DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

June 23, 2015

Nicholas A. Toumpas
Commissioner
Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301

Dear Mr. Toumpas:

The Centers for Medicare and Medicaid Services (CMS) is issuing technical corrections to New Hampshire's Medicaid section 1115 demonstration, entitled "New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration" (Project Number 11-W-00298/1) under authority of section 1115(a) of the Social Security Act (the Act), to ensure that the special terms and conditions (STC) reflect how the state is currently operating its demonstration.

The technical corrections include the following clarifications:

- The state may begin enrollment activities for the demonstration before November 1, 2015;
- Individuals who are determined to be eligible for (as well as enrolled in) the state's mandatory Health Insurance Premium Payment (HIPP) program will be excluded from the demonstration; and
- NHHPP beneficiaries will receive a Medicaid card from the state to ensure that they are able to access wrap benefits.

To reflect upon the agreed terms between the state and CMS, we have incorporated the technical changes into the latest version of the STCs. Please find enclosed the updated STCs.

If you have any questions, please do not hesitate to contact your project officer, Ms. Megan Lepore. Ms. Lepore can be reached at (410) 786-4113, or at megan.lepore@cms.hhs.gov.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Angela D. Garner
Acting Director
Division of State Demonstrations and Waivers

Enclosure

cc: Richard McGreal, Associate Regional Administrator, CMS Boston Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 4, 2015

Nicholas A. Toumpas
Commissioner, Department of Health and Human Services
Brown Building,
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Toumpas:

The Centers for Medicare & Medicaid Services (CMS) is approving New Hampshire's application for a one-year Medicaid demonstration project entitled, "New Hampshire Health Protection Program (NHHPP) Premium Assistance" (Project Number 11-W-00298/1). The demonstration is approved on March 4, 2015 in accordance with section 1115(a) of the Social Security Act (the Act). The demonstration is effective on January 1, 2016 and is approved through December 31, 2018, assuming the state fulfills the requirements outlined within the Special Terms and Conditions (STCs) to continue the demonstration beyond December 31, 2016 and contingent upon the reauthorization of the program by the New Hampshire legislature. Enrollment for the demonstration will begin on November 1, 2015, with eligibility effective on January 1, 2016.

The demonstration will affect non-medically frail individuals aged 19-64 in the new adult coverage group. The approved demonstration provides authority to New Hampshire to provide premium assistance to such individuals in the new adult group to enable them to enroll in qualified health plans (QHPs) offered in the Marketplace. Beginning November 1, 2015, non-medically frail individuals enrolled in the state's current delivery system for the new adult group (the managed care program called "The Bridge Program"), as well as new non-medically frail applicants, will be able to select a QHP for enrollment effective January 1, 2016.

For such individuals, most benefits would be accessed through the QHP network, and the QHP payment rate would be payment in full for such benefits, subject to cost sharing consistent with New Hampshire's approved state plan. Such individuals would receive the benefits described in New Hampshire's Alternative Benefit Plan (ABP) under its state plan. Beneficiaries under age 21 will be eligible for early and periodic screening and diagnostic treatment (EPSDT) services and all beneficiaries in the demonstration shall be able to access out-of-network family planning, non-emergency transportation, adult vision and limited adult dental benefits through the state Medicaid agency in coordination with the QHPs. Cost sharing will be consistent with New Hampshire's state plan. The demonstration includes a conditional waiver of retroactive coverage, with implementation of the waiver conditioned upon receipt of data demonstrating that the state's coverage system provides a seamless eligibility determination experience for the beneficiary that ensures that the beneficiary will not have periods of uninsurance.

The authority to deviate from Medicaid requirements is limited to the specific waivers and expenditure authorities described in the enclosed lists, and to the purposes indicated for each of those waivers and expenditure authorities. The enclosed STCs further define the nature, character, and extent of anticipated federal involvement in the project, and the state's implementation of the waivers and expenditure authorities, and the state's responsibilities to CMS during the demonstration period. Our approval of the demonstration is conditioned upon the state's compliance with these STCs. Our approval is further subject to CMS receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for these demonstrations is Ms. Megan Lepore. She is available to answer any questions concerning your section 1115 demonstration Ms. Lepore's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4113
E-mail: Megan.Lepore@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lepore and to Mr. Richard McGreal, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
JFK Federal Building
Room 2275
Boston, MA 02203-0003
Telephone: (617) 565-1299
E-mail: Richard.McGreal@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Thank you for all your work with us, as well as stakeholders in New Hampshire, over the past several months on developing this important demonstration. Congratulations on this approval.

Sincerely,

/s/
Andy Slavitt
Acting Administrator

Enclosures

cc: Richard McGreal, ARA, Region I

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00298/1**

TITLE: **New Hampshire Health Protection Program Premium Assistance**

AWARDEE: **New Hampshire Department of Health and Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall for the period of this demonstration extension be regarded as expenditures under the state's Title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the New Hampshire Health Protection Program Premium Assistance section 1115 demonstration.

1. **Premium Assistance and Cost Sharing Reduction Payments.** Expenditures for part or all of the cost of private insurance premiums, and for payments to reduce cost sharing, for individuals affected by the demonstration.

Requirements Not Applicable:

1. **Cost Effectiveness** **Section 1902(a)(4)**
42 CFR 435.1015(a)(4)

   To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER LIST

NUMBER: **11-W-00298/1**

TITLE: **New Hampshire Health Protection Program Premium Assistance**

AWARDEE: **New Hampshire Department of Health and Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from March 31, 2015 through December 31, 2018. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs.

1. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To enable New Hampshire to require that beneficiaries enroll in a QHP to obtain a source of third party coverage, and to limit beneficiary choice of providers to those participating in the network of the beneficiary's QHP.

2. **Prior Authorization** **Section 1902(a)(54) insofar as it incorporates Section 1927(d)(5)**

   To permit New Hampshire to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.

3. **Payment to Providers** **Section 1902(a)(13)**
   Section 1902(a)(30)

   To the extent necessary to permit New Hampshire to provide payment to providers equal to the market-based rates determined by the QHP providing primary coverage for services.

4. **Retroactivity** **Section 1902(a)(34)**

   Contingent on a satisfactory submission pursuant to STC 21, to the extent necessary to enable New Hampshire not to provide medical coverage to NHHPP members in the NHHPP Premium Assistance demonstration for any time prior to the first day of the month in which an individual applies.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00298/1

TITLE: New Hampshire Health Protection Program Premium Assistance

AWARDEE: New Hampshire Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Hampshire Health Protection Program Premium Assistance section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the State of New Hampshire (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs further set forth in detail the nature, character, and extent of Federal involvement in the demonstration, the state's implementation of the waivers and expenditure authorities, and the state's obligations to CMS during demonstration period. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population will begin on or before November 1, 2015, at which time Medicaid eligible adults can enroll into health coverage under qualified health plans (QHPs) and receive premium assistance with coverage effective January 1, 2016. This demonstration will sunset after December 31, 2016, consistent with the current legislative approval for the New Hampshire Health Protection Program pursuant to N.H. RSA 126-A:5, XXIII-XXV, but may continue for up to two additional years, through December 31, 2018, if the New Hampshire legislature authorizes the state to continue the demonstration and the state provides notice to CMS, as described in these STCs.

The STCs have been arranged into the following subject areas:

XIV. Monitoring
XV. Health Information Technology and Premium Assistance
XVI. T-MSIS

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the NHHPP Premium Assistance demonstration, the state will use premium assistance to support the purchase of coverage by beneficiaries eligible under the new adult group provided by certain qualified health plans (QHPs) doing business in the individual market through the Marketplace. The demonstration will affect individuals in the new adult group covered under Title XIX of the Social Security Act who are adults from age 19 up to and including 64 with incomes up to and including 133 percent of the federal poverty level (FPL) who are neither enrolled in (or eligible for) Medicare or enrolled in or eligible for the state's mandatory Health Insurance Premium Payment (HIPP) program.

New Hampshire expects approximately 50,000 beneficiaries to be enrolled into the Marketplace through this demonstration program. NHHPP Premium Assistance beneficiaries will receive the State plan Alternative Benefit Plan (ABP) and will have cost sharing obligations consistent with the state plan, as amended by the state. The ABP is the same benchmark plan chosen by the New Hampshire Marketplace to establish Essential Health Benefits. QHP will pay primary for covered services. QHP payment rates will be considered payment in full for covered services, and individuals affected by the demonstration will be limited to the QHP provider network, except in the case of family planning providers.

The demonstration will further the objectives of Title XIX by reducing coverage disruptions for individuals moving between Medicaid and the Marketplace due to changes in income. The demonstration will also test whether the premium assistance structure and resulting coverage affords beneficiaries access to wider provider networks, provides for higher provider payments for covered services, encourages more cross-participation by plans in Medicaid and the Exchange, and achieves cost reductions due to greater competition.

The state proposes to evaluate whether the demonstration will achieve the following goals-

- Continuity of coverage- For individuals whose incomes fluctuate, the demonstration will permit continuity of health plans and provider networks. Individuals and families may receive coverage through the same health plans and may seek treatment and services through the same providers regardless of whether their underlying coverage is financed by Medicaid or through the Marketplace. The state will evaluate whether individuals remain in the same QHP when Medicaid payment is terminated.
- Plan Variety - The demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace would afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and would increase the

selection of plans for both Medicaid and Marketplace enrollees. The state will evaluate whether there is an increase in plan variety because of this cross-program participation.

- Cost Effective Coverage – The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs. This, in turn, may result in coverage that achieves cost reductions in comparison to direct Medicaid coverage. The state will evaluate whether QHP coverage is cost effective, looking at the entire demonstration period and trends that emerge as the demonstration proceeds.
- Uniform provider access – The state will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such

legislation was required to be in effect under the law.

5. **State Plan Amendments.** If the eligibility of a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

    a. Should the state amend the state plan to make any changes to eligibility for this population, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request a corresponding technical correction to the demonstration.

6. **Changes Subject to the Amendment Process.** Changes related to demonstration features including eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to the demonstration without prior approval by CMS through an amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC **7** below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the state, consistent with the requirements of STC 16, prior to submission of the requested amendment;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An up-to-date CHIP allotment neutrality worksheet, if necessary; and

    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Option to Continue Demonstration Beyond DY 1. If the state intends to continue operating this demonstration beyond DY 1 and the legislature authorizes such continuation, the state must submit a letter of intent to CMS no later than 6 months prior to the end of each DY for which the state seeks continuation of the demonstration,. Otherwise, the state should submit a phase-out plan consistent with the requirements of STC 10.

9. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than six months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 10.

a. Compliance with Transparency Requirements at 42 CFR §431.412.

b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements at 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 16.

10. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised plan.

b. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.

c. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage

for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category described in 42 CFR Section 435.916.

e. Exemption from Public Notice Procedures described in 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).

f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

11. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 45 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 47.

12. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.

13. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the

affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration enrollees as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration enrollee requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling enrollees.

14. **Withdrawal of Waiver Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.

15. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

16. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), to the extent applicable. The state must also comply, to the extent applicable, with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements

contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The state must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

17. Federal Financial Participation (FFP). No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. Eligibility

18. Populations Affected by the NHHPP Premium Assistance Demonstration. Except as described in STCs 19, 20, and 23, the NHHPP Premium Assistance Demonstration affects the coverage and delivery of benefits for adults aged 19 through 64 eligible under the state plan consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR Section 435.119 who are not medically frail or eligible for or enrolled in the HIPP program. Eligibility and coverage for these individuals are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except to the extent expressly waived. Implementation of such waiver authority must be consistent with these STCs. Any Medicaid state plan amendments to this eligibility group will apply to this demonstration.

Medicaid State Plan Mandatory Groups	Federal Poverty Level	Funding Stream	Expenditure and Eligibility Group Reporting
Adults in Section VIII Group	Adults at or below 133 percent FPL, who are not medically frail or eligible for or enrolled in the HIPP program.	Title XIX	MEG – 1

19. **Medically Frail Individuals.** New Hampshire will institute a process to determine whether an individual is medically frail. The process will be described in the ABP state plan provisions. Individuals who are medically frail will be excluded from the demonstration.

20. **American Indian/Alaska Native Individuals.** Individuals identified as American Indian or Alaskan Native (AI/AN) have the ability to opt out of the demonstration and access the ABP offered under the Alternative Benefit State Plan. An AI/AN individual who does not opt out of enrolling in a QHP through the NHHPP Premium Assistance will be able to access covered benefits through I/T/U facilities. Under the Indian Health Care Improvement Act (IHCIA), AI/AN I/T/U facilities are entitled to payment notwithstanding network restrictions. As of the approval of this demonstration, there are no I/T/U facilities in the state of New Hampshire.

21. **Retroactive Coverage.** Prior to making any change in policies regarding retroactive coverage for the demonstration population, the state shall submit data to CMS to establish that there is seamless coverage that does not result in gaps in coverage prior to the time that a Medicaid application is filed, for individuals in the populations affected by the demonstration. The state will submit a description of its renewal process and data related to that process, as well as any relevant data related to coverage continuity to evaluate whether individuals are losing coverage upon renewal. Upon a CMS determination that sufficient data has been provided to establish that retroactive coverage prior to the date of application is not necessary to fill gaps in coverage, the state shall not have to provide retroactive coverage prior to the date of application under the demonstration; coverage for demonstration applicants will begin at the date of application.

V. NHHPP PREMIUM ASSISTANCE ENROLLMENT

22. **NHHPP Premium Assistance.** For individuals who are eligible for the NHHPP Premium Assistance, enrollment in a QHP will be mandatory unless the individual is determined to be exempt or excluded as described in STC 23.

23. Exclusions and Exemptions from Enrollment. The following individuals are either not permitted or not required to enroll in the NHHPP Premium Assistance.

a. Individuals who are eligible for the NH state plan HIPP program for individuals with access to cost-effective ESI are not permitted to enroll in NHHPP Premium Assistance.
b. Individuals who are determined to be medically frail are not permitted to enroll in NHHPP Premium Assistance.
c. Individuals who are AI/AN are not required to enroll in NHHPP Premium Assistance.

24. Notices. NHHPP Premium Assistance beneficiaries will receive a notice from New Hampshire Medicaid advising them of the following:

a. QHP Plan Selection. The notice will include information regarding how NHHPP Premium Assistance beneficiaries can select a QHP, including guidance on selecting the plan that will best address their needs and information on the state's auto-enrollment process in the event that the beneficiary does not select a plan.
b. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and Medicaid card. The notice will include information on how beneficiaries can use the CIN number or Medicaid card to access services until their QHP enrollment is effective.
c. Wrapped Benefits. The notice accompanying the Medicaid card will also include information on how enrollees can use the card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 36.
d. Appeals. The notice will also include information regarding the grievance and appeals process.
e. Exemption from the demonstration. The notice will include information describing how new adult enrollees who believe they may be exempt from the NHHPP Premium Assistance program can request an exemption determination. The notice will include information on the difference in benefits under the Premium Assistance ABP as compared to the other benefits available.
f. Additional Notices. The eligibility determination notice will advise that the NHHPP Premium Assistance program is subject to cancellation upon notice.

25. QHP Selection. The QHPs in which NHHPP Premium Assistance beneficiaries will enroll will be reviewed by the New Hampshire Insurance Department (NHID) and certified through the Federally Facilitated Marketplace's QHP certification process. The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.

26. Enrollment Process. The enrollment process will begin on or before November 1, 2015 through the following procedures for new applicants and transition population.

New Applicants:

a. Individuals will submit a joint application for insurance affordability programs –

Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions – electronically, via phone, by mail, or in-person.

b. An eligibility determination will be made through the New Hampshire Eligibility & Enrollment Framework (EEF).

c. Medicaid eligible individuals determined to be eligible for the demonstration will receive coverage through the state plan until January 1, 2016, after which they will receive coverage through the demonstration except as specified in d.

d. Individuals who are determined to be medically frail based on the definition and process identified in the state's approved alternative benefit plan will be excluded from the demonstration and will receive direct coverage as described in the state plan Alternative Benefit Plan for the medically frail. Individuals who are determined to be eligible for the HIPP program will be excluded from the demonstration.

e. Individuals who are not identified as medically frail will receive a notice informing them that they may select a QHP and providing guidance on how to select a QHP. The notice will also include information on selecting a QHP and comparisons highlighting the differences between plans with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.

f. Individuals may select a QHP (1) through the state's online portal, NHEASY, (2) by phone, or (3) in person.

g. Individuals who fail to select a QHP within 30 days of an eligibility determination will be auto-assigned. New Hampshire will send individuals a notice informing them of the QHP to which they have been auto-assigned and that they have the right to select a different plan.

h. Once an individual has either selected a QHP or the time period to select a QHP has ended, New Hampshire will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.

i. Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.

j. On at least a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for New Hampshire's Department of Health and Human Services (NHHHS) to reconcile. Upon reconciliation NHHHS will send back an updated list for carriers.

k. The state's MMIS will generate an 820 transaction to pay premiums and cost sharing reductions on behalf of beneficiaries directly to the QHP issuer.

l. State MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail; or determined to be eligible for or enrolled in the HIPP program and excluded from NHHPP Premium Assistance.

Transition Population:

a. Prior to and during the open enrollment period, New Hampshire Medicaid will send enrollees a notice informing them either: (1) that they have been auto-assigned to the QHP offered by their Medicaid managed care organization (MCO) in which they are currently enrolled (if the MCO elects to offer QHPs), but that they may select a different plan that is included in the NHHPP program or (2), if they have not been auto-assigned, that they may select a QHP that is included in the NHHPP Premium Assistance program. The notices will provide guidance on how to select a QHP. The notice will also include comparisons highlighting the differences between plans with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.

b. Individuals may select a QHP (1) through the state's online portal, NHEASY, (2) by phone, or (3) in person.

c. Individuals who were not auto-assigned to a QHP offered by their MCO and who fail to select a QHP within 30 days of receiving the notice informing them to select a QHP will be auto-assigned. New Hampshire Medicaid will send the individuals a notice informing them of the QHP to which they have been auto-assigned and that they have the right to select a different plan.

d. Once an individual has either selected a QHP or the time period to select a QHP has ended, New Hampshire will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.

e. Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.

f. On at least a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for New Hampshire's Department of Health and Human Services (NHHHS) to reconcile. Upon reconciliation NHHHS will send back an updated list for carriers.

g. The state's MMIS will generate an 820 transaction to pay premiums and cost sharing reductions on behalf of beneficiaries directly to the QHP issuer.

h. State MMIS premium and cost sharing reduction payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; the individual is determined to be

medically frail; or determined to be eligible for or enrolled in the HIPP program and excluded from NHHPP Premium Assistance.

27. **Auto-assignment.** The following categories will be auto-assigned a QHP: (1) individuals who are enrolled in a Medicaid MCO that offers a QHP, and (2) individuals who are not enrolled in a Medicaid MCO or whose Medicaid MCO is not offering a QHP and who fail to select a QHP within 30 days of an eligibility determination or receipt of a notice to select a plan. New Hampshire Medicaid will send the individuals a notice informing them of the QHP to which they have been auto-assigned and their right to select a different plan. Individuals will be given a thirty-day period to request enrollment in another plan.

28. **Auto-assignment Methodology.** The auto-assignment methodology in DY 1 will take into account, among other factors, family affiliation, primary care provider affiliation, and premium costs.

29. **Changes to Auto-assignment Methodology.** The state will advise CMS 60 days prior to implementing a change to the auto-assignment methodology.

30. **Disenrollment.** Enrollees in the NHHPP Premium Assistance may be disenrolled if (i) they are determined to be medically frail after they were previously determined eligible or (ii) if they are determined eligible for or enrolled in the mandatory HIPP program.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

31. **Memorandum of Understanding.** The New Hampshire Department of Health and Human Services shall enter into a memorandum of understanding (MOU) with each QHP issuer that will enroll individuals covered under the demonstration. Areas to be addressed in the MOU include, but are not limited to:

    a. Enrollment of individuals in populations affected by the demonstration;
    b. Payment of premiums and cost-sharing reductions;
    c. Reporting and data requirements necessary to monitor and evaluate the NHHPP Premium Assistance including those referenced in STC 69, ensuring coordination of benefits and enrollee access to EPSDT and other covered benefits through the QHP;
    d. Noticing requirements; and,
    e. Audit rights.

32. **Qualified Health Plans.** The state will provide premium assistance to support the purchase of coverage for NHHPP Premium Assistance beneficiaries through Marketplace QHPs.

33. **Choice.** Each NHHPP Premium Assistance beneficiary will have the option to choose between at least two silver plans offered in the individual market through the Marketplace. The state will pay the full cost of QHP premiums and will provide cost sharing reductions.

a. NHHPP Premium Assistance enrollees with incomes below 100 percent of the FPL will be enrolled in plans that effectively are 100 percent actuarial value (AV) high-value silver plans (after accounting for cost sharing reductions). Enrollees with incomes above 100 up to 133 percent of the FPL will be enrolled in plans that effectively are 94 percent AV high-value silver plans (after accounting for cost sharing reductions).
b. NHHPP Premium Assistance beneficiaries will be able to choose from at least two silver plans in each rating area of the state.
c. The state will comply with Essential Community Provider network requirements, as part of the Qualified Health Plan certification process.

