MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

November 20, 2014

The Honorable Sylvia Mathews Burwell
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re. New Hampshire Section 1115 Demonstration Waiver for Premium Assistance

Dear Secretary Burwell:

On behalf of the citizens of the State of New Hampshire, I am pleased to submit to the United States Department of Health and Human Services (HHS) the enclosed application for a demonstration waiver under Section 1115 of the Social Security Act.

As authorized by the New Hampshire Health Protection Act (Chapter 3 of New Hampshire Laws of 2014), bipartisan legislation that I signed into law earlier this year, the Demonstration will allow the State to implement a key component of the New Hampshire Health Protection Program - namely, establishing a mandatory qualified health plan premium assistance program ("QHP premium assistance") for individuals in the new adult group.

The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals as they transition across different sources of coverage ensuring consistent access to providers, rationalizing provider reimbursement and enhancing integration and efficiency of public and private coverage in New Hampshire. Ultimately, the Demonstration will provide truly integrated coverage for low-income New Hampshire residents regardless of their income or source of coverage. Additionally, by adding up to an estimated 45,000 persons to the Marketplace, the Program may sustain existing and attract additional QHP carriers, creating a more competitive market which will benefit all individuals purchasing coverage on the Marketplace.

The enclosed application reflects the program elements discussed with the Centers for Medicare and Medicaid Services over the last several months, as well as input from legislators and stakeholders received during the public hearing and comment process in New Hampshire. The State will also submit any State Plan Amendments necessary to effectuate the Demonstration.

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Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.nh.gov/ • Email: governorhassan@nh.gov
TDD Access: Relay NH 1-800-735-2964

We appreciate the ongoing assistance of your department as we strive to meet the implementation timeline set forth in our bipartisan legislation and we look forward to your continued support as we implement QHP premium assistance.

With every good wish,

[redacted]

Margaret Wood Hassan
Governor

enc.
cc: Marilyn Tavenner, CMS Administrator
Cindy Mann, JD, CMS Deputy Administrator/Director
Eliot Fishman, PhD, Director, Children and Adults Health Programs Group

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Director, Audit Division
(603) 271-2785

November 13, 2014

Nicholas Toumpas, Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

Dear Commissioner Toumpas,

The Fiscal Committee, pursuant to the provisions of Chapter 3 (SB413), Laws of 2014, codified at **RSA 126-A:5, XXIII-XXVI**, on November 10, 2014, **amended** and approved the request of the Department of Health and Human Services for approval of the waiver application to submit to the Centers of Medicare and Medicaid Services for the implementation of the Premium Assistance Program under the New Hampshire Health Protection Program, as specified in your letter dated November 7, 2014.

The Fiscal Committee further authorized **the Department of Health and Human Services to make technical and administrative changes which are necessary to reflect the intent of this item as approved, reporting back to the Fiscal Committee all changes made under this approval**.

Sincerely,

[redacted]

Jeffry A. Pattison
Legislative Budget Assistant

JAP/pe
Attachment

Cc: Jeffrey A. Meyers ✓
Director, Intergovernmental Affairs

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 FAX: 603-271-4912 TDD ACCESS: RELAY NH 1-800-735-2964

NICHOLAS A. TOUMPAS
COMMISSIONER

FIS 14 195

November 7, 2014

The Honorable Mary Jane Wallner, Chairman
Fiscal Committee of the General Court
Legislative Office Building, 104 North State Street
Concord, NH 03301

Requested Action

Pursuant to the requirements of the New Hampshire Health Protection Act (SB 413), codified at RSA 126-A:5,XXII-XXVI, the New Hampshire Department of Health and Human Services requests approval of the enclosed waiver application to submit to the Centers of Medicare and Medicaid Services for the implementation of the Premium Assistance Program under the New Hampshire Health Protection Program. The approval of this waiver by CMS will allow the New Hampshire Health Protection population to be enrolled in private Qualified Health Plans on the federal marketplace in 2016.

Premium Assistance Program

Under SB 413, as long as CMS approves a premium assistance waiver on or before March 31, 2015, the Voluntary Bridge to Marketplace Program will continue through December 31, 2015, and newly eligible adults who are not in the mandatory HIPP program and who are not deemed to be "medically frail," will begin enrollment into private Qualified Health Plans on the federal marketplace in New Hampshire in October 2015. Coverage under QHPs on the marketplace would begin on January 1, 2016. The purchase of QHPs on the federal marketplace will be paid for with 100% federal funds through December 31, 2016. In accordance with the provisions of SB 413, the Department's application seeks a waiver solely for calendar year 2016.

The enclosed waiver application also includes copies of the public notice issued for the draft waiver, the proposed standard copayment plan for the program, copies of the written public comments received by the Department and the Department's responses to those public comments. We have also enclosed a three page summary of the major waiver features.

We look forward to presenting this waiver to the Committee next Monday.

Sincerely,

[redacted]

Nicholas A. Toumpas, Commissioner

[redacted]

Jeffrey A. Meyers, Director
Intergovernmental Affairs

Enclosures

cc: Jeffry A. Pattison
Members, Fiscal Committee

New Hampshire
Department of Health and Human Services
&
New Hampshire Insurance Department

New Hampshire Health Protection Program Premium Assistance Section 1115 Research and Demonstration Waiver

Final Application

November 7, 2014

NEW HAMPSHIRE 1115 WAIVER APPLICATION
PREMIUM ASSISTANCE PROGRAM
November 7, 2014

Section I - Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

On March 27, 2014, Governor Maggie Hassan signed into law Senate Bill 413, an Act relative to health insurance coverage (the "Act"), (2014 NH Laws Chap. 3) establishing the New Hampshire Health Protection Program to expand health coverage in New Hampshire for adults with incomes up to 133 percent of the Federal Poverty Level.[1]

The New Hampshire Health Protection Program includes several 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 through December 31, 2015; and (3) a mandatory individual qualified health plan (QHP) premium assistance program beginning on January 1, 2016. Coverage for the new adult group became effective on August 15, 2014, and as of September 29, 2014, over 18,000 new adults were enrolled in coverage. This Demonstration is intended to implement the mandatory QHP premium assistance program established in the Act.

Under the Demonstration, the State will implement a mandatory premium assistance program ("Premium Assistance Program" or "Program") through which the State will purchase from insurance carriers QHPs that have been certified for sale in the individual market on the federally facilitated New Hampshire Health Insurance Marketplace. Individuals eligible for the Program will include those covered under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 133 percent of the federal poverty level (FPL) who are neither enrolled in (or eligible for) Medicare nor incarcerated[2] or (2) parents between the ages of 19 and 65 with incomes between 38 percent (for non-working parents) or 47 percent (for working parents) and 133 percent FPL who are neither enrolled in (or eligible for) Medicare nor incarcerated (collectively "QHP Premium Assistance enrollees"). QHP Premium Assistance enrollees will receive the Alternative Benefit Plan (ABP) through a QHP that they select and will have cost-sharing obligations consistent with Medicaid cost-sharing requirements.

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[1] While the Patient Protection and Affordable Care Act expands coverage to 133 percent of the federal poverty level, the ACA otherwise establishes a 5 percent disregard for program eligibility, which extends coverage to those persons up to 138 percent of the federal poverty level.

[2] The term "incarcerated" means "any individual who is an inmate of a public institution (except as a patient in a medical institution)."

The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals as they transition across different sources of coverage ensuring consistent access to providers, rationalizing provider reimbursement, and enhancing integration and efficiency of public and private coverage in New Hampshire. Ultimately, the Demonstration will provide truly integrated coverage for low-income New Hampshire residents regardless of their income or source of coverage.

Additionally, by adding up to an estimated 45,000 persons to the Marketplace, the Program may attract additional QHP carriers creating a more competitive market, which will benefit all individuals purchasing coverage on the Marketplace.

2) Include the rationale for the Demonstration

This 1115 Demonstration waiver request supports implementation of the Act, which provides an integrated and market-based approach to covering low-income New Hampshire residents through offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.

The specific purposes of the approach to coverage established in the Act are to:

- Provide private insurance coverage for low-income New Hampshire citizens in a manner that ensures consistent access to coverage across payers and income levels that will help address the issue of churn for the new adult group;
- Rationalize provider reimbursement systems and encourage greater market competition;
- Promote the overall health of low-income citizens by creating sustainable private coverage options; and
- Relieve the burden of uncompensated care in New Hampshire.

The Demonstration program described in this 1115 waiver application is specifically designed to meet the requirements of the Act and address challenges in covering the new adult population.

First, the new adults are likely to have frequent income fluctuations that lead to changes in eligibility. Studies indicate that more than 35 percent of adults will experience a change in eligibility within six months of their eligibility determination.[3] These frequent changes in eligibility could lead to (i) coverage gaps during which individuals lack any health coverage, even though they are eligible for coverage and/or (ii) disruptive changes in benefits, provider networks, premiums, and cost-sharing as individuals transition from one source of coverage to another, especially since the same carriers do not currently serve both the Medicaid and commercial markets in New Hampshire.

[3] Health Affairs, "Frequent Churning Predicted Between Medicaid and Exchanges," February 2011.

Additionally, the State has faced challenges attracting carriers to the State because of the small size of the individual and Medicaid markets. The small number of carriers historically operating in these markets limits choice and reduces competition.

Finally, by expanding Medicaid to include nearly all individuals with incomes at or below 133 percent FPL, New Hampshire increased its Medicaid program enrollment by nearly 40 percent. New Hampshire must continue to ensure access to care for Medicaid enrollees that is comparable to access for the general population in the state.

