example, one of the two calls to the same PCP may have resulted in contact with the scheduling staff while the other call did not.

Error! Reference source not found. highlights the reasons for being unable to schedule a preventive appointment with a provider. Of the 324 cases in which an appointment could not be scheduled, 133 of the unscheduled appointments (i.e., 41.0 percent) were due to the provider no longer accepting new patients followed by 64 cases (i.e., 19.8 percent) where the office staff indicated that additional steps were required before an appointment could be made. These reasons were consistently cited for both programs accounting for close to two-thirds of the incomplete appointments for the NHHPP and MCM Programs. None of the proportionate values for the different reasons substantively differed between the programs.

Table 11—Reasons Associated with Callers being Unable to Schedule Routine/Episodic Appointments[1]						
Reasons for Incomplete Appointments[1]	Total		MCM		NHHPP	
	Number	Percent	Number	Percent	Number	Percent
Not accepting new patients[2]	133	41.0%	72	40.0%	61	42.4%
New patients process[3]	64	19.8%	39	21.7%	25	17.4%
Panel review[4]	39	12.0%	20	11.1%	19	13.2%
Requires medical record review	32	9.9%	18	10.0%	14	9.7%
Won't schedule, referred out	29	9.0%	16	8.9%	13	9.0%
Appointment unavailable in a timely manner[5]	24	7.4%	16	8.9%	8	5.6%
Unable to reach the appointment scheduling staff	22	6.8%	9	5.0%	13	9.0%
Accepts patients but with limitations[6]	16	4.9%	8	4.4%	8	5.6%
Leaving practice	10	3.1%	3	1.7%	7	4.9%
Other	3	0.9%	1	0.6%	2	1.4%

[1] The total for all reasons is greater than the number of outreach calls ending in no appointment since one negative outcome may be associated with multiple reasons. As such, the percent calculations are based on the number of calls that did not end in an appointment as noted in Table 5 (i.e., MCM 180 and NHHPP 144).

[2] HSAG conducted two supplemental investigations to ensure the accuracy of its findings. First, HSAG conducted 64 calls as "commercial" health plan members to confirm offices were not accepting new patients independent of Medicaid status. Results indicated no differences between commercial health plan and Medicaid enrollees. Additionally, HSAG identified confirmed the providers' *new patient status* against health plan online directories. In approximately 60 percent of the cases, the *new patient status* was verified suggesting that the source provider data contained insufficient or inaccurate information to correctly identify provider actively accepting patients. Future studies will adjust for this limitation.

[3] The *New patient process* refers to physician offices that require patients to complete additional steps before an appointment can be scheduled (e.g., register with the office, complete new patient paperwork, participate in new patient interview, etc.).

[4] A *Panel review* refers to provider offices that require the patient to supply clinical information for review by a panel of physicians. If accepted following the panel review process, the patient is assigned to an appropriate provider and scheduled for an appointment.