34. **Coverage Prior to Enrollment in a QHP.** The state will provide coverage through fee-for-service Medicaid from the date of application for coverage under the new adult group until the individual's enrollment in the QHP becomes effective.

    a. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment).
    b. For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).

VII. BENEFITS

35. **Alternative Benefit Plan.** Individuals affected by this demonstration will receive benefits described in an alternative benefit plan set forth in the approved state plan. Individuals enrolled in QHPs will be restricted to the QHP provider network (except for family planning providers) to receive such benefits and the QHP will pay primary to Medicaid for covered benefits. The QHP payment rate will be payment in full for such benefits.

36. **Medicaid Wrap Benefits**. The state will provide through its fee-for-service Medicaid program wrap-around benefits that are included in the ABP but not covered by qualified health plans. These benefits include non-emergency medical transportation (NEMT), early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21, family planning services and supplies, and certain limited adult dental and adult vision services.

37. **Access to Wrap Around Benefits**. In addition to receiving an insurance card from the applicable QHP issuer, NHHPP Premium Assistance beneficiaries will be sent a notice and Medicaid card from the New Hampshire Department of Health and Human Services. The notice will contain information on how enrollees can use their Medicaid card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 36.

38. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The state must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

39. **Access to Federally Qualified Health Centers and Rural Health Centers.** NHHPP Premium Assistance enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC.

VII. COST SHARING

40. **Cost sharing.** Cost sharing for NHHPP Premium Assistance enrollees must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR Section 447.56. All cost sharing on demonstration participants will be consistent with New Hampshire's approved state plan, as amended by the state.

41. **Payment Process for Payment of Cost Sharing Reduction to QHPs.** Agreements with QHP issuers may provide for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for NHHPP Premium Assistance beneficiaries. Such payments will be subject to reconciliation at the conclusion of the benefit year based on enrollee's actual usage of services. The state's reconciliation process will follow 45 CFR Section 156.430 to the extent possible.

IX. APPEALS

Beneficiary safeguards of appeal rights will be provided by the state, including fair hearing rights. No waiver will be granted related to appeals. The state must ensure compliance with all federal and state requirements related to beneficiary appeal rights.

X. GENERAL REPORTING REQUIREMENTS

42. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XII of these STCs.

43. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

44. **Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the NHHPP Premium Assistance beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal

policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

Areas to be addressed include, but are not limited to:

1. Transition and implementation activities;
2. Stakeholder concerns;
3. QHP operations and performance;
4. Enrollment;
5. Cost sharing;
6. Quality of care;
7. Beneficiary access,
8. Benefit package and wrap around benefits;
9. Audits;
10. Lawsuits;
11. Financial reporting and budget neutrality issues;
12. Progress on evaluation activities and contracts;
13. Related legislative developments in the state; and
14. Any demonstration changes or amendments the state is considering.

45. Quarterly Progress Reports. The state will provide quarterly reports to CMS.

a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

46. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

47. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of DY 1 and after the end of each additional demonstration year, if applicable. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.

a. All items included in the quarterly report pursuant to STC 45 must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and

c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

48. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

49. Quarterly Expenditure Reports. The state must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XII of the STCs.

50. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 62.

b. Cost Settlements. For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet sine 10B, in lieu of lines 9 or 10C. For any cost settlement

not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.

c. Premium and Cost Sharing Contributions. To the extent New Hampshire collects premiums, premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.

e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The state must complete separate waiver forms for the following eligibility groups/waiver names:

i. MEG 1 – "New Adult Group"

f. The first Demonstration Year (DY1) will begin on January 1, 2016. In the event that the state requests an extension of the demonstration consistent with STC 8, subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	January 1, 2016	12 months
Demonstration Year 2 (DY2)	January 1, 2017	12 months
Demonstration Year 3 (DY3)	January 1, 2018	12 months

51. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs ("ADM").

52. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the

demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

53. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 45, the actual number of eligible member months for the demonstration populations defined in STC 18. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

   To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

54. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

55. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section XII:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

56. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

57. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that

incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

58. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 61, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

59. Risk. The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 61, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

60. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 61below. In the event that there is more than one DY, the annual limits will then be added together to

obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 63 below.

61. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 80. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

MEG	TREND	DY 1 - PMPM
New Adult Group	3.7%	$701.53

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

62. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of

budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

63. **Future Adjustments to the Budget Neutrality Expenditure Limit**. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

64. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, in the event that there is more than one Demonstration Year. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	3%
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	0%

65. **Exceeding Budget Neutrality**. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

66. **Submission of Evaluation Design.** The state shall submit a draft evaluation design to CMS no later than 90 days after the award of the Demonstration. The evaluation design, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 69, is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the state. The state shall provide the Final Evaluation Design within 45 days of receipt of CMS comments. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment A.

67. **Cost-effectiveness.** While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the NHHPP Premium Assistance Demonstration using premium assistance when considered in its totality demonstrates cost effectiveness taking

into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

b. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the NHHPP Premium Assistance Demonstration compared to what would have happened for a comparable population in Medicaid Care Management.

c. The state will compare total costs under the NHHPP Premium Assistance Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

d. The state will compare changes in access and quality to associated changes in costs within the NHHPP Premium Assistance. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in New Hampshire will be determined and compared to improvement efforts undertaken in other delivery systems.

68. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall be a summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, data collection and analysis, interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the

evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

69. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

i. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
ii. Premium assistance beneficiaries will have equal or better access to preventive care services.
iii. Premium assistance beneficiaries will have lower non-emergent use of emergency room services.
iv. Premium assistance beneficiaries will have fewer gaps in insurance coverage.
v. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
vi. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.
vii. Premium assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
ix. Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
x. Premium assistance beneficiaries will have appropriate access to non-emergency transportation.
xi. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC 69 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
xii. The demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace could afford beneficiaries seamless coverage during times of

transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees.

b. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:

1. Comparisons of provider networks;
2. Consumer satisfaction and other indicators of consumer experience;
3. Provider experience; and
4. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

c. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered

d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically valid sample size is available.

e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the impact and/or effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the state may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Centers for Medicare and Medicaid Services Medicaid Adult Core measures, for meaningful use under HIT, or from the National Quality Forum. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.

f. Data Collection: This discussion shall include:

1. A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

i. Medicaid encounter and claims data,
ii. Enrollment data, and
iii. Consumer and provider surveys

g. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.

h. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow to the greatest extent possible that the effects of the Demonstration are isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.

i. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

j. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

70. Interim Evaluation Report. If the state continues the demonstration beyond DY 1, then the state is required to submit a draft Interim Evaluation Report 90 days following completion of year two of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC72 for the Final Summative Evaluation Report.

71. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from the Demonstration. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the expiration date of the Premium Assistance Demonstration, the State shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 30 days.

72. The Final Summative Evaluation Report. The Final Summative Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

73. State Presentations for CMS. The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 69. The State will present on its interim evaluation in conjunction with STC 70. The State will present on its summative evaluation in conjunction with STC 71.

74. Public Access. The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

a. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

75. Electronic Submission of Reports. The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.

76. **Cooperation with Federal Evaluators**. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

77. **Cooperation with Federal Learning Collaboration Efforts.** The State will cooperate with improvement and learning collaboration efforts by CMS.

78. **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

79. **Deferral for Failure to Provide Summative Evaluation Reports on Time.** The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIV. MONITORING

80. **Quarterly Evaluation Operations Report.** The State will provide quarterly reports to CMS. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration, including the reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

81. **Annual Discussion with CMS.** In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

82. **Rapid Cycle Assessments.** The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

83. Health Information Technology (Health IT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

a. Health IT: New Hampshire must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange, to the greatest extent possible. Federal funding for developing HIE infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.

c. All requirements must also align with New Hampshire's State Medicaid HIT Plan, as applicable, and other planning efforts such as the ONC HIE Operational Plan.

XVI. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in New Hampshire against which the premium assistance demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

2016 NEW HAMPSHIRE HEALTH PROTECTION PROGRAM - *PREMIUM ASSISTANCE PROGRAM* WAIVER (NHHPP PAP)

WAIVER EVALUATION DESIGN PLAN

This program is operated under an 1115 Research and Demonstration Waiver initially approved by the Centers for Medicare & Medicaid Services (CMS) on March 4, 2015.

Table of Contents

Synopsis of New Hampshire Health Protection Program – Premium Assistance Waiver

On March 4, 2015, the New Hampshire Department of Health and Human Services (DHHS) received approval from the Center for Medicare & Medicaid Services (CMS) to develop the New Hampshire Health Protection Program's Premium Assistance Program component as an 1115 Medicaid Demonstration Waiver program. The New Hampshire Health Protection Program (NHHPP) Act includes three components: (1) a mandatory Health Insurance Premium Payment Program (HIPP) for individuals with access to cost-effective employer-sponsored insurance; (2) a bridge program to cover the new adult group in Medicaid managed care plans from August 15, 2014 through December 31, 2015; and (3) a mandatory individual qualified health plan (QHP) premium assistance program (PAP) beginning on January 1, 2016.

In accordance with CMS' waiver requirement, DHHS must develop an evaluation plan for the NHHPP PAP Demonstration waiver no later than 90 days following waiver approval from CMS. The proposed PAP evaluation plan is built on monitoring both process and outcome performance measures that increase in number over the three years potentially available for the waiver due to data varying in collection, processing, and finalization cycles. This increase in available evaluation data over time means that the data available towards the end of 2016 (i.e., first year of the NHHPP PAP) will not be complete and should be considered a first approximation for the first set of monitoring measures, rather than definitive results.

Enrollment activities for the PAP adult population will begin on or before November 1, 2015, depending on whether beneficiaries are enrolled in the Bridge Program. However, regardless of prior enrollment status, Medicaid eligible adults can enroll into health coverage under QHPs and receive premium assistance beginning November 1, 2015, for coverage effective January 1, 2016. This Demonstration will sunset after December 31, 2016 consistent with the current legislative approval for the New Hampshire Health Protection Program pursuant to N.H. RSA 126-A:5, XXIII-XXV, but may continue for up to two additional years, through December 31, 2018, if the New Hampshire legislature authorizes the State to continue the Demonstration and the State provides notice to CMS, as described in the Special Terms and Conditions.[1]

[1] Special Terms and Conditions (STC) Document #11-W-00298/1.