The Demonstration is crafted to address each of these issues and challenges as follows:

- **Continuity of coverage** – For households with some members eligible for coverage under Title XIX and others receiving coverage through the Marketplace, and for individuals whose incomes fluctuate, the Demonstration will create 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 insurance affordability programs offered through the Marketplace.

  The Demonstration will also promote continuity between Medicaid and QHP coverage by encouraging carriers currently participating in the Medicaid Care Management program to offer coverage in the Marketplace. Because of this, individuals who transition from Medicaid Care Management to QHP coverage upon implementation of the Demonstration may be able to retain the same carrier.

- **Rational provider reimbursement** – New Hampshire fee-for-service Medicaid provides rates of reimbursement that are lower than that of Medicare or commercial payers, causing some providers to forego participation in the program. As part of the New Hampshire Health Protection Program, New Hampshire now requires that Medicaid managed care plans pay most providers at Medicare-levels for individuals in the new adult group. The Demonstration will provide a more sustainable solution by using private market plans, in which provider reimbursement levels are set in a competitive market environment.

- **Uniform provider access** – By leveraging commercial coverage, New Hampshire will ensure that access to providers for individuals in the Demonstration will not be merely comparable to the access afforded to the general population in New Hampshire, as is required under the Social Security Act, but rather that the provider base will be, in fact, identical. Under the Demonstration, the same providers will serve Medicaid and commercial populations, with no segregation of the low-income population.

- **Integration and efficiency** – New Hampshire is taking an integrated and market-based approach to covering low-income New Hampshire residents, rather than relying on a system for insuring lower income families that is separate and duplicative. This transition to the private market is a more efficient way of covering New Hampshire residents.

  Further, the Demonstration improves efficiency in the Marketplace by expanding the population of potential enrollees, potentially attracting new market entrants and promoting competition in the Marketplace.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

The Demonstration will authorize the delivery of health insurance benefits to a new group of low-income adults through an alternative to traditional Medicaid programs and will test the following hypotheses during the approval period:

Evaluation Question	Hypothesis	Waiver Component Being Addressed	Data Source
What are the effects of the QHP premium assistance plan on member quality of care?	QHP premium assistance enrollees will have equal or better quality of care (e.g., preventive visits, primary care, etc.).	Comparability of delivery system and freedom of choice; Limit retroactive coverage to application date (vs. 90 day retrospective).	CHIS & Medicaid claims and encounter data, CAHPS
	QHP premium assistance enrollees will report equal or greater satisfaction with their health care.	Comparability of delivery system and freedom of choice	CAHPS
	QHP premium assistance enrollees will report equal or greater satisfaction with their personal doctor.	Comparability of delivery system and freedom of choice	CAHPS
	QHP premium assistance enrollees will report equal or greater satisfaction with their health plan.	Comparability of delivery system and freedom of choice	CAHPS
What are the effects of the QHP premium assistance plan on member access to care?	QHP premium assistance enrollees will have equal or greater timely access to primary, specialty, and behavioral health care services.	Comparability of delivery system and freedom of choice	CHIS & Medicaid claims and encounter data, CAHPS

Evaluation Question	Hypothesis	Waiver Component Being Addressed	Data Source
	QHP premium assistance enrollees will have equal or lower use of emergency department services.	Comparability of delivery system and freedom of choice; Limit retroactive coverage to application date (vs. 90 day retrospective).	CHIS & Medicaid claims and encounter data
	QHP premium assistance enrollees will have equal or lower rates of potentially avoidable ambulatory care sensitive hospital admissions.	Comparability of delivery system and freedom of choice; Limit retroactive coverage to application date (vs. 90 day retrospective).	CHIS & Medicaid claims and encounter data
	QHP premium assistance enrollees will have equal or greater access to needed non-emergency transportation whether delivered by the QHP or delivered through a Medicaid FFS wraparound.	Comparability of delivery system and freedom of choice; Limit retroactive coverage to application date (vs. 90 day retrospective).	CHIS & Medicaid claims and encounter data
	19-20 year old QHP premium assistance enrollees will have equal or greater access to EPSDT services whether delivered by the QHP or delivered through a Medicaid FFS wraparound.	Comparability of delivery system and freedom of choice; Limit retroactive coverage to application date (vs. 90 day retrospective).	CHIS & Medicaid claims and encounter data
What are the effects of the QHP premium assistance plan on member insurance coverage (uptake) and coverage gaps and loss of coverage?	QHP premium assistance enrollees will experience equal or less coverage gaps and loss of coverage (regardless of source of coverage).	Freedom of choice; Limit retroactive coverage to application date (vs. 90 day retrospective).	Enrollment data
	QHP premium assistance enrollees will maintain continuous access to a regular source of health care.	Freedom of choice; Limit retroactive coverage to application date (vs. 90 day retrospective).	Survey
	Potentially eligible NHHPP Medicaid enrollees will be equal or more likely to enroll in NHHPP into QHP premium assistance than HPP-Bridge MCM.	Freedom of choice	Enrollment projection and trends

Evaluation Question	Hypothesis	Waiver Component Being Addressed	Data Source
What are the effects of the QHP premium assistance plan copayments on members?	The copayments will not pose a barrier to accessing care	Comparability of cost sharing	CHIS & Medicaid claims and encounter data

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration

The Act authorizes the Premium Assistance Program for the single calendar year of 2016. Accordingly, approval is sought for a one-year demonstration. Were the legislature to reauthorize the Program prior to the end of the 2016 legislative session in June, 2016, New Hampshire would seek to extend the proposed time frame for the demonstration for up to two additional years, with precise timeframes dependent upon the terms of such reauthorization.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

No. The demonstration will not modify the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing or delivery systems.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group,

please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

The Demonstration will not affect any of the eligibility categories or criteria that are set forth in the New Hampshire Medicaid State Plan (hereinafter "State Plan").

Participation in the Demonstration, however, will be mandatory for QHP Premium Assistance-eligible individuals. QHP Premium Assistance Individuals will consist of those new adults as defined in § 1902(a)(10)(A)(i)(VIII), who are not eligible for the New Hampshire Health Insurance Premium Assistance Program for persons with access to cost-effective employer sponsored insurance and who are not medically frail. Individuals who qualify for the QHP Premium Assistance program will be required to receive coverage through QHPs, and those QHP eligible persons who decline coverage through QHPs will not be permitted to receive benefits through the State Plan.

Eligibility Chart

Mandatory State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Expansion Populations

Eligibility Group Name	N/A	Income Level

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible for QHP Premium Assistance, New Hampshire will apply the same eligibility standards and methodologies as those articulated in the State Plan.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no caps on enrollment in the Demonstration. To be eligible to participate in the Demonstration an individual must: (1) be a childless adult between 19 and 65 years of age, with an income at or below 133 percent FPL who is neither enrolled in (or eligible for) Medicare nor incarcerated or be a parent between 19 and 65 years of age, with an income between 38 percent FPL (non-working parents)/47 percent FPL (working parents) and 133 percent FPL who is neither enrolled in (or eligible for) Medicare nor incarcerated and (2) be a United States citizen or a documented, qualified alien. Individuals in the above described population who either identify as medically frail or are eligible to receive premium assistance for employer-sponsored insurance will not be eligible for the Demonstration.

Description	Income	Age	Exceptions
Adults in Section VIII Group	*Childless Adults:* 0-133 percent FPL *Non-Working Parents:* 38-133 percent FPL *Working Parents:* 47-133 percent	19-65	▪ Dual Eligibles ▪ Individuals who are medically frail ▪ Incarcerated individuals ▪ Individuals who qualify for premium assistance for employer-sponsored insurance

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Up to 45,000 individuals are anticipated to enroll in the Demonstration as the new adult group established under Section 1902(a)(10)(A)(i)(VIII). It is projected that roughly 90 percent of newly eligible Medicaid enrollees will also be eligible for the Demonstration, with the remaining 10 percent of the new adults ineligible for the Demonstration due to medical frailty or because they are eligible to receive premium assistance for employer-sponsored insurance. Individuals who identify as medically frail will receive coverage either under the ABP or standard coverage under the State Plan.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State)

N/A. Long-term services and supports will not be provided through the Demonstration, since the ABP, as set forth in the State Plan, does not cover long-term services and supports.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

N/A. The State will not institute continuous eligibility or express lane eligibility.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes __X__ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes _X__ No (if no, please skip questions 8 - 11)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Eligibility Group	Benefit Package

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
_X_ Secretary Approved

Since individuals in the new adult group are required to receive coverage through the Alternative Benefit Plan ("ABP"), the State is not electing ABP-equivalent coverage for a population; instead, the State is providing the statutorily required benefit package. New Hampshire's State Plan Amendment outlines its selection of a Secretary-approved ABP.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

N/A. Benefits are the same under the Demonstration and the State Plan.

Benefit Chart

Benefit	Description of Amount, Duration, and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration, and Scope	Reference

Although the benefits in the ABP will be identical across the State Plan and the Demonstration, the appeals process relating to coverage determinations will differ. Under the Demonstration, QHP Premium Assistance enrollees will use their QHP appeals process to appeal denials of benefits covered under the QHP. (QHP Premium Assistance enrollees will continue to use the Medicaid appeals process for denials of wrapped benefits.) All QHP carriers must comply with federal and state standards governing internal insurance coverage appeals. Additionally, all QHP carriers must comply with New Hampshire standards governing external review of insurance coverage appeals[4], which CMS has found to be consistent with Affordable Care Act external review standards.[5] QHP Premium Assistance enrollees will have access to the following two levels of appeals:

Internal Review

Each QHP must provide all enrollees with:

1) Notice identifying the claim or claims being denied;

2) A description of the reason for the denial;

3) Copies of the guidelines used to deny the claim; and

4) Notice that the recipient may request more explanation of the reason for the denial.