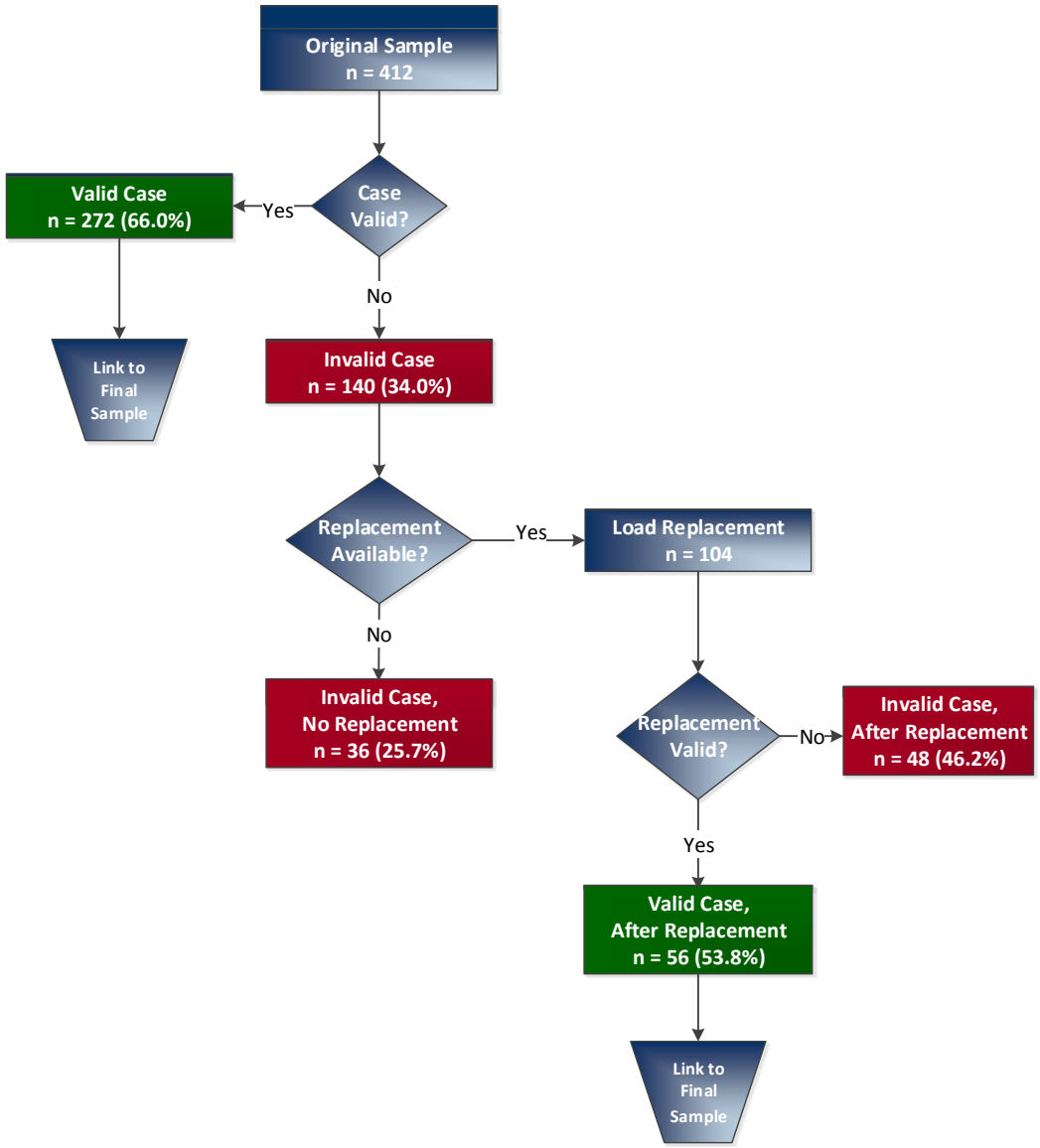
[5] An *Appointment unavailable in a timely manner* refers to physician offices that could not offer an appointment in a timely manner when the patient presents with a symptom. In this situation, the physician office recommended seeking treatment through another provider (e.g., urgent care).

[6] The *Accepts patients but with limitations* reason refers to physician offices that limit their patient panel—i.e., children only. Since the population for this study is limited to adults, these calls led to no appointments.

Appendix C—Telephone Survey Outcome Maps

Preventive Appointment Outcome Map for Sampled Cases

The figure below shows the call pathway followed by the secret shopper callers when making preventive appointments with provider offices. The diagram offers a high-level visual representation of the different outcomes encountered during the telephone calls. Decision points are identified with diamonds while key outcomes are displayed in boxes. Invalid cases (i.e., red boxes) represent cases that are eventually excluded from the comparative analyses while valid cases (i.e., green boxes) are included in the final evaluation.



Routine/Episodic Appointment Outcome Map for Sampled Cases

The figure below shows the call pathway followed by the secret shopper callers when making routine/episodic appointments with provider offices. The diagram offers a high-level visual representation of the different outcomes encountered during the phone calls. Decision points are identified with diamonds while key outcomes are displayed in boxes. Invalid cases (i.e., red boxes) represent cases that are eventually excluded from the comparative analyses while valid cases (i.e., green boxes) are included in the final evaluation.