Key Components and Objectives of the QHP PAP

The NHHPP PAP Demonstration will assist the State in its goals to ensure:

1. **Continuity of coverage**—*For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks;*[2]
2. **Plan variety**—*The Demonstration will encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and will encourage QHP carriers to seek Medicaid managed care contracts;*
3. **Cost-effective coverage**—*The premium assistance approach will increase QHP enrollment and result in greater economies of scale and competition among QHPs; and*
4. **Uniform provider access**—*The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.*

New Hampshire's Demonstration evaluation will include an assessment of the following research hypotheses that address the four goals just described:[3]

1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
4. The Demonstration could lead to an increase in plan variety by encouraging health plans in the Medicaid Care Management Program to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management Program and the Marketplace could afford

[2] The NHHPP PAP Demonstration does not include the medically frail population. Members who self-identify as medically frail will be dropped from the program and enrolled in traditional Medicaid. As such, they will be excluded from the evaluation using appropriate methods but will be counted to report on the frequency of self-declaration.

[3] Reordered from STC #69.1 i-xii to correspond with the content and ordering of four goals of the waiver, delineated on pages 2-3 of the Special Terms and Conditions document (pa_termsandconditions.pdf), and consistent with Appendices A, B, and D.

beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees.

5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.
6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions.
7. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
9. Premium assistance beneficiaries will have equal or better access to preventive care services.
10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
11. Premium assistance beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.
12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation.

The evaluation design, taking into account the four goals and 12 hypotheses outlined above, considers through its performance measures and analysis plan the coverage for the following dimensions of access and quality, as shown in Appendix A:

- Comparisons of provider networks;
- Consumer satisfaction and other indicators of consumer experience;
- Provider experience; and
- Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes.

Each of these four aspects of access and quality is associated with specific measures tied to the 12 research hypotheses and are listed in Appendix A. Appendix A illustrates the relationship between the research hypotheses and Demonstration goals, while Appendix B addresses the specific measures used to evaluate each of the 12 research hypotheses.

2. EVALUATION DESIGN

The core purpose of the evaluation is to determine the costs and effectiveness of the NHHPP PAP, when considered in its totality, and taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes. The evaluation will explore and explain the effectiveness of the Demonstration for each research hypothesis, including total costs in accordance with the evaluation design as approved by CMS. As shown in Appendix B, each research hypothesis includes one or more evaluation measures. Wherever feasible, each measure will be in a standardized form comparable to and compared against national values.

Included in the evaluation will be examinations of NHHPP PAP performance on a set of access and clinical quality measures against a comparable population in the New Hampshire Medicaid Care Management Program. These measures will be taken from the list of required data fields for the claims submitted by each QHP for each PAP recipient. The State will compare costs (i.e., total, administrative, and medical) under the NHHPP Premium Assistance Demonstration to costs of what would have happened under a traditional Medicaid expansion. In this case, the evaluation will compare the costs of the PAP program to the estimated costs if that population would have remained in the Bridge program, which was created for Medicaid expansion.

The cost comparison will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses. The State will assess access and quality for the NHHPP PAP beneficiaries and Medicaid beneficiaries in managed care to ensure appropriate services are provided to the PAP beneficiaries. Moreover, to the extent possible, component contributions to changes in access and quality and their associated levels of investment in New Hampshire will be determined and compared to improvement efforts undertaken in other delivery systems.[4] Both cross-sectional and sequential cross-sectional analyses will be used, depending on the whether the measure is across one point in time or multiple points in time, along with the specific research hypothesis being addressed.

The operational details for the PAP evaluation are contained in the following four appendices:

- Appendix A – Evaluation Components
- Appendix B – Research Hypotheses, Groups, and Associated Methodologies
- Appendix C – Milestones and Timeline
- Appendix D – Rapid Cycle Assessment Measures

[4] To access and utilize administrative cost information, the non-encounter cost information will be generated by the State and provided to the evaluation contractor, as needed.

Before addressing the 12 research hypotheses and associated measures, the next section of the PAP evaluation plan defines the study and comparison groups, data sources, analytic methods, and limitations to the evaluation of the PAP Demonstration.

Study Population

The study population consists of all beneficiaries covered under Title XIX of the Social Security Act in the State of New Hampshire from 19 years through 64 years of age who are not medically frail, incarcerated, or enrolled in cost-effective employer sponsored insurance and who are enrolled in Medicaid managed care.[5] This study population will be divided into two groups to operationalize the evaluation—i.e., the study group and the comparison group.

Study Group

The study group is the NHHPP PAP group and consists of beneficiaries covered under Title XIX of the Social Security Act who are either:

1) Childless adults between the ages from 19 through 64 with incomes at or below 133 percent of the federal poverty level who are neither enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance or
2) Parents between the ages of 19 through 64 with incomes between 38 percent (for non-working parents) or 47 percent (for working parents) and 133 percent of the Federal Poverty Level and who are not enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance

The NHHPP PAP membership is estimated to contain approximately 45,000 beneficiaries.[6]

Comparison Groups

Two comparison groups are needed for this evaluation. The sequential cross-sectional comparison group (used in longitudinal analyses) consists of newly eligible members of the Bridge Program, most of whom will be eligible for the PAP program the following year. The Bridge Program is a transition program that enrolled Medicaid expansion beneficiaries into New Hampshire's Medicaid managed care program beginning in

[5] Coverage and delivery of benefits to eligible members are consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR Section 435.119.

[6] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf , Page 9 of 146. Last accessed on May 28, 2015.

August 2014. Assuming these beneficiaries remain eligible, Bridge Program members will be automatically enrolled in the PAP program in January 2016 leading to substantial overlap between the two populations. As such, the Bridge Program comparison group includes members enrolled in the Bridge Program beginning in August 2014 through December 31, 2015.

The non-PAP comparison group for all measures, except those derived through survey instruments,[7] consists of a statistically matched group of Title XIX beneficiaries in the State in parent/caretaker eligibility groups from 19 through 64 years of age who are not in the study group, not disabled, or incarcerated, and who are enrolled in a Managed Care Organization (MCO), updated at each measurement time.[8] The comparison group is estimated to contain between 12,000 and 15,000 beneficiaries, depending upon the number lost through the statistical matching process.[9] This group provides a baseline frame of reference for expected changes over time to assess the PAP program and its changes over time in subsequent years, if the PAP is continued. The start for this group's data should coincide with the start of the Bridge Program and its data.

Specifically for the cost-effectiveness analyses, the comparison group will consist of a statistically derived cohort of beneficiaries and their estimated costs if the Bridge Program were continued. The analysis will estimate what this population would have cost if the Bridge program continued past December 31, 2015, adjusting for items such as medical cost trend, demographic differences, acuity differences, and changes to targeted Bridge program provider reimbursement levels.

The evaluation of the Demonstration will be performed using rigorous actuarial and statistical methods to assess whether the beneficiaries in the NHHPP PAP are doing as well or better than in the Bridge program on the various measures in the evaluation. The population enrolled in the Bridge program will have very similar characteristics to the population enrolled in the PAP program, but the methodology will also use statistical matching techniques to ensure the populations used for comparison are as similar as possible. The analysis will compared the actual experience of the Bridge program population (trended and adjusted to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program. The methodology will be designed to determine the extent to which observed differences are statistically significant and meaningful to assess the research goals of the Demonstration.

[7] The evaluation contractor may use the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey or CAHPS-like survey for the intended data source. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[8] Statistical matching will be validated through a discriminant analysis with power set at approximately .8 for the comparison between groups on a set of criteria determined in coordination with subject matter experts.

[9] Email from Andrew Chalsma, Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services to Debra L. Chotkevys, Director, Professional Services, Health Services Advisory Group, Inc., on May 27, 2015.

Data Sources

New Hampshire is in the process of finalizing Memorandums of Understanding (MOU) with the QHPs for their participation in the PAP. While the MOUs are not yet signed, the Department and the QHPs have agreed on the terms that require the QHPs to provide encounter data to the state. The QHPs will submit data to the Department using the format and quality requirements of the State's Comprehensive Health Care Information System (CHIS), New Hampshire's All Payer Claims Database. Because the submission of data to the CHIS is a legal requirement to be a carrier in New Hampshire, the QHPs are already obligated to process and format the data according to the CHIS requirements. Existing CHIS data quality assurance processes will be employed to ensure the data are complete and of high quality. The QHPs will need to submit a separate duplicate feed for PAP members, because the CHIS data normally contain encrypted identifiers. The separate CHIS-like file the QHPs will provide to the Department will contain identifiers including member Medicaid ID which will allow linking the data to Medicaid membership and claims.

DHHS and its evaluation contractor will use multiple sources of data to assess the 12 research hypotheses. The data collected will include both administrative and survey-based data (e.g., CAHPS, CAHPS-like, telephonic information gathering). Administrative data sources include information extracted from DHHS's Medicaid Management Information System (MMIS), the State's Comprehensive Health Care Information System (CHIS), and the State's All-payer Hospital database. The three data sources are used to collect, manage, and maintain Medicaid recipient files (i.e., eligibility, enrollment, and demographics), fee-for-service (FFS) claims, and managed care encounter data. These data bases serve as central repositories for significant portions of the data DHHS will use to mine, collect, and query while addressing the 12 research hypotheses. DHHS and its evaluation vendor will work together with key data owners to ensure the appropriate data use agreements are in place to obtain the data. Data sharing Memorandums of Understandings (MOU) will be initiated with entities to allow access to and use of Medicaid claims and encounters, member demographics and eligibility/enrollment, and provider data.

Administrative Data

New Hampshire's Demonstration evaluation offers an opportunity to synthesize information from several data sources to determine the impact of the NHHPP PAP. The administrative data sources—i.e., CHIS, MMIS (including member, provider, and enrollment data), the All-payer Hospital databases—are necessary to address the 12 research hypothesis outlined in the evaluation design. Each measure (see Appendix B) associated with each research hypothesis lists the data source(s) used in addressing it. Three key fields that must be present to conduct the evaluation include the date of birth (for defining the study populations and some individual measures), a flag to identify

whether a Medicaid recipient is enrolled in the PAP, and a flag to identify if the recipient is in a traditional Medicaid managed care.

Use of FFS claims and managed care encounters will be limited to final, paid status claims/ encounters. Interim transaction and voided records will be excluded from all evaluations, because these types of records introduce a level of uncertainty (from matching adjustments and third party liabilities to the index claims) that can impact reported rates.

CHIS

"The New Hampshire Comprehensive Health Care Information System (CHIS) was created by NH statute to make health care data 'available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.'"[10] The same legislation that created the CHIS also enacted statutes that mandated health insurance carriers to submit encrypted health care claims data and Health Employer Data and Information Set (HEDIS®[11]) data to the State. HEDIS® data will be collectd at the plan level. As a result, CHIS data will be useful in calculating several of the measures used in the Demonstration evaluation.