Any enrollee whose claim for health care is denied or is not acted upon with reasonable promptness may:

1) Appeal to the QHP; and

2) Present evidence and testimony to support the claim.

The QHP must render a decision regarding an internal appeal within:

1) 72 hours for denial of a claim for urgent care;

2) 30 days for non-urgent care that has not yet been delivered; and

3) 60 days for denials of services already delivered.

External Review

If the QHP does not render a decision within the timeframe specified above, or affirms the denial in whole or in part, the enrollee may request review, and in some cases expedited review, by a Qualified Independent Review Organization (QIRO) that has been selected by the New Hampshire Insurance Department (NHID). Each QIRO must use qualified and impartial

[4] Multi-state plans administered by the federal Office of Personal Management are not subject to state appeal or external review standards; for this reason, New Hampshire anticipates excluding these plans from the Demonstration, subject to ensuring sufficient choice of QHPs for enrollees.
[5] See http://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.

clinical reviewers who are experts in the treatment of the enrollee's medical condition and have recent or current actual clinical experience treating patients similar to the enrollee. Additionally, under NHID administrative rules the enrollee is permitted to submit a statement in writing to support its claim, may receive an oral or in-person hearing, and is entitled to assistance from NHID consumer services staff upon request.[6] The QIRO will render its decision in 45 days, or within 72 hours in the case of an expedited review.

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.)

- ☐ Homemaker
- ☐ Case Management
- ☐ Adult Day Health Services
- ☐ Habilitation – Supported Employment
- ☐ Habilitation – Day Habilitation
- ☐ Habilitation – Other Habilitative
- ☐ Respite
- ☐ Psychosocial Rehabilitation
- ☐ Environmental Modifications (Home Accessibility Adaptations)
- ☐ Non-Medical Transportation
- ☐ Home Delivered Meals Personal
- ☐ Emergency Response
- ☐ Community Transition Services
- ☐ Day Supports (non-habilitative)
- ☐ Supported Living Arrangements
- ☐ Assisted Living
- ☐ Home Health aide
- ☐ Personal Care Services
- ☐ Habilitation – Residential Habilitation
- ☐ Habilitation – Pre-Vocational
- ☐ Habilitation – Education (non-IDEA Services)
- ☐ Day Treatment (mental health service)
- ☐ Clinic Services

[6] N.H. Code of Admin. Rules Ins 2703.05 and Ins 2703.09(g).

- ☐ Vehicle Modifications
- ☐ Special Medical Equipment (minor assistive devices)
- ☐ Assistive Technology
- ☐ Nursing Services
- ☐ Adult Foster Care
- ☐ Supported Employment
- ☐ Private Duty Nursing
- ☐ Adult Companion Services
- ☐ Supports for Consumer Direction/Participant Directed Goods and Services
- ☐ Other (please describe)

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below)
_X_ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

N/A. The State has a premium assistance program for employer-sponsored coverage that is currently in place, and the Demonstration will not affect that program.

b) Include the minimum employer contribution amount.

N/A

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

N/A

d) Indicate how the cost-effectiveness test will be met.

N/A

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

No enrollees will pay premiums under the Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

QHP Premium Assistance enrollees with incomes below 100 percent FPL will not have cost-sharing obligations. Individuals with incomes of 100-133 percent FPL will be responsible for cost-sharing in amounts consistent with Medicaid cost-sharing rules, as laid out in standardized cost-sharing requirements that the NHID will establish for those QHPs that will be available to QHP Premium Assistance enrollees. New Hampshire will amend its State Plan to reflect these cost-sharing amounts applicable for individuals with incomes above 100 percent FPL, effective January 1, 2016. For individuals with income between 100-133 percent FPL, aggregate quarterly cost-sharing will be capped at 5 percent of quarterly household income. A table identifying the copayments applicable to individuals with incomes of 100-133 percent FPL is included in the Appendix to the waiver application.

Demonstration participants will not be required to pay a deductible prior to receiving coverage. Providers will collect all applicable co-payments at the point of care. Enrollees' aggregate amount of co-payments will be monitored to ensure that they do not exceed the annual limit.

New Hampshire will pay QHP issuers advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for QHP Premium Assistance enrollees. The State will rely on the federal Marketplace's calculation of the advance monthly CSR payments for individuals between 138 and 150 percent FPL. Issuers will receive per member per month payments during the benefit year on the basis of this formula. Issuers may request mid-year adjustments to the monthly advance CSR payments if they can demonstrate that the advance CSR amount significantly over- or under-estimates utilization.

These payments will be subject to reconciliation at the conclusion of the benefit year based on enrollees' actual usage of services. Each QHP issuer will report actual cost-sharing reduction amounts to HHS (for members receiving APTCs/CSRs) and New Hampshire Medicaid (for members enrolled in the QHP Premium Assistance program) to reconcile CSR amounts with the advance payments. The New Hampshire Medicaid process for such reconciliations will be modeled on the HHS process. HHS has announced that issuers may choose one of two methods to calculate the actual cost-sharing reductions. The standard method requires the issuer to adjudicate each claim and determine the plan's liability twice: first calculating plan liability using the standard silver plan cost sharing and a second time with reduced cost sharing under the silver plan variant. The CSR payment the issuer is entitled to is the difference between the second number and the first. The simplified methodology does not require re-adjudication of claims. Instead, issuers will enter certain basic cost sharing parameters of its silver plans into a formula that will model the amount of CSR payments, based on total incurred claims. Issuers may choose either method, but a single issuer must apply the same method to all its plans. See 45 C.F.R. § 156.430(c) for additional details.

As part of the cost-sharing reconciliation, New Hampshire Medicaid will establish a process with QHP issuers whereby the issuer will pay the provider for deductible amounts, and Medicaid will reimburse the issuer for these payments.

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

10) Indicate if there are any exemptions from the proposed cost sharing.

Yes. All individuals who are statutorily required to be exempt from cost sharing will be exempt from cost sharing under the Demonstration, including pregnant women and American Indians/Alaskan Natives. Additionally, the State requests waiver authority to exempt individuals from cost sharing while they are receiving coverage through fee-for-service Medicaid pending enrollment in a QHP or Medicaid managed care plan (for medically frail individuals or other individuals excluded from the Demonstration).

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

_X_ Yes
___ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

By leveraging premium assistance to purchase private coverage for QHP Premium Assistance enrollees, the Demonstration will improve quality and value in the healthcare system not only for program enrollees but also for other New Hampshire residents who obtain health insurance coverage in the individual market.

First, the Demonstration will support continuity of care in a population that experiences a high rate of income fluctuation. Reducing gaps in coverage and interruptions in established provider relationships and treatment plans will result in higher utilization of timely preventive care and will assure continuity of treatment of chronic illnesses that left untreated even in the short term result in higher costs to the Medicaid program as the individual's health declines.

Sustaining continuity of care is also key to achieving positive health outcomes and/or mitigating the erosion of health status, where quality of care and the tracking of clinical risk scores will be measured through the established New Hampshire DHHS/Medicaid Quality Program. In partnership with the State's Department of Insurance and the Division of Public Health Services, the health of this population will be monitored and compared to the overall health of the New Hampshire population and national population health metrics in both commercial and public funded insurance coverage programs. Both of these assessments will inform decision making and policy development for the future that will be aimed at providing the most efficient and cost-effective care while meeting fiduciary responsibilities for the wise investment of limited federal and state funds.

Second, the Demonstration will support the State's commitment to the integration of primary care and behavioral health care (including substance use disorders) and provide access to the QHP provider network. The State's commitment and the inclusion of SUD as one of the ten essential health benefits is driving a market reaction where investment in primary care, mental health and SUD provider education is increasing as evidenced by a number of New Hampshire universities establishing advance practice nursing programs and graduate degree programs in mental health related disciplines where none previously existed. By participating in Marketplace QHP networks, providers will receive reimbursements that reflect the commercial, private market. As more primary care, SUD and mental health providers participate in the New Hampshire Health Protection Program it expands options and stimulates investment in the health care delivery system for all Medicaid, CHIP and New Hampshire Health Protection Program enrollees.

Also, by nearly doubling the number of individuals who will enroll in QHPs, the Demonstration is expected to encourage carrier entry and competition in the Marketplace.

Taken together, the factors described above will improve quality, promote access, and potentially reduce the growth of health care costs statewide. All New Hampshire residents who obtain coverage in the individual market will benefit from improved quality and increased

competition spurred by the Demonstration. And all Medicaid enrollees, including those served through fee-for-service Medicaid, will benefit from spreading the growing Medicaid population across a broader network of providers.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ **Managed care**
  - ☐ **Managed Care Organization (MCO)**
  - ☐ **Prepaid Inpatient Health Plans (PIHP)**
  - ☐ **Prepaid Ambulatory Health Plans (PAHP)**
- ☐ **Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)**
- ☐ **Health Homes**
- ☒ **Other (please describe)**

The Demonstration is utilizing Premium Assistance to purchase QHPs in the individual market, and not Medicaid managed care plans, to deliver benefits. Although the Medicaid managed care regulations do not apply to the proposed premium assistance model, the State responds to the questions below that refer to managed care to provide additional detail and context for its proposal to leverage qualified health plans as the delivery system for the Demonstration.

The Demonstration will use premium assistance to purchase cost-effective QHP coverage for Program enrollees. Each beneficiary will have the option to choose between at least two plans that have been certified as QHPs by the federally-facilitated Marketplace, and that meet criteria that have been developed to ensure that the selected plans are cost-effective, both in terms of their premium levels and in terms of their management of care. New Hampshire anticipates that Program enrollees will select among QHPs that include managed care features and emphasize the use of in-network providers.

For enrollees with incomes between 100 percent and 133 percent of the FPL, New Hampshire expects these plans will be 94 percent AV high-value silver plans that have been certified as QHPs and that conform to a standard cost-sharing design outlined by the NHID that is consistent with Medicaid cost-sharing requirements. For program enrollees with incomes below 100 percent of the FPL, New Hampshire expects these plans will be 100 percent AV high-value silver plans.

In keeping with the program's cost-effectiveness requirements, New Hampshire will reserve the right to exclude QHPs that are significant cost-outliers.

Additionally, 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—namely, non-

emergency transportation, adult vision and limited adult dental benefits, and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the Demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT services to the extent such services are not covered under the QHP). EPSDT services are relevant to the QHP Premium Assistance program only because the Affordable Care Act defines 19 and 20 year olds as children for purposes of service benefit requirements, but adults for purposes of eligibility. If family planning services are accessed at out-of-network providers, the State's fee-for-service Medicaid program will cover those services, as required under federal Medicaid law.

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Delivery System Chart

Eligibility Group	Delivery System	Authority

5) If the Demonstration will utilize a managed care delivery system:

As is noted above, the Demonstration is utilizing Premium Assistance to purchase QHPs in the individual market—not Medicaid managed care plans—to deliver benefits. The State nevertheless responds to the questions discussing Medicaid managed care plans to provide additional information about the Demonstration. Each of the responses to questions 5a – 5e are answered as though the questions refer to QHPs, rather than "managed care" or "MCOs."

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

For individuals who are eligible for the QHP Premium Assistance program, enrollment in a QHP will be mandatory. Individuals who are identified as medically frail are not eligible for the QHP Premium Assistance program, and such individuals will be excluded from enrolling in QHPs. All individuals who indicate on their Medicaid eligibility application that they either (1) have a physical, mental, or emotional condition that causes limitations in daily activities (like bathing, dressing, and daily chores) or (2) reside in a

medical facility or nursing home will be identified as medically frail. Individuals identified as medically frail will be eligible for coverage under Title XIX, and they will have the option of receiving either the ABP (through managed care) or the standard Medicaid benefit package through the State Plan.

Recognizing that medical needs may emerge throughout the year, New Hampshire will notify enrollees that they also may self-identify as medically frail at any time. The New Hampshire Medicaid program will retain full responsibility for notifying enrollees of their rights to self-identify as medically frail. The ultimate decision to identify as medically frail is the enrollee's.

The State will comply with all requirements set forth in Section 1937 of the Social Security Act, including, but not limited to, ensuring that all individuals determined to be medically frail, as well as individuals in other ABP-exempt populations identified in Section 1937 of the Social Security Act, will be given the option to receive through fee-for-service Medicaid either the ABP or the standard Medicaid benefit package.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

The Demonstration will be statewide.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

There will not be a phased-in rollout. The Demonstration will begin statewide on January 1, 2016.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

QHP Premium Assistance enrollees will be able to choose from at least two high-value silver plans in each county of the State. The QHP certification process includes an evaluation of network adequacy, including QHP compliance with Essential Community Provider network requirements. QHP Premium Assistance enrollees will have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid enrollees have access to care comparable to the access available to the general population in the geographic area.

e) Describe how the managed care providers will be selected/procured

As described in more detail in response to question 3 above, QHP Premium Assistance enrollees will select among those QHPs available in their county that meet cost-effectiveness criteria. These criteria include care management features, limitations on the use of out-of-network providers and, for enrollees whose income is at or above the federal poverty level, standardized cost-sharing that comports with Medicaid cost-sharing requirements.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Wrap-Around Benefits

All services will be provided through QHPs, except for a limited number of services that are not fully covered under the QHP benefit package but that are included in the ABP. Specifically, the State will provide a fee-for-service wrap around benefit for: (1) non-emergency medical transportation; (2) Early Periodic Screening Diagnosis and Treatment for individuals under age 21 (to the extent the service is not otherwise included in the QHP benefit and is medically necessary as provided under federal regulation); and (3) adult vision and limited adult dental benefit, as described in the State's ABP State Plan Amendment. In addition, if a QHP Premium Assistance beneficiary accesses family planning services through an out-of-network provider, those services will be covered through fee-for-service Medicaid, consistent with federal law.

Retroactive Coverage

New Hampshire seeks to waive the requirement to provide retroactive coverage for medical expenses incurred prior to an individual being determined eligible for Medicaid.

New Hampshire anticipates that, by the beginning of the Demonstration in 2016, most individuals applying to Medicaid will have previously had access to other forms of coverage. Specifically, individuals in New Hampshire with incomes below 133 percent FPL would have had access to Medicaid coverage beginning as of August 15, 2014 through either HIPP or the bridge program. Individuals with incomes above 133 percent FPL would have had access to federal insurance affordability programs to assist in purchasing qualified health plans as of January 1, 2014. Taken together, New Hampshire believes that most individuals new to Medicaid in 2016 will be transitioning from other coverage sources, thereby reducing the need for retroactive coverage.

Coverage Prior To QHP Enrollment

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). 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).

The State will ensure that enrollment in a Medicaid managed care plan remains in effect until the QHP coverage effective date for all individuals transitioning from Medicaid Care Management to the Demonstration. For new applicants, the State will also seek a waiver of the requirement to provide coverage prior to the date of application. As is described further above, the State anticipates that most new applicants will be transitioning to the Demonstration from other sources of coverage that could remain in place until the QHP coverage effective date.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

___ Yes
_X_ No

The Demonstration will not provide long-term services and supports or personal care.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

For services covered by the QHP, providers will be reimbursed for care provided to QHP Premium Assistance enrollees at the rates the providers have negotiated with the QHP carrier.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

N/A

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

New Hampshire Medicaid will not make supplemental payments directly to providers through the Demonstration.

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

QHP coverage under the QHP Premium Assistance program will be effective January 1, 2016, with enrollment beginning October 15, 2015. A proposed implementation timeframe is included below:

Milestone	Timeframe
Issue public notice of waiver	October 1, 2014
Accept comments on waiver	October 1 – October 31, 2014
Hold public hearings on waiver	October 8 and 20, 2014
Submit waiver application to CMS	December 1, 2014
Receive waiver approval	By March 31, 2015
Launch shopping and enrollment function on State Portal	October 15, 2015
Coverage under QHP Premium Assistance becomes effective	January 1, 2016

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Notices

New Hampshire Medicaid will send notices to Medicaid enrollees transitioning to QHP Premium Assistance under the Demonstration, as well as to new applicants. Notices to existing Medicaid enrollees will be sent prior to the beginning of the plan selection process. Notices to new Medicaid enrollees will be sent after the individual is determined eligible for Medicaid coverage. All notices will include the following information:

- *QHP Plan Selection.* The notice will include, among other things, information regarding how QHP Premium Assistance enrollees can select a QHP, including guidance on selecting the plan that will best address their health needs and information on the State's auto-enrollment process in the event that the beneficiary does not select a plan.

- *Wrapped Benefits.* A Medicaid card will be mailed to enrollees within two weeks of eligibility determination and accompanying the card will be a notice containing

information on how enrollees can use the card to access wrapped benefits. The notice will include specific information regarding wrapped benefits, including what services are covered directly through fee-for-service Medicaid, what phone numbers to call for information how to access wrapped services, and any cost-sharing for wrapped services.

- *Appeals.* The notice will also include information regarding the grievance and appeals process. Specifically, the notice will inform QHP Premium Assistance enrollees that, for all services covered by the QHP, the beneficiary should begin by filing a grievance or appeal pursuant to the QHP's grievance and appeals process.

- *Exemption from the Alternative Benefit Plan delivered through the QHP Premium Assistance Program.* The notice will include information describing how new adult enrollees who believe they may be exempt from the Premium Assistance program, including pregnant women and the medically frail, can request an exemption determination and, if they are exempt, choose between receiving coverage through the ABP delivered through managed care or the standard Medicaid benefit package. The notice will include information on the difference in benefits under the ABP as compared to the standard (State Plan) benefit package.

- *Additional notices.* The notice sent to enrollees advising them of their eligibility determination will also advise them that the Premium Assistance Program is subject to cancellation upon notice as provided in the state authorizing statute, SB 413. Enrollees who identify themselves as unemployed at the time of enrollment will be referred to the New Hampshire Department of Employment Security for job counselling services offered by that department.

Enrollment

QHP shopping and enrollment will begin during the individual market open enrollment period for 2016 coverage (October 15, 2015 – December 7, 2015). The plan selection and enrollment process will vary depending on whether an individual is transitioning from the State's Medicaid Care Management program or is a new applicant.

Transition Population

Individuals transitioning from the Medicaid Care Management program to the QHP Premium Assistance program will be enrolled in a QHP through the following process:

- 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 the 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 or (2), if they have not been auto-assigned, that they may select a QHP that is

included in the Premium Assistance program. The notices will provide guidance on how to select a QHP and will include comparisons highlighting the differences between QHPs with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.