MMIS

Not all data required for the evaluation will be in the CHIS database. As such, access to Medicaid claims and encounters will be required to optimize the information available to calculate the various measures. In general, Medicaid encounters are received and processed by the State's fiscal agent on a weekly basis with a historical 'run-out' of three months. In addition to service utilization data, the NHHPP PAP evaluation will require access to supplemental Medicaid data contained in the State's MMIS—e.g., member demographics, eligibility/enrollment, and provider information.

New Hampshire Medicaid began processing managed care encounter data in July of 2015. New Hampshire is employing a three-fold strategy to ensure completeness and accuracy of the encounter data: 1) New Hampshire's Medicaid managed care contracts contain robust requirements for timeliness, completeness and accuracy with the possibility of liquidated damages if the standards are not met; 2) New Hampshire's encounter data processing solution pseudo adjudicates encounters through the State's MMIS applying many of the same quality edits employed for FFS claims; and 3) New Hampshire has availed itself of the optional EQRO activity of Encounter Data Validation (current EQRO contract includes activity and EQRO is currently implementing a EDI based solution for loading the data as part of validation). Because the processing of the data only began recently, NH does not yet have summary analysis

[10] New Hampshire Comprehensive Health Care Information System. https://nhchis.com, Last accessed on May 26, 2015.
[11] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

on data quality. However, NH is confident that their strategies will produce valid and reliable data and is committed to that outcome.

Member Demographics—Member data are used to assess member age, gender, and other demographic and economic information required for the calculation of specific measures. For example, member demographics are used to determine member's age in order to define the comparison group relative to the distribution of the population in the study group. Additionally, fields such as gender will be used for the prenatal and postpartum measures. Finally, key financial data will be used when assessing gaps in coverage.

Eligibility/Enrollment—The eligibility/enrollment file will also be used create the study and comparison groups, as well as the assessment of health insurance and enrollment gaps.

Provider—Provider data, such as office location and specialty, will be used to assess the availability of services for both study and comparison groups.

All-payer Hospital Data

All-payer Hospital Data will be used to generate baseline data on new enrollees to the NHHPP PAP. As newly enrolled members, data for this population will not be available in other State data sources since many of the NHHPP PAP beneficiaries will be new to Medicaid.

Consumer Surveys

CAHPS and/or CAHPS-like surveys will be used to assess satisfaction with provided health care services.[12] These instruments will include specific survey items designed to elicit information that address research hypotheses regarding members' continuity of health care coverage and health plan market diversity.

One option is for the State to work with New Hampshire's CAHPS vendor to seek approval from NCQA to supplement its annual CAHPS administration to include three evaluation-specific questions. These questions will be designed to capture elements of the waiver STCs that cannot be addressed through administrative data or currently collected survey items. These three items will address the following concepts:

1) Continuity in member health insurance coverage—research hypothesis 1 states that premium assistance beneficiaries will have equal or fewer gaps in health insurance coverage.

[12] Depending on the State's CAHPs vendor and survey logistics related to adding items to the annual CAHPS survey, DHHS may decide to administer a CAHP-like custom survey to maximize applicability to the study population and increase the likelihood of return.

2) Continuous access to the same health plan—research hypothesis 2 states that premium assistance beneficiaries will have access to the same health plans and maintain continuous access to the same providers.
3) Continuity in plan enrollment—research hypothesis 3 states that premium assistance beneficiaries will have equal or fewer gaps in plan enrollment leading to equal or greater continuity of care.

In choosing the potential responses for each of the three questions being proposed, the response categories will mimic other response categories used on the CAHPS form, such as the degree of respondent agreement with a statement or a Yes/No response. The final wording for each of the proposed items will be submitted to NCQA for review after collaboration with the State and its CAHPS vendor.

The CAHPS vendor is aware that the State is interested in comparing its Medicaid populations. For 2015, the CAHPS vendor has already prepared separate surveys for the NHHPP population and for the traditional Medicaid population. If the evaluation continues in successive years, the vendor will also separate the Medicaid population into three groups making the comparisons in this evaluation possible--i.e., the traditional managed care group, the NHHPP group, and the NHHPP PAP group.

An alternative option would be for the evaluation contractor to deploy an independent survey that is structured in a similar manner to CAHPS but could be administered in a more strategic and targeted manner than would normally be possible for CAHPS. This type of survey would capture the information required by each of the eight evaluation measures currently citing CAHPS as a potential data source.

Analytic Methods

The evaluation reporting will meet traditional standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation (e.g., for the evaluation design, data collection and analysis, and the interpretation and reporting of findings). The Demonstration evaluation will use the best available data, will use controls and adjustments where appropriate and available, and will report the limitations of data and the limitations' effects on interpreting the results. All research hypotheses and methods will incorporate results from sensitivity, specificity, and power analyses to ensure the validity of the evaluation findings. Lastly, the evaluation will discuss the generalizability of results in the context of the limitations.

As outlined earlier, the existence of the Bridge Program creates a unique comparison group for understanding various aspects of the Demonstration's research hypotheses. In order to ensure the appropriateness of comparisons, preliminary population profile reviews will be conducted on the Bridge and NHHPP PAP populations. These analyses will confirm key assumptions regarding the similarities and overlap in these populations on key demographic characteristics and serve as a foundation for future discriminant analyses and statistical matching. Furthermore, rates of enrollment (i.e., speed in

reaching the eligible populations) will be assessed and compared for the Bridge Program and NHHPP PAP populations. As a result of the unique transition from Bridge Program to NHHPP PAP program, two distinct approaches to the analyses will be used in order to maximize the retention of beneficiaries in each group over time. Specifically, the evaluation analyses will include the following methods.

1. **Cross-sectional Analysis:** These analyses examine results for selected measures for two different groups at the same point in time. For example, cross-sectional analyses will be used to evaluate NHHPP PAP members' access to certain services versus non-NHHPP PAP MCO members' access.
2. **Sequential, Cross-sectional Analysis:** These analyses will include both *single group* and *multiple group* evaluations of multiple measures over time. Single group evaluations involve pre- and post-testing of a population that is conceptually longitudinal but changes some percentage of its membership each year, such as the Medicaid population. Multiple group evaluations involve pre- and post-testing for all evaluation groups to create difference scores that are then compared across groups.

Both comparative methods will be used in the following NHHPP PAP evaluation. The specific choice of methods depends on the measure under discussion and the theoretical and empirical implications for policy-relevant and defensible results. For this reason, the specific comparative method is detailed within each of the measures used in the evaluation (See Appendix B and Appendix D). If the Demonstration is continued for an additional one or two years, the measures are also continued using the analogously extended groups (i.e., Bridge becomes NHHPP PAP and 'becomes' NHHPP PAP for three cycles of measurement).

The three main analytic methods used to determine whether the beneficiaries in the NHHPP PAP are doing as well or better than Medicaid beneficiaries in the traditional Medicaid managed care program on the various measures in the evaluation are the t-test, the z-test, and discriminant analysis. The t-test will be used for pre-post single group methods of assessment (e.g., sequential cross-sectional) as well as for cross-sectional comparisons of two groups at one point in time. A z-test will be used for comparative sequential cross-sectional designs where a difference-in-differences approach (i.e., absolute or relative) is applied, depending on the measures and scales used for their assessment. A discriminant analysis will also be used to ensure that Non-PAP comparison group is appropriately and statistically matched to the study population.

In situations where neither the t-test nor z-test is appropriate (e.g., a need to risk-adjust), a fourth method, multiple regression analysis, will be used to determine the size of group differences through the grouping variable in the model. This method has a long history of generating empirically robust results when the evaluation model is correctly specified. The evaluation contractor will utilize clinical subject matter experts (SMEs) when building multivariate models and identifying relevant control variables.

The cost-effectiveness portion of the evaluation examines costs in three ways: total and the medical and administrative components that, when summed, represent total healthcare costs. As a result, all costs (and credits) are required to fit into either the medical or the administrative category. Both of the cost-effectiveness measures are reported in these three ways. There are three annual measures (i.e., 3-3, 7-1, and 7-2) and three rapid-cycle quarterly measures (i.e., CEC-1, CEC-2, and CEC-3) used assess the cost-effectiveness of the Demonstration. To do so, the costs (i.e., total and breakdown for medical and administrative) will be tracked for comparing actual NHHPP PAP costs to the estimated costs if the Bridge program were continued. After evaluating the available data, these comparisons may be modified or additional cost effectiveness comparisons may be developed if they are deemed to further the research goals of the Demonstration.

Finally, where appropriate, supplemental analyses will be conducted to further investigate and understand the impact of the NHHPP PAP program. These analyses may include plan-based comparative findings as well as the stratification of results by key demographic and/or programmatic characteristics. When possible, evaluation results will incorporate national or state-defined standards and/or benchmarks for comparison purposes. Together, the findings from these sub-group analyses will further inform the State regarding the impact of the NHHPP PAP program.

Process/Outcome Measures

When possible, process measures will be used since they do not require any form of risk adjustment beyond eligibility. The reason is related to the nature of process measures in that the 'processes' are required for anyone who meets the inclusion and exclusion criteria for the measure. Theoretically, a process measure should be able to reach 100 percent among the eligible populations.

Outcome measures often require some form of risk adjustment or stratification. Certain demographic characteristics must be stratified for CMS reporting, such as race, rather than used as a risk-adjustment variable in a multivariate model. For comparison purposes, a comparison group is formed from the non-PAP MCO Medicaid beneficiaries such that a discriminant analysis with policy-relevant predictor variables cannot distinguish group membership beyond randomness, with statistical power set to approximately .8 for the comparison.

Comparative Statistics

The t-tests (and z-tests where appropriate) will be used to assess whether any differences found between the study and comparison groups are statistically significant (i.e., unlikely to have occurred in the data through random chance alone). The traditionally accepted risk of error ($p \leq .05$) will be used for all comparisons. If risk adjustment is used, p-values will be generated through multiple regression analysis and assessed against the same critical p-value.

Limitations

The limitations surrounding this evaluation center on the lack of truly comparative data for the NHHPP PAP members for outcome variables in the first year of the Demonstration beyond the All-payer Hospital data. When a new and empirically different group is added to Medicaid, there is often no comparison group with data to assess potential programmatic differences between the new group and the effects of joining the ongoing Medicaid program, instead. As a result, assumptions on comparability are sometimes made that lack empirical evidence for support or that have somewhat inconsistent evidence of comparability.

Additionally, little or no data will exist in sufficient time for the New Hampshire legislature to decide whether it will continue the NHHPP PAP past its first year of operation. This situation will require the State legislature to make program decisions without the knowledge and support of the first annual evaluation of the program, or from the interim evaluation conducted after full implementation of the Demonstration.