- Individuals may select a QHP (1) through New Hampshire Medicaid's online portal, NHEASY, (2) by phone, or (3) in person.
- Individuals who were not auto-assigned to a QHP offered by their MCO and who fail 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.
- Once an individual has either selected a QHP or the time period to select a QHP has ended, New Hampshire Medicaid will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.
- Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.
- On a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for DHHS to reconcile. Upon reconciliation, DHHS will send back an updated list for the carriers.

New Applicants

New applicants will enroll in QHPs through the following process:

- 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.
- An eligibility determination will be made through the New Hampshire Eligibility & Enrollment Framework (EEF).
- Individuals who indicate on their eligibility application that they either (1) have a physical, mental, or emotional condition that causes limitations in activities (like bathing, dressing, and daily chores) or (2) reside in a medical facility or nursing home will be identified as medically frail. Individuals who are identified as medically frail will not be permitted to enroll in QHPs.
- 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.

- Individuals may select a QHP (1) through the State's online portal, NHEASY, (2) by phone, or (3) In person.
- Individuals who fail to select a QHP will be auto-assigned. New Hampshire 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.
- 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.
- Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.
- On a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for DHHS to reconcile. Upon reconciliation, DHHS will send back an updated list for the carriers.

Auto-assignment

The State's goal is to minimize the number of QHP Premium Assistance enrollees who do not complete the QHP selection process and therefore need to be auto-assigned. During enrollment for the Medicaid Care Management program, more than 55 percent of enrollees selected a managed care organization. New Hampshire anticipates that it will need to auto-assign a similarly small percentage of QHP Premium Assistance enrollees.

Individuals who are enrolled in a Medicaid managed care organization (MCO) through the Medicaid Care Management program will be auto-assigned to the QHP offered by their existing MCO, if the MCO elects to offer a QHP. Individuals who are either not enrolled in a Medicaid MCO or whose Medicaid MCO is not offering a QHP will be auto-assigned if they fail to select a QHP. The State anticipates using auto-assignment methodology that takes into account, among other factors, family affiliation, geographic coverage, and the opportunity for care coordination.

Individuals who are auto-assigned will be notified of their assignment and will be given a sixty day period to request enrollment in another plan.

Access To Wrap Around Benefits

In addition to receiving an insurance card from the applicable QHP carrier, QHP Premium Assistance enrollees will have a Medicaid card, indicating a Medicaid Client Identification Number (CIN) through which providers may bill Medicaid for wrap-around benefits. The notice enclosing the card will include information about which services QHP Premium Assistance enrollees may receive through fee-for-service Medicaid and how to access those services. Similar information will be provided on New Hampshire Medicaid's website. Staff at the New Hampshire Medicaid beneficiary call centers will be trained to provide information regarding

the scope of wrap-around benefits and how to access them. Finally, New Hampshire Medicaid will work closely with carriers to ensure that the carriers' call center staff is aware that QHP Premium Assistance enrollees have access to certain services outside of the QHP and that staff can direct the QHP Premium Assistance enrollees to the appropriate resources to learn more about wrap-around services.

3) If applicable, describe how the state will contract with insurance carriers to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

No procurement action is needed.

New Hampshire Medicaid will not contract directly with the insurance carriers. Instead, there will be inter-agency and any such other agreements as are necessary to implement the Premium Assistance Program.

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

To demonstrate budget neutrality, the State worked with its actuary to develop estimates of the without waiver baseline and projected with waiver costs. The State estimates that the demonstration will cost no more than it would have to provide coverage without the waiver. An overview of how the State's actuary developed without waiver and with waiver costs is described below:

Without Waiver. The State's actuary used the current New Hampshire Health Protection Program (NHHPP) premium rates effective beginning September 2014 as the starting point for its analysis. The rates were adjusted to account for the demographics of the population that has enrolled in the NHHPP to date, and the rates were also trended forward to calendar year 2016. The actuary also adjusted the rates to account for a reduction of the impact of pent up demand

and adverse selection that were incorporated in the NHHPP rates. Finally, the rates were adjusted to account for the rate at which individuals were identifying as medically frail.

With Waiver. The State's actuary developed an estimate of premiums for silver-level QHPs in 2016 based on available plan data for a silver plan offered in the Marketplace in 2014. The premiums were trended forward to 2016 using a larger-than-expected trend rate to ensure a conservative analysis. The premiums were adjusted to reflect that the NHHPP population is significantly younger than the 2014 Marketplace population, bringing down the average acuity for the risk pool. The premiums were then adjusted upward slightly to account for increased age-adjusted acuity. Further, the actuary adjusted the premiums to include an estimate of induced utilization due to reduced cost-sharing. To reflect the actuary's experience in commercial market pricing, the rates were further adjusted to incorporate changes to the reinsurance program and market corrections seen throughout the country. The actuary also added in a relatively high estimate of the cost of services provided through fee-for-service Medicaid to ensure conservative projections. Finally, the total cost was adjusted to reflect the current blend of income levels in NHHPP.

Even with the actuary's conservative estimate of with waiver expenditures, the analysis reflects that the costs under the demonstration will not exceed the projected without waiver costs.

Section VII – List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid enrollees.
- § 1902(a)(17): To permit the State to exempt individuals with incomes above 100 percent FPL who are awaiting enrollment in a QHP or Medicaid managed care plan (if excluded from the Demonstration) from cost sharing requirements to which they would otherwise be subject under the State Plan.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for QHP Premium Assistance enrollees and to permit the State to limit enrollees' freedom of choice among providers to the providers participating in the network of the QHP Premium Assistance beneficiary's QHP.
- § 1902(a)(34): To permit the State to provide coverage beginning on the date of application.
- § 1902(a)(54): To permit the State 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.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(17)	To permit the State to provide coverage through different delivery systems for different populations of Medicaid enrollees. Specifically, to permit the State to provide coverage for QHP Premium Assistance eligible Medicaid enrollees through QHPs offered in the individual market.	This waiver authority will allow the State to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid enrollees.
§ 1902(a)(17)	To permit the State to exempt individuals with incomes above 100 percent FPL who are awaiting enrollment in a QHP or Medicaid managed care plan (if excluded from the Demonstration) from cost sharing requirements to which they would otherwise be subject under the State Plan.	This waiver authority will allow the State to impose cost-sharing only once an individual is enrolled in a QHP or Medicaid managed care plan (if excluded from the Demonstration).
§ 1902(a)(23)	To make premium assistance for QHPs in the Marketplace mandatory for QHP Premium Assistance enrollees and to permit the State to limit enrollees' freedom of choice among providers to the providers participating in the network of the QHP Premium Assistance beneficiary's QHP.	This waiver authority will allow the State to require that QHP Premium Assistance enrollees receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the State to align the network available to QHP Premium Assistance enrollees with the network offered to QHP enrollees who are not Medicaid enrollees.
§ 1902(a)(34)	To permit the State to provide	This waiver authority will allow the

Waiver Authority	Use for Waiver	Reason for Waiver Request
	coverage beginning on the date of application.	State to align the beginning of Medicaid coverage with the date of application.
§ 1902(a)(54)	To permit the State to require that requests for prior authorization for on formulary 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.	This waiver authority will allow the State to align prior authorization standards for QHP Premium Assistance enrollees with standards in the commercial market.

Section VIII – Public Notice

1) Start and end dates of the state's public comment period.

The State's comment period was October 1, 2014 to October 31, 2014.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

New Hampshire certifies that it provided public notice of the application on the State's Medicaid website (http://www.dhhs.nh.gov/ombp/medicaid/) beginning on October 1, 2014. New Hampshire also certifies that it provided notice of the proposed Demonstration in *The Union Leader*. A copy of the notice that appeared in the newspaper is attached here as an Appendix.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

New Hampshire certifies that it convened two public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, New Hampshire held the following hearings:

Wednesday, October 8, 2014
6:30-8:30 PM
New Hampshire Department of Health and Human Services

29 Hazen Drive
Concord, NH 03301

Monday, October 20, 2014
1:00-3:00 PM
Medical Care Advisory Committee
New Hampshire Hospital Association
125 Airport Road
Concord, NH 03301

Individuals could attend both hearings by webinar or conference call.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

New Hampshire certifies that it used an electronic mailing list to provide notice of the proposed Demonstration to the public. Specifically, New Hampshire Medicaid provided notice through email lists of key stakeholders, including payers, providers, and advocates, as well as legislators.

5) Comments received by the state during the 30-day public notice period.

New Hampshire received sixteen comment letters during the public notice period, as well as several questions and comments during the public hearings. Copies of the comments are attached here.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.
We attach here at the Appendix a document summarizing and responding to the comments received.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

New Hampshire contains no federally recognized tribes or Indian health programs. As a result, tribal consultation was not required.

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Jeffrey A. Meyers, Director, Intergovernmental Affairs, New Hampshire Department of Health and Human Services
Telephone Number: (603) 271-9210
Email Address: jeffrey.meyers@dhhs.state.nh.us

Section X – Appendices

Table of Contents

Notice of Application for Demonstration Authority

Notice is hereby given that the New Hampshire Department of Health and Human Services (DHHS) intends to apply for authority under Section 1115 of the Social Security Act to enroll certain individuals eligible for coverage under Title XIX of the Social Security Act in qualified health plans offered on the federally facilitated New Hampshire Health Insurance Marketplace.

Summary of Demonstration

On March 27, 2014, Governor Maggie Hassan signed into law Senate Bill 413, an Act relative to health insurance coverage (the "Act"), (2014 NH Laws Chap. 3) establishing the New Hampshire Health Protection Program to expand health coverage in New Hampshire for adults with incomes up to 133% of the Federal Poverty Level.

The New Hampshire Health Protection Program includes several 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 through December 31, 2015; and (3) a mandatory individual qualified health plan (QHP) premium assistance program beginning on January 1, 2016. Coverage for the new adult group became effective on August 15, 2014. This Demonstration is intended to implement the mandatory QHP premium assistance program established in the Act.

Under the Demonstration, the State will implement a mandatory premium assistance program ("Premium Assistance Program" or "Program") through which the State will purchase from insurance carriers QHPs that have been certified for sale in the individual market on the federally facilitated New Hampshire Health Insurance Marketplace. Individuals eligible for the Program will include those covered under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 133% of the federal poverty level (FPL) who are neither enrolled in (or eligible for) Medicare nor incarcerated or (2) parents between the ages of 19 and 65 with incomes between 38% (for non-working parents) or 47% (for working parents) and 133% FPL who are neither enrolled in (or eligible for) Medicare nor incarcerated (collectively "QHP Premium Assistance beneficiaries"). Premium Assistance Program beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and will have cost-sharing obligations consistent with Medicaid cost-sharing requirements.

The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals as they transition across different sources of coverage ensuring consistent access to providers, rationalizing provider reimbursement, and enhancing integration and efficiency of public and private coverage in New Hampshire. Ultimately, the Demonstration will provide truly integrated coverage for low-income New Hampshire residents regardless of their income or source of coverage.

Additionally, by adding up to an estimated 45,000 persons to the Marketplace, the Program may attract additional QHP carriers creating a more competitive market, which will benefit all individuals purchasing coverage on the Marketplace.

The Demonstration will be statewide and will operate during calendar year 2016. The State anticipates that approximately 45,000 individuals will be eligible for the Demonstration. The State expects that, over the life of the Demonstration, covering New Hampshire Health Protection Program beneficiaries will be comparable to what the costs would have been for covering the same expansion group through Medicaid Care Management.

Hypotheses To Be Evaluated Through Demonstration

The Demonstration will evaluate the following questions:

- What are the effects of the QHP premium assistance plan on member quality of care?
- What are the effects of the QHP premium assistance plan on member access to care?
- What are the effects of the QHP premium assistance plan on member insurance coverage (uptake) and coverage gaps and loss of coverage?
- What are the effects of the QHP premium assistance plan on the costs of providing care?
- What are the effects of the QHP premium assistance plan copayments on members?

Waivers Requested

The State will request the following waivers to operate the Demonstration:

- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries.
- § 1902(a)(17): To permit the State to vary cost sharing requirements for individuals in the Demonstration with incomes above 100% FPL from cost sharing to which they would otherwise be subject under the State Plan.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for QHP Premium Assistance beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the QHP Premium Assistance beneficiary's QHP.
- § 1902(a)(34): To permit the State to provide coverage as of the application date.

The State continues to evaluate whether it will request other waivers.

Opportunity for Public Input

The complete version of the current draft of the Demonstration application is available for public review at http://www.dhhs.nh.gov/pap-1115-waiver/index.htm. The Demonstration application may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Department of Health and Human Services
Office of Medicaid Business and Policy
Legal and Policy Unit
129 Pleasant Street-Thayer Building
Concord, NH 03301-3857

Public comments may be submitted until midnight on October 31, 2014. Comments may be submitted by email to PAP1115Waiver@dhhs.state.nh.us or by regular mail to Department of Health and Human Services, Office of Medicaid Business and Policy, Legal and Policy Unit, 129 Pleasant Street-Thayer Building, Concord, NH 03301-3857. Comments should be addressed to Jeffrey A. Meyers, Director, Intergovernmental Affairs, NH Department of Health and Human Services.

To view comments that others have submitted, please visit http://www.dhhs.nh.gov/pap-1115-waiver/index.htm. Comments may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Department of Health and Human Services
Office of Medicaid Business and Policy
Legal and Policy Unit
129 Pleasant Street-Thayer Building
Concord, NH 03301-3857

The State will host two public hearings during the public comment period.

Wednesday, October 8, 2014
6:30-8:30 PM
New Hampshire Department of Health and Human Services
Division of Public Health Services
29 Hazen Drive
Concord, NH 03301

To attend by webinar:
https://pcgus.webex.com/pcgus/j.php?MTID=m033af3335f479e13d8da20c7f52e4447
Meeting number: 763 259 638
Meeting password: nhdhhs

To join by phone:
1-877-668-4493 Access code: 763 259 638

Monday, October 20, 2014
1:00-3:00 PM
Medical Care Advisory Committee

New Hampshire Hospital Association
125 Airport Road
Concord, NH 03301

To attend by webinar:
https://pcgus.webex.com/pcgus/j.php?MTID=m5b940af84f4d96ba72abe2b9e9c8ca0a
Meeting number: 768 829 221
Meeting password: nhdhhs

To join by phone:
1-877-668-4493 Access code: 768 829 221

Proposed Cost-Sharing Design

Service	Co-Pay
Primary Care Physician	$0
Specialty Physician	$8
Other Medical Professionals	$8
Generic Prescription Drug	$2
Preferred and Non-Preferred Brand Prescription Drugs	$6
Specialty Prescription Drugs	$6
Behavioral Health Professional	$0
Behavioral Health Outpatient Visit	$0
Behavioral Health Inpatient Admission	$50
Hospital Outpatient Visit	$0
Hospital Inpatient Admission	$50
Imaging (CT/PET Scans, MRIs)	$25
Durable Medical Equipment	$0
Lab and Radiology	$0
Skilled Nursing Facility	$0
Emergency Room Visit	$0
Other	$0

NEW HAMPSHIRE LEGAL ASSISTANCE

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1-800-562-3174
Fax: 603-622-5576

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Portsmouth, NH 03801
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1-800-334-3135
Fax: 603-431-8025

Berlin Office
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Berlin, NH 03570
603-752-1102
1-800-698-8969
Fax: 603-752-2248

Administration
117 North State Street
Concord, NH 03301
603-224-4107
Fax: 603-224-2053

TTY: 1-800-735-2964

October 8, 2014

Jeffrey A. Meyers, Director
Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street – Thayer Building
Concord, NH 03301-3857

Via Hand Delivery

RE: New Hampshire Health Protection Program
Premium Assistance Section 1115 Research and Demonstration Waiver

Dear Mr. Meyers:

New Hampshire Legal Assistance looks forward to reviewing the response of the Department of Health and Human Services ("the Department") to the following questions regarding the proposed Section 1115 waiver:[1]

1. Appeals. Can you confirm the following:

    a. That the ordinary Medicaid appeals process, including fair hearings, will be available to "new adult" applicants for eligibility determinations, e.g. whether the applicant meets age, income, and other requirements and whether the applicant is exempt from mandatory participation in the qualified health plan ("QHP") premium assistance program ("PAP") because of medically frail status, dual eligibility, or pregnancy;
    b. That the ordinary Medicaid appeals process, including fair hearings, will be available to new adults who are exempt from mandatory participation in the QHP PAP for benefits denials;

[1] NHLA submits these questions without prejudice to our law firm's right to submit additional questions and/or comments in advance of the October 31, 2014 public comment deadline, and without prejudice to the right of our law firm and/or our current or future clients to make any claims in any current or future litigation.

c. That the ordinary Medicaid appeals process, including fair hearings, will be available to all new adults for denials of wrapped benefits; and
d. That the ordinary Medicaid appeals process will not be available to QHP PAP enrollees for benefits denials and that such enrollees will instead be limited to the QHP's internal appeal review process and the Qualified Independent Review Organization external review process. Specifically, can you confirm that QHP PAP enrollees will not be entitled to fair hearings for benefits denials?

2. Cost-sharing.

a. Can you confirm that QHP PAP enrollees' cost-sharing obligation is limited to payment of co-pays, in other words, that enrollees will not be responsible for deductible or coinsurance payments?
b. Can you confirm that QHP PAP enrollees' cost-sharing obligation will be capped at 5 percent of projected quarterly household income within each quarter, in other words, that once an enrollee has made co-pays totaling 5 percent of projected quarterly household income in a particular quarter, he or she will have no further co-pay obligation until the next quarter?
c. Can you confirm that a QHP PAP enrollee's projected quarterly household income will be adjusted on a pro rata basis for the remainder of a quarter if he or she reports a change in household income?
d. Can you confirm that a QHP PAP enrollee's cost-sharing obligation will cease immediately if he or she reports a change in income which would cause him or her to drop below 100 percent of the Federal Poverty Line?
e. Could you describe how the Department intends to track co-payments so that QHP PAP enrollees are not asked for co-payments at the point of care after meeting their quarterly maximum?

3. Could you estimate the number of new adults who will enroll on or after January 1, 2016 and therefore not be eligible for 90 days of retroactive coverage?

Thank you for your consideration of these questions. If you need clarification, please call me at 206-2214.