3. REPORTING

Following its annual evaluation of the NHHPP PAP and subsequent synthesis of the results, DHHS and its evaluation vendor will prepare a report of the findings and how the results compare to the research hypotheses. Both the interim annual reports and the final summative evaluation report will be produced in alignment with STCs and the schedule of deliverables listed in Table 1 below. (See Appendix C for a detailed timeline.) Following approval to continue the NHHPP PAP in Year 2 and Year3 by the New Hampshire State Legislature, the schedule of deliverables will be updated to reflect additional reporting requirements.

Table 1—Schedule of Deliverables for the NHHPP PAP Waiver Evaluation

Deliverable	Date
NHHPP PAP Evaluation Design (STC #66)	
DHHS submits PAP Waiver Evaluation Methodology to CMS	6/4/2015
DHHS to post PAP Waiver Evaluation Methodology on the State's website for public comment	6/4/2015
DHHS to post final approved Evaluation Design on the State's website within 30 days of approval by CMS	On or before 10/15/2015
DHHS presentation to CMS on approved Evaluation Design (STC #73)	As Requested
Demonstration Year 1	
Quarterly: DHHS to report progress of Demonstration to CMS (STC #82)	30 days after the quarter
If Demonstration Continued, Interim Annual Evaluation Report (STC #70)	3/31/2017
If Demonstration Ended, Preliminary Summative Evaluation Report (STC #71)	6/29/2017
If Demonstration Ended, Final Summative Evaluation Report (STC #71)	12/31/17
DHHS presentation to CMS on Final Summative Evaluation Report (STC #73)	As Requested

Each evaluation report will present findings in a clear, accurate, concise, and timely manner. At minimum, all written reports will include the following six sections: Executive Summary, Demonstration Description, Study Design, Findings and Conclusions, Policy Implications, and Interactions with Other State Initiatives. Specifically, the reports will address the following:

1) The **Executive Summary** concisely states the goals for the Demonstration, the evaluation questions and hypotheses tested in the report, and updates on questions and hypotheses scheduled for future reports. In presenting the key

findings, budget neutrality and cost-effectiveness will be placed in the context of policy-relevant implications and recommendations.

2) The **Demonstration Description** section focuses on programmatic goals and strategies, particularly related to budget neutrality and cost-effectiveness. The section succinctly traces the development of the program from the recognition of need to the present degree of implementation. This section will also include a discussion of the State's roll-out of the NHHPP PAP program along with its successes and challenges.

3) The **Study Design** section contains much of new information in the report. Its five sections include: evaluation design with the 12 research hypotheses and associated measures, along with the type of study design; impacted populations and stakeholders; data sources that include data collection field, documents, and collection agreements; analysis techniques with controls for differences in groups or with other State interventions, including sensitivity analyses when conducted; and limitations for the study.

4) The **Findings and Conclusions** section is a summary of the key findings and outcomes. The section focuses on cost-effectiveness, along with the successes, challenges, and lessons learned from the implementation of the Demonstration.

5) The **Policy Implications** section contains the policy-relevant and contextually appropriate interpretations of the conclusions. This section includes the existing and expected impact of the Demonstration within the health delivery system in the State in the context of the implications for State and federal health policy, including the potential for successful strategies to be replicated in other State Medicaid programs.

6) The **Interactions with Other State Initiatives** section contains a discussion of this Demonstration within an overall Medicaid context and consideration for the long-range planning efforts by the State. This discussion includes the interrelations between the Demonstration and other aspects of the State's Medicaid program, including interactions with other Medicaid waivers, the State Innovation Models (SIM) award, and other federal awards affecting service delivery, health outcomes, and the cost of care under Medicaid.

All reports, including the Evaluation Design, will be posted on the State Medicaid Website within 30 days of the approval of each document to ensure public access to evaluation documentation and to foster transparency. DHHS will notify CMS prior to publishing any results based on Demonstration evaluation for CMS' review and approval. The reports' appendices present more granular results and supplemental findings. The State will work with CMS to ensure the transmission of all required reports and documentation occurs within approved communication protocols.

Independent Entity

Based on State protocols, DHHS will follow established policies and procedures to acquire an independent entity or entities to conduct the NHHPP PAP Demonstration evaluation. The State will either undertake a competitive procurement for the evaluator or will contract with entities that have an existing contract relationship with the State. An assessment of potential vendors' experience, knowledge of State programs and populations, and resource requirements will determine selection of the final candidate, including steps to identify and/or mitigate any conflicts of interest.

Budget

Due to the complexity and resource requirements of the NHHPP PAP Demonstration, DHHS will need to conduct a competitive procurement to obtain the services of an independent entity to perform the services outlined in this evaluation design. As such, an estimated budget is currently unavailable and will be determined through the competitive bid process. Upon selection of an evaluation vendor, a final budget will be prepared in collaboration with the selected independent entity. Table 2 displays the proposed budget shell that will be used for submitting total costs for the Demonstration. Costs are broken out by staff, estimated hours, costs, and anticipated subcontractors. At this time, DHHS is working with its Actuarial vendor to secure their assistance in preparing all cost-related measures.

Table 2—Proposed Budget Template for NHHPP PAP			
	Year X (January 2016-2017)		
Staff Title	*Loaded Rate*	*Hours*	*Total*
Executive Director, Research & Analysis			
Project Director, Research & Analysis			
Project Director			
Project Manager			
Project Support			
Analyst			
Database Developer			
Reports Team			
Subtotal Direct and Indirect Costs			
Subcontractor - Statistician			
Subcontractor –Survey Vendor			

Subcontractor – Actuarial Vendor			
Annual Total			

As noted earlier, the costs presented in Table 2 will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning analyses and report generation. A final budget will be submitted once a final evaluation contractor has been selected.

5. APPENDIX A: EVALUATION COMPONENTS

PAP Waiver Goal[1]	Hypothesis Being Addressed[13]	Dimension of Access and/or Quality[14]
1. Continuity of coverage - For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks	1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage	Comparisons of provider networks
	2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers	Provider experience
2. Plan Variety - The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts	3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs	Evidence of improved access and quality across the continuum of coverage and related health outcomes
	4. The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts	Comparisons of provider networks over time.
3. Cost-effective Coverage - The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs	5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	7. The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS	Comparisons of provider networks
4. Uniform provider access - The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire	8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	9. Premium assistance beneficiaries will have equal or better access to preventive care services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided	Consumer satisfaction and other indicators of consumer experience
	11. Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes

[13] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf, Page 10 of 146. Last accessed on May 26, 2015.

[14] ibid, STC #69.1.a.

6. APPENDIX B: EVALUATION RESEARCH HYPOTHESES AND MEASURES

The 12 research hypotheses are grouped according to the four waiver goals delineated in Appendix A. The definitions presented below are generally quoted from Section II. Program Description and Objectives in the Special Terms and Conditions document.[15] Numbering of the individual research hypotheses from STC #69 is changed herein to correspond with the goals of the waiver shown in Appendix A.

Continuity of Coverage

Definition: For individuals whose incomes fluctuate, the NHHPP PAP Demonstration will permit continuity of health plans and provider networks. Individuals and families may receive coverage through the same health plans and seek treatment and services through the same providers regardless of whether their underlying coverage is financed by Medicaid or through the Marketplace. The State will evaluate whether individuals remain in the same QHP when Medicaid payment is terminated.

Hypothesis 1: ***Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage***

Gaps in insurance coverage decrease the potential for preventive care and, therefore, increase the potential for more expensive emergency and/or inpatient care. Due to the insurance premiums being paid by New Hampshire for eligible beneficiaries, any gaps in coverage should be for income level changes, moving out of State, aging out, death, incarceration, or other situation beyond the control of the State for ensuring continuous insurance coverage.

Measure 1-1	Continuity in Member Health Insurance Coverage
Definition:	The average number of gaps in insurance coverage
Technical Specifications:	The average number of gaps in insurance coverage per 100 members enrolled in PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[15] pa_termsandconditions.pdf

Measure 1-2	Continuity in Member Health Insurance Coverage
Definition:	The percentage of eligible members with gaps in insurance coverage
Technical Specifications:	The percentage of eligible members with gaps in insurance coverage, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 1-3	Patient Perspective on Continuity in Health Insurance Coverage
Definition:	Patient perspective on the continuity of health insurance coverage
Technical Specifications:	Eligible recipients will be surveyed to whether the members reported being without health insurance during the previous six months. "In the last six months, were you without health insurance at any time?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3[16]
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[16] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.

Hypothesis 2: ***Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers***

This two-part research hypothesis examines continuity of care within health plans and continuous access to providers associated with the member's health plan. For this research hypothesis, the providers are the groups of PCPs delivering care to the MCO's members. With the State paying for the beneficiaries' premiums, the intent is that members will see the same group of providers as least as commonly as the comparison group members.

Measure 2-1	Continuous Access to the Same Health Plan
Definition:	The percentage of eligible members with continuous access to the same health plan for the measurement year
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to the same health plan during the measurement period – one plan the entire time.
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 2-2	Patient Perspective on Continuity in Same Plan Coverage
Definition:	Patient perspective on continuous access to the same health care plan
Technical Specifications:	Eligible recipients will be surveyed to whether the members had continuous access to the same health care plan during the previous six months. "In the last six months, did you have to switch to a different health care plan?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.

National Benchmark:	None

Measure 2-3	Patient Perspective on Continuous Access to Providers
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q6
Exclusion Criteria:	Subject to income level qualifications
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 2-4	Numbers of Medically Frail Self-Declarations
Definition:	The number of PAP members each year who self-declare as medically frail.
Technical Specifications:	The number of PAP members each year who self-declare as medically frail and leave the PAP population.
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	Annual, if the Demonstration is continued
Comparison Method(s):	None
National Benchmark:	None

Plan Variety

Definition: The NHHPP PAP Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace would afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and would increase the selection of plans for both Medicaid and Marketplace enrollees. The State will evaluate whether there is an increase in the number of available QHPs because of this potential for dual participation.

Hypothesis 3: ***Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower***

administrative costs

Beyond the continuity of insurance coverage previously addressed, this research hypothesis examines gaps in actual enrollment, the empirical continuity of care, and the administrative costs of care. If the NHHPP PAP functions as designed, actual enrollment should be at least as continuous as for the beneficiaries in the comparison group, their continuity of care should be at least as good due to improved access, and the overall administrative costs should decrease through knowledge of premium costs weighed against the costs in the comparison group. Three measures will, in combination, be used to assess this research hypothesis.