Very truly yours,

[redacted]

Sarah Mattson Dustin, Esq.
Policy Director

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Fax: 603-224-2053

TTY: 1-800-735-2964

October 20, 2014

Jeffrey A. Meyers, Director
Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street – Thayer Building
Concord, NH 03301-3857

Via Hand Delivery at MCAC Meeting

RE: New Hampshire Health Protection Program
Premium Assistance Section 1115 Research and Demonstration Waiver

Dear Mr. Meyers:

Thank you for the opportunity to comment on the proposed Section 1115 Research and Demonstration Waiver. New Hampshire Legal Assistance (NHLA) looks forward to reviewing the response of the Department of Health and Human Services ("DHHS") and/or the Insurance Department to the following questions regarding the proposed Waiver:[1]

1. Appeals.
    a. Under the existing managed care law, RSA 420-J, what percentage of internal appeals/grievances result in claim denials being reversed or otherwise resolved fully favorably to the enrollee?
    b. Under the existing managed care law, RSA 420-J, what percentage of independent external reviews result in claim denials being reversed or otherwise resolved fully favorably to the enrollee?
    c. What percentage of appeals to the DHHS Administrative Appeals Unit, addressing a Medicaid service for which coverage has been denied in whole or in part, result in the denial being reversed or otherwise resolved fully favorably to the enrollee?
    d. Will DHHS or the Insurance Department collect data on the success rate of internal appeals/grievances and independent external reviews filed by New Hampshire Health Protection Plan enrollees, as distinguished from other managed care plan enrollees, starting in 2016?

[1] NHLA submits these questions without prejudice to our law firm's right to submit additional questions and/or comments in advance of the October 31, 2014 public comment deadline, and without prejudice to the right of our law firm and/or our current or future clients to make any claims in any current or future litigation.

e. Can you confirm that all New Hampshire Health Protection Plan enrollees will be entitled to an oral hearing on a claim denial?

2. Co-payments.
   a. How will DHHS and/or the Insurance Department track enrollees' co-payments so as to avoid exceeding the maximum quarterly obligation, and what, if any, duty will enrollees have to track their own co-payments? If enrollees will have a duty to track their own co-payments, how will DHHS, the Insurance Department, or carriers instruct them about that process?
   b. Will DHHS and/or the Insurance Department be able to make within-quarter adjustments to an enrollee's quarterly cost-sharing obligations, including lowering quarterly cost-sharing obligations based on reduced income or ceasing cost-sharing obligations immediately if the enrollee's income falls below 100 percent of the federal poverty level?
   c. How will refunds be processed if an enrollee exceeds his or her maximum quarterly cost-sharing obligation?

3. Retroactivity.
   a. Can you confirm that New Hampshire Health Protection Plan coverage will be retroactive to the date that a person submits an initial application using any of the various application mediums available (such as in-person paper application, NH Easy application, et al.), even if any documents required to verify eligibility have not yet been submitted by the applicant?

4. Health Literacy and Reading Level.
   a. How will DHHS and the Insurance Department ensure that their own communications and those of carriers, including paper and electronic correspondence and websites, are appropriate to the typical language ability, reading level, and health literacy of New Hampshire Health Protection Plan enrollees?

Thank you for your consideration of these questions and for the extensive work you and your colleagues are doing on this crucially important proposal. If you need clarification, please call me at 206-2214.

Very truly yours,

[redacted]

Sarah Mattson Dustin, Esq.
Policy Director

NEW HAMPSHIRE VOICES FOR HEALTH

October 20, 2014

Via E-Mail & Hand-Delivery

Jeffrey A. Meyers, Esq.
Director of Intergovernmental Affairs
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3587
E-Mail: PAP1115Waiver@dhhs.state.nh.us

Re: NH Health Protection Program – Questions Concerning Draft Premium Assistance Section 1115 Demonstration Waiver Application

Dear Mr. Meyers:

NH Voices for Health (VOICES) looks forward to and will be submitting written comments concerning New Hampshire's draft Premium Assistance Program (PAP) Demonstration Waiver application.

However, at this juncture and for clarity of public understanding, we are respectfully requesting that the NH Department of Health and Human Services (Department) provide written response to the following questions concerning the draft Section 1115 Waiver application.

1. *Proposed Waiver of 90-Day Retroactive Coverage Requirement.* The draft Waiver application proposes that PAP coverage begin on the enrollee's date of application (or on January 1, 2016, whichever is later). Please answer the following:
   a. How does the Department define 'date of application' in this context?

2. *Proposed Waiver of 24-Hour Prior Authorization Requirement for Prescription Drugs.* For PAP enrollees, the draft Waiver application proposes to replace Medicaid's 24-hour prior authorization requirement for prescription drugs with a 72-hour prior authorization standard. The draft application also indicates that 'a 72-hour supply of the requested medication will be provided in the event of an emergency'. Please answer the following:
   a. How does the Department define 'emergency' in this context?

3. *Cost Sharing Plan.* Can you please confirm the following:
   a. That there is no cost-sharing proposed for PAP enrollees with incomes at less than 100% of the federal poverty level (FPL);
   b. That for PAP enrollees with incomes at 100% of FPL and above:
      i. There is no premium or deductible or coinsurance payable by enrollees;
      ii. Enrollee cost-sharing is limited to copays, with an out of pocket maximum; and
      iii. An enrollee's out of pocket maximum for aggregate quarterly copays is equal to 5% of the enrollee's applicable quarterly income?

4. *Cost Sharing Plan.* Please answer the following:
   a. Will persons who identify as 'medically frail' be subject to the same cost-sharing as PAP enrollees?
   b. Please identify the 'Other Medical Professionals' that are listed in the Cost Sharing Plan as requiring an $8 copay?
   c. Is the listed 'Imaging' copay of $25 limited to CT and PET scans and MRIs; and
      i. If not, please specify additional 'Imaging' that you expect to be subject to this $25 copay?

5. *Auto-Assignment.* Can you please confirm the following:
   a. That when a person is determined to be PAP eligible and is either not a Bridge Program enrollee, or is a Bridge Program enrollee whose Medicaid managed care organization (MCO) is not offering a certified QHP (qualified health plan), he or she will have sixty (60) days to select a qualified health plan before being subject to QHP auto-assignment; and
   b. That if, in that circumstance, the PAP enrollee fails to select a plan within sixty (60) days, he or she will be auto-assigned to a QHP with health care provider network access in his or her geographic area?

6. *Auto-Assignment.* Please answer the following:
   a. In the context of New Hampshire's anticipated auto-assignment methodology, what does the Department mean by taking 'family affiliation' into account?
   b. For Medicaid Bridge Program enrollees who are auto-assigned to the QHP offered by their MCO, what, if any, existing or proposed requirement is there that the MCO-offered qualified health plan have a health care provider network serving the PAP Medicaid enrollee's geographic area?

7. *PAP QHP Health Care Provider Network Adequacy.* Please answer the following:
   a. How will New Hampshire ensure that certified QHPs provide PAP enrollees with access to care that is comparable to the access available to the general population in the enrollee's geographic area, as required by federal Medicaid law?

8. *Consumer Assistance.* Please answer the following:
   a. How does the Department propose to assist those who are determined to be PAP eligible with understanding their available qualified health plan enrollment options and the QHP selection process?

VOICES is grateful for the opportunity to submit these questions as part of the public process for New Hampshire's proposed Premium Assistance Program Section 1115 Demonstration Waiver. We look forward to submitting formal written comments.

Sincerely,

[redacted]

Thomas G. Bunnell, Esq.
Policy Consultant

Goodwin
Community Health

October 29, 2014

Jeffrey A. Meyers
Director of Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
PAP1115Waiver@dhhs.state.nh.us

Dear Jeffrey:

Thank you for the opportunity to provide comments on the New Hampshire Health Protection Program Premium Assistance Section 1115 Research and Demonstration Waiver (Waiver). Goodwin Community Health located at 311 Route 108 in Somersworth, NH is thrilled to see the State is taking steps to expand health care coverage to low-income New Hampshire residents. If approved, the Waiver will allow the State to provide health insurance coverage to adults between the ages of 19 and 65 with incomes at or below 133% of the Federal Poverty Level through the Premium Assistance Program (PAP Program).[1] We appreciate and support the State's goals of: 1) addressing the continuity of coverage for the newly eligible adult Medicaid population; 2) rationalizing provider reimbursement; 3) promoting overall health of our low-income citizens; and 4) relieving the burden of uncompensated care affecting providers statewide. Our comments below address our concerns as to how the Waiver may affect New Hampshire's low-income population's access to health care.

Cost-sharing

Goodwin Community Health understands that our comments must be directed at the Waiver, however, we feel it is important to provide input on the Proposed Standard Cost-sharing Plan (Plan) included on the NH Department of Health and Human Services' Premium Assistance Program Section 1115 Demonstration Waiver website.[2] The Waiver specifies that the State will amend its State Plan Amendment to include cost-sharing measures for individuals living between 100% and 133% of the federal poverty level (FPL) and caps the cost-sharing at 5% of quarterly household income.[3] The comments outlined below address the cost-sharing included in the Plan. The Waiver hypothesizes that enrollees "will have equal or greater timely access to primary, specialty, and behavioral health care services."[4] The Waiver also states that enrollees will have equal or lower rates of emergency department use, and avoidable ambulatory care sensitive hospital admissions.[5] The Waiver indicates that the co-payments envisioned in the waiver "will not pose a barrier to accessing care."[6] These are admirable goals that we support, however, we believe that the cost-sharing structure included in the Plan will negatively affect enrollees' access

[1] NH DHHS, NH Health Protection Program Premium Assistance, §1115 Research and Demonstration Waiver, 1 (October 2014).
[2] *See* Proposed Standard Cost-sharing Plan, http://www.dhhs.state.nh.us/pap-1115-waiver/documents/cost-sharing-10012014.pdf (October 2014).
[3] Waiver at 14.
[4] Waiver at 4.
[5] Waiver at 5.
[6] Waiver at 6.

to care because cost-sharing inhibits low-income patients from accessing not only primary and preventive care, but behavioral health services as well.[7]

Prescription Co-pays

We believe personal responsibility measures can be effective if employed correctly, but the cost-sharing measures included in the Plan will discourage low-income residents from accessing necessary care.[8] Individuals living between 100% and 133% of the FPL earn between $11,670 and $15,521 annually. This population includes individuals with complex socioeconomic backgrounds and individuals who are more likely to have chronic conditions that require pharmaceutical treatment and monitoring by a health care provider than an individual with a higher income.[9] In addition, this population is more likely to experience barriers to care due to cost than a person with traditional private insurance.[10] If PAP Program enrollees did not participate in the Bridge Program, it is likely this population was uninsured and paid out of pocket for their health care needs prior to participation in the PAP Program. As a result, those PAP Program enrollees are less likely to have accessed a primary care provider.[11] The Plan includes pharmaceutical co-payments as high as $6 despite evidence that co-payments as low as $2 to $3 for prescription medications decrease adherence to prescription regimens.[12] In contrast, studies show that decreased cost-sharing improves health outcomes, including for those with chronic conditions.[13]

Decreasing adherence to treatment plans contradicts the hypothesis stated in the Waiver: "[t]he co-payments will not pose a barrier to accessing care" and has the potential impact of negatively affecting those with chronic conditions such as mental illness.[14] "One multistate study of Medicaid claims data found generic co-pays of only $2 or $3 correlated with significantly lower adherence to medications for schizophrenia as compared with no co-pays."[15] Delayed or discontinued prescription use has a greater impact on the low-income population and results in an increase of low-income patients foregoing prescription treatment.[16] Combined with the behavioral health inpatient co-pay of $50, the Plan has the potential to reduce access within an already fragile behavioral health care delivery system in New Hampshire.[17] If patients are able to access the care they need when the symptoms are acute and manageable, New Hampshire's health care systems will save money because adverse health outcomes will be avoided.[18]

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[7] *See* Danny McCormick, Assaad Sayah, Hermione Lokko, et al., Access to Care After Massachusetts' Health Care Reform: A safety Net Hospital Patient Survey, 1552 (July 2012).

[8] *See* National Health Law Program, Medicaid Premiums and Cost-sharing, 1 (March 2014).

[9] *See id.* at 5, 11.

[10] *See* McCormick at 1550; *see also* Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, 6 (February 2013).

[11] *See* McCormick at 1550.

[12] Plan; *see* National Health Law Program at 6, 9.

[13] National Health Law Program at 3, 6.

[14] *See* Waiver at 6.

[15] National Health Law Program at 9.

[16] *Id.* at 5.

[17] *See* Plan.

[18] *See* Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, 1 (February 2013).

In addition to affecting the ability of patients to comply with prescription treatments, the cost-sharing included in the Plan will negatively affect the ability of patients to access outpatient services for behavioral health and other health care needs.[19] The Plan includes cost-sharing for imaging services, behavioral health inpatient services, hospital inpatient services, and "other medical professionals."[20] Studies show that patients are likely to reduce utilization of these services in particular because of cost-sharing.[21] This will negatively affect patients with chronic illnesses, such as cancer and mental illness, as evidence suggests a likelihood patients will discontinue necessary services, especially those who need access to behavioral health services.[22] In addition, the term "other medical professionals" is not defined in the Waiver or Plan.[23] If this term includes services that are accessed on a daily basis, such as home health care services, PAP Program participants will experience exponential costs; making it less likely that the participant will access necessary care that delays more expensive medical intervention.

Cost Shifting

The level of cost-sharing included in the Plan will negatively affect providers because of cost shifting.[24] The Waiver requires providers collect "all applicable co-payments at the point of care."[25] FQHCs and CHCs cannot deny a patient care because of the patient's inability to pay. If the provider cannot collect payment from the patient, the provider will not only lose the amount of the co-payment, but also the administrative costs of trying to collect the co-payment. This will increase the uncompensated care burden on providers. Further, patients who cannot afford co-payments are more likely to rely on the services of safety net primary care providers such as the FQHCs and CHCs, which will place more financial burden on these small, non-profit businesses.[26] Cost shifting due to co-payments may result in an inability of safety net providers to continue to provide services at the level currently seen statewide.[27]

Alternatives to cost-sharing

Personal responsibility can take many forms, including participation in care management programs, many of which are offered by providers, participation in group therapy for chronic illnesses, and wellness programs. For example, like many chronic diseases, diabetes requires prescription treatment and provider monitoring. It is also a disease that can lead to more costly interventions if not managed correctly. Similar to other chronic conditions, chronic disease management is shown to reduce overall health care costs in patients with diabetes and improve the quality of care.[28] As currently written, the Plan discourages adherence to a provider's recommended course of treatment for chronic and non-chronic conditions through the use of cost-sharing. Therefore, we ask the State to consider requiring participation in programs that educate and encourage chronic disease self-management and overall wellness rather than

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[19] *See* National Health Law Program at 8; *see also* Kaiser Commission on Medicaid and the Uninsured at 6.
[20] *See* Plan.
[21] National Health Law Program at 8.
[22] *See id.* at 8, 9.
[23] *See* Plan.
[24] *See* National Health Law Program at 3.
[25] Waiver at14.
[26] *See* Kaiser Commission on Medicaid and the Uninsured at 1.
[27] *See* McCormick at 1553.
[28] *See* Jaan Sidorov, Robert Shull, Janet Tomcavage, et al., Does Diabetes Disease Management Save Money and Improve Outcomes?, 684 (April 2002).

employing cost-sharing measures. These programs "more strongly govern" health care costs than cost-sharing, especially for our low-income residents.[29]

Calculating and Collecting Cost-sharing

The Waiver requires aggregate quarterly cost-sharing and places an annual cap on cost-sharing at 5% of quarterly household income.[30] In addition, PAP Program enrollees must notify the State within 10 days of any changes in financial eligibility.[31] The Waiver also states that the enrollees' aggregate amount of co-payments will be monitored to ensure the enrollee does not exceed the annual limit.[32] However, it is unclear who will conduct the monitoring of these co-payments and how often.[33] This could potentially negatively affect PAP Program enrollees, especially those whose incomes fluctuate frequently. A large number of the adults who are eligible for health insurance coverage through the PAP Program work in the service industries, including restaurants, hotels, construction, and grocery stores, and their employment is often seasonal.[34] Their incomes are likely to frequently fluctuate given the nature of employment. Tracking of enrollees' income in order to ensure an individual's costs do not exceed that cap will be a costly endeavor, regardless of whether the State or the QHP collects this information. As currently written, it is unclear what the notification process will be for ensuring a PAP Program enrollee receives notice that the cap has been met. It is also unclear how providers will be notified as to whether or not to collect payment from the patient at the time of service and how quickly the PAP Program will respond to enrollees' notification of change in income. A patient with a chronic condition could potentially pay in excess of the 5% cap for an entire quarter unless the State's monitoring system is in real time. Minimal cost-sharing results in the delay of accessing necessary care and a reduction in the utilization of less costly health care services.[35]

Grievance and Appeals Process

The Waiver creates a bifurcated grievance and appeals process based on the service at issue for the PAP Program enrollee.[36] Goodwin Community Health is pleased to see the Waiver include notification to enrollees of the QHP appeals process governed by statute, which services are covered by the QHP appeals process, and notification of the services that will be subject to the Medicaid appeals process.[37] We understand that PAP Program enrollees are QHP consumers, however, this population has different needs, socioeconomic backgrounds, and education levels than a typical privately insured consumer. While notification from the State as to which services are covered by which appeals process is beneficial, we do not believe this will adequately meet the needs of this population. We respectfully request the State consider a monthly grievance and appeals process review program to ensure the appellate process established by statute for the QHPs is as effective for the PAP Program enrollees as that of the Medicaid appeals process. In addition, we ask the State to create and appoint an Ombudsman to assist PAP Program enrollees

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[29] *See* National Health Law Program at 4.
[30] Waiver at 14.
[31] N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014).
[32] Waiver at 14.
[33] *Id.*
[34] *See* Fact Sheet: Impact of Medicaid Expansion by Industry, http://www.nhfpi.org/research/fact-sheet-impact-medicaid-expansion-industry.html (October 2013).
[35] Kaiser Commission on Medicaid and the Uninsured at 6.
[36] Waiver at 11.
[37] Waiver at 23.

with the navigation of not only the QHP appellate process, but also the Medicaid fair hearing process.

Auto-Assignment of PAP Program Enrollees to QHPs

The Waiver prescribes an auto-assignment process for individuals transitioning from Medicaid Care Management to the PAP Program, allows individuals to select a different QHP than the auto-assignment if they desire with 60 days, and allows individuals who were not auto-assigned to select a QHP.[38] We appreciate that the notice sent to enrollees will include guidance on how to select a QHP, however, we hope enrollees will have access to information such as network adequacy and provider participation. The FQHCs and CHCs experienced significant financial and administrative burdens due to the auto-assignment of their patients during the rollout of Medicaid Managed Care. One FQHC noted that over 1000 of their patients were auto-assigned to another provider. In addition, our patients and staff experienced difficulty in determining which providers were covered by which Managed Care Organization (MCO). One MCO's