Measure 3-1	Continuity in Plan Enrollment
Definition:	The average number of gaps in enrollment from any Medicaid plan
Technical Specifications:	The average number of gaps in enrollment of any kind from any Medicaid MCO or PAP plan per 100 enrollee years, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State Eligibility and Enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-2	Continuity in Plan Enrollment
Definition:	Percentage of eligible members with continuous health plan access
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to any Medicaid MCO or PAP health plan during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-3	Patient Perspective on Continuity of Care
Definition:	The cornerstone of continuity of care is in knowing one's PCP. For this reason, this portion of the research hypothesis is defined through whether the beneficiary has a personal doctor. For respondents, this item is defined as the proportional choice for "A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?" for responses 'Yes' or 'No'.
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q10
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 3-4	Members' Administrative Cost (Total Costs and Medical Costs Captured in Research Hypotheses 7-1 and 7-2)
Definition:	Administrative per member per month (PMPM) cost
Technical Specifications:	Annual administrative costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Hypothesis 4: ***The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees***

The idea supporting this research hypothesis is that market forces will take note of the influx of covered beneficiaries from the NHHPP PAP and will compete for market share. If the intended effect materializes, one benefit might be seamless transitions between the traditional marketplace and the NHHPP PAP. Beneficiaries might see an advantage to belonging to plans offering both types of coverage, which then might increase the total number of plans competing for market share and the potential of dual participation.

Measure 4-1	Medicaid Care Management Carriers Offering QHPs in the Marketplace
Definition:	Desk audit for the number of Medicaid Care Management carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter for which dual participation could be an option
Technical Specifications:	Count of the number of Medicaid Care Management carriers offering QHPs in the Marketplace for which dual participation could be an option
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None
Measure 4-2	**QHPs in the Marketplace Offering Medicaid MCO Plans**
Definition:	Desk audit for the number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO Plans at the start of the waiver and annually thereafter
Technical Specifications:	Count of the number of QHPs in the Marketplace offering Medicaid MCO Plans
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None

Cost-effective Coverage

Definition: The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs. This, in turn, may result in coverage that achieves cost reductions in comparison to traditional Medicaid managed care coverage. The State will evaluate whether QHP coverage is cost-effective, looking at the entire NHHPP PAP Demonstration period and trends that emerge as it proceeds.

Hypothesis 5: ***Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services***

'Non-emergent use' is interpreted to mean that the service could have been appropriately delivered at a lower level, such as an urgent care clinic or at a PCP's office. One of the intended functions of the NHHPP PAP is to treat beneficiaries in the appropriate setting, which is often the PCP's office. The appropriate setting is frequently less expensive and provides more local access than is found with non-emergent use of emergency room services.

Measure 5-1	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Eligibility Group
Definition:	Ambulatory emergency department visits for conditions potentially treatable in primary care per 1,000 member months by eligibility group
Technical Specifications:	AMBCARE.09 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf[17]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 6: ***Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions***

'Potentially preventable' in operationalized as ambulatory sensitive conditions, suggesting that more timely PCP care could have prevented the admission, rather than the admission being at too high a level of service, distinguishing the research hypothesis from research hypothesis 5. For example, emergency room use and/or hospitalization for complications from the flu are potentially preventable with influenza and pneumococcal immunizations, as appropriate.

Measure 6-1	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members
Definition:	Quarterly rate of inpatient hospital utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members

[17] NH Medicaid Care Management Quality Oversight Health Plan Reporting Specifications – V2.3

Technical Specifications:	HPP_INPASC.01 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 6-2	**Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members**
Definition:	Quarterly rate of emergency department utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members
Technical Specifications:	Analogous to HPP_INPASC.01, but in the Emergency Department setting
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 7: ***The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS***

This research hypothesis examines the relative costs in a comparative format between the more traditional Medicaid managed care program comprised of the comparison group and the new beneficiary program comprised of the study group. By knowing the premiums in advance, the State can make comparisons with the costs for non-premium assistance beneficiaries to ensure that the new beneficiaries in the NHHPP PAP will not cost New Hampshire more than if the State had enrolled the expansion group in the more traditional Medicaid managed care program comprising the comparison group.[18]

Measure 7-1	**Total Costs by Group**
Definition:	Total per member per month (PMPM) cost
Technical Specifications:	Annual total costs divided by total number of member months, calculated separately for the study and comparison groups

[18] Administrative costs are captured in research hypothesis 3.

Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Measure 7-2	**Medical Costs by Group**
Definition:	Annual per member per month (PMPM) cost
Technical Specifications:	Annual medical costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Uniform Provider Access

Definition: The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the NHHPP PAP Demonstration to determine if it is comparable to the access afforded to the general Medicaid managed care population in New Hampshire.

Hypothesis 8: ***Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services***

One critical feature of the NHHPP PAP is the contracted QHPs' ability to deliver appropriate access to care through the availability of primary care and specialty physicians and associated services. The research hypothesis examines the extent to which the NHHPP PAP is successful in maintaining the access and services found in the traditional Medicaid managed care program.

Measure 8-1	Medication Management for People with Asthma (MMA)[19]
Definition:	The percentage of members 19–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period
Technical Specifications:	State-modified HEDIS specifications[20]
Exclusion Criteria:	Diagnosis of emphysema, chronic obstructive pulmonary disease (COPD), obstructive chronic bronchitis, cystic fibrosis, acute respiratory failure, or members who have no asthma controller medications dispensed during the measurement year
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-2	Timeliness of Prenatal Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received prenatal care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.01 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

[19] The presented specifications are derived from the NCQA HEDIS 2015 Technical Specifications, Volume 2.
[20] HEDIS has some specifications that extend beyond the age range for the PAP program and are, therefore, State-modified to account for the age range difference.

Measure 8-3	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received postpartum care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.02 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-4	Patients' Perception of Ease of Getting Appointments with Specialists
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q18, CAHPS 5.0[21]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 8-5	Patients' Perception of Quick Access to Needed Care
Definition:	For respondents, a proportional choice for "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q4, CAHPS 5.0[22]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison	1. Two-group t-test.

[21] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.
[22] Ibid.

Measure 8-5	Patients' Perception of Quick Access to Needed Care
Method(s):	2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Hypothesis 9: ***Premium assistance beneficiaries will have equal or better access to preventive care services***

Access to preventive care services is important for several reasons, as already seen through previous research hypotheses. Preventive services can help to maintain health and avoid more expensive emergency department use or hospitalization and are an important aspect of restraining the growth in the cost of providing health care. This research hypothesis evaluates access to preventive services.

Measure 9-1	Annual Access to (use of) Preventive/Ambulatory Health Services Adults by Age Group (i.e., 20-44, 45-64)
Definition:	The percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit, by age group
Technical Specifications:	HEDIS_AAP - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid managed care national rates

Measure 9-2	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)
Definition:	The percentage of discharges for members 19 years through 64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge
Technical Specifications:	HEDIS_FUH.01 - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-3	Annual Influenza Immunization, 19-64
Definition:	Flu vaccinations for adults ages 19 to 64: percentage of members 18 to 64 years of age who received an influenza vaccination between July 1 of the measurement year and the date on which the CAHPS 5.0 survey was completed
Technical Specifications:	NCQA
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-4:	Comprehensive Diabetes Care - Eye Exam
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who had an eye exam (retinal exam) performed
Technical Specifications:	HEDIS_CDC.05 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-5	Comprehensive Diabetes Care - Medical Attention for Nephropathy
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who received medical attention for nephropathy
Technical Specifications:	HEDIS_CDC.06 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-6	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Definition:	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-7	Mental Health Utilization - 1
Definition:	Mental health inpatient discharges
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-8	Mental Health Utilization - 2
Definition:	Mental health inpatient average length of stay
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-9	Diabetes Monitoring for People With Diabetes and Schizophrenia
Definition:	The percentage of members 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test.

	2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Hypothesis 10: *Premium assistance beneficiaries will report equal or better satisfaction in the care provided*

Patient-centered health care is important for many reasons, not the least of which is the relationship between greater satisfaction and low costs of care. Patients tend to utilize preventive services and follow medical advice more often when they are satisfied with the care they receive. For that reason, this research hypothesis compares the satisfaction of the more traditional Medicaid managed care beneficiaries for their provided care with that of the NHHPP PAP beneficiaries.

Measure 10-1	Patients' Rating of Overall Health Care
Definition:	For respondents, a proportional choice for "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"
Technical Specifications:	CAHPS 5.0 specifications, Q8
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Measure 10-2	Patients' Rating the Health Plan
Definition:	For respondents, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"
Technical Specifications:	CAHPS 5.0 specifications, Q26
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Hypothesis 11: *Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits*

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are important to maintain health, catch illness early, and prevent disease when possible. The medically recommended schedule for these services continues until the beneficiary's 21st birthday. This research hypothesis examines the extent to which premium assistance beneficiaries 19 and 20 years of age received these services compared with the comparison group.

Measure 11-1	EPSDT Screening
Definition:	Total eligible beneficiaries who received at least one initial or periodic Screen
Technical Specifications:	EPSDT.06 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 12: *Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT)*

Non-emergency transportation services support timely access to care at the appropriate level of care, which helps to reduce cost, as discussed in previous research hypotheses. This research hypothesis seeks to ensure that premium assistance members maintain appropriate access to non-emergency transportation services.

Measure 12-1	NEMT Request Authorization Approval Rate by Mode of Transportation
Definition:	The percentage of NEMT requests authorized, of those requested during the measure data period, by mode of transportation (i.e., contracted transportation provider - non-wheelchair van, volunteer driver, member, public transportation, wheelchair van, other), for the eligible population
Technical Specifications:	NH specifications for HPP_NEMT.06 (including A-F)[23]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

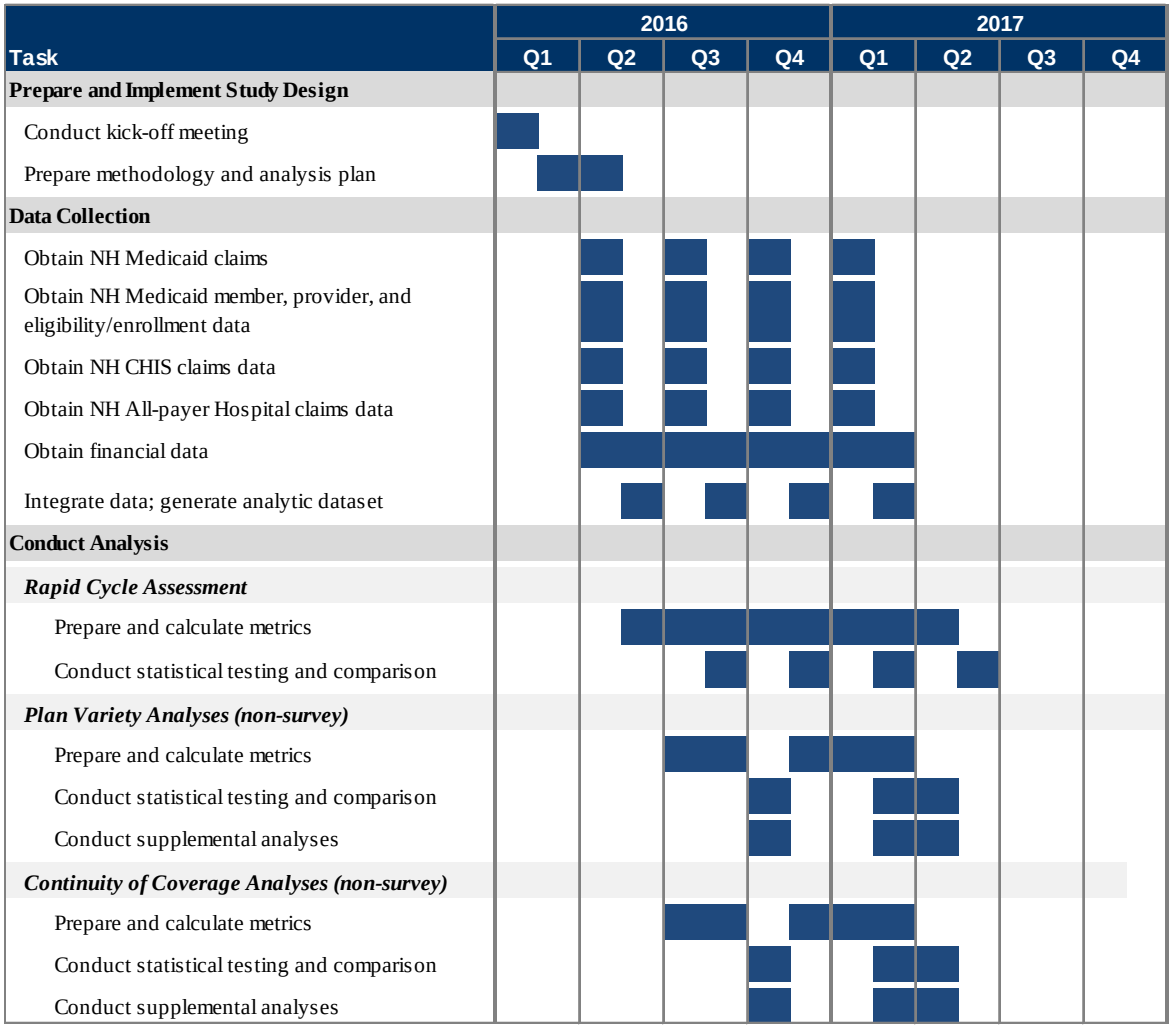
[23] New Hampshire Medicaid Quality Information System (MQIS), Specifications, Non-Emergent Transportation - NH Health Protection Program, Version 1.0, Published March 31, 2015.

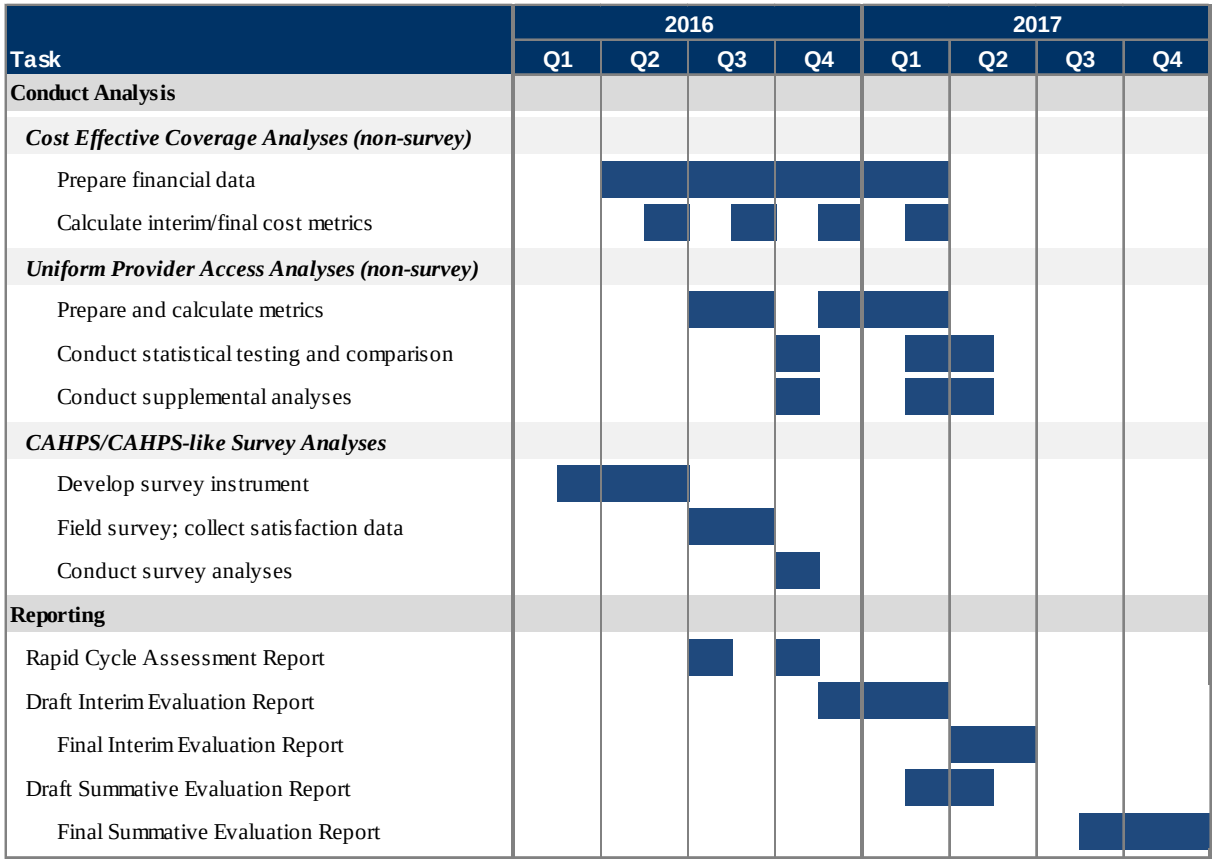
7. APPENDIX C: EVALUATION TIMELINE

The following project timeline has been prepared for the Demonstration evaluation outlined in the preceding sections. This timeline should be considered preliminary and subject to change based upon approval of the Evaluation Design and implementation of the NHHPP PAP. A final detailed timeline will be developed upon selection of the Independent Entity tasked with conducting the evaluation.

Figure C- 1 outlines the proposed timeline and tasks for conducting the NHHPP PAP evaluation.

Figure C-1—NHHPP PAP Evaluation Project Timeline


Task
2016
2017
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Prepare and Implement Study Design
Conduct kick-off meeting
Prepare methodology and analysis plan
Data Collection
Obtain NH Medicaid claims
Obtain NH Medicaid member, provider, and eligibility/enrollment data
Obtain NH CHIS claims data
Obtain NH All-payer Hospital claims data
Obtain financial data
Integrate data; generate analytic dataset
Conduct Analysis
Rapid Cycle Assessment
Prepare and calculate metrics
Conduct statistical testing and comparison
Plan Variety Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses
Continuity of Coverage Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses


Task
2016
2017
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Conduct Analysis
Cost Effective Coverage Analyses (non-survey)
Prepare financial data
Calculate interim/final cost metrics
Uniform Provider Access Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses
CAHPS/CAHPS-like Survey Analyses
Develop survey instrument
Field survey; collect satisfaction data
Conduct survey analyses
Reporting
Rapid Cycle Assessment Report
Draft Interim Evaluation Report
Final Interim Evaluation Report
Draft Summative Evaluation Report
Final Summative Evaluation Report

8. APPENDIX D: RAPID-CYCLE ASSESSMENT MEASURES

Continuity of Coverage (COC)

From a policy perspective in public health, continuity of coverage (COC) begins at the onset of available coverage (i.e., January 1, 2016, for NHHPP PAP members), rather than once coverage has been secured at a potentially later date. By definition, therefore, the 45,000 New Hampshire residents who are eligible for NHHPP PAP coverage before January 1, 2016,[24] and have NHHPP PAP coverage on January 1, 2016, have started continuity of coverage on time and do not have a *de facto* gap at the start of their available coverage.

Measure COC-1	Cumulative Initiation of Continuity in Member Health Insurance Coverage
Definition:	The cumulative number of NHHPP PAP beneficiaries with initiated coverage
Technical Specifications:	The total (i.e., sum) of the number of NHHPP PAP beneficiaries per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Measure COC-2	Proportional Initiation of Continuity in Member Health Insurance Coverage
Definition:	The proportion of the expected population of NHHPP PAP beneficiaries who have initiated coverage
Technical Specifications:	The ratio of the total (i.e., sum) of the number of NHHPP PAP beneficiaries to the 45,000 eligible people per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

[24] New Hampshire Health Protection Program, Premium Assistance, Section 1115, Research and Demonstration Waiver, Final Application, November 7, 2014, Section 1, page 2

Plan Variety (PV)

One intended outcome of the NHHPP PAP is to motivate private insurers to create a dual participation in the Medicaid Care Management program and the Marketplace. This dual participation would afford Medicaid beneficiaries with seamless coverage during times of transition, either across eligibility groups within Medicaid or from Medicaid to the Marketplace. From a rapid cycle perspective, the policy relevant outcome would be an increase in dual participation insurers.

Measure PV-1	Dual Participation Providers
Definition:	The number of dual participation providers
Technical Specifications:	The quarterly number of dual participation providers from the implementation of the potential for dual participation on November 1, 2015 through April 30, 2016 and quarterly thereafter
Data Source(s):	Administrative review
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Cost-effective Coverage (CEC)

One of the intended consequences of the premium assistance approach is to increase QHP enrollment and, therefore, result in greater economies of scale and competition among QHPs, lowering PMPM costs for Medicaid coverage.

Measure CEC-1	Total PMPM Total Cost - Quarterly
Definition:	Total per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly total costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-2	Medical PMPM Total Cost - Quarterly
Definition:	Medical per member per month (PMPM) cost, reported quarterly

Technical Specifications:	Monthly medical costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-3	Administrative PMPM Total Cost - Quarterly
Definition:	Administrative per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly administrative costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Uniform Provider Access (UPA)

One of the requirements for the NHHPP PAP is that it should provide equal or better access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration. One performance measure that has the potential not only to be available to rapid fire assessment, but could also touch on all three settings for uniform provider assess (i.e., primary, specialty, and behavioral health care services), is postpartum care. Regardless of how long the beneficiary has been enrolled in the NHHPP PAP, postpartum care is a valid measure of uniform provider access.

Measure UPA-1	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between each quarter who received timely and appropriate postpartum care
Technical Specifications:	HEDIS_PPC.02 – modified from NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf to be reported quarterly
Data Source(s):	All-payer Hospital, CHIS, Medicaid claims, and encounter data

Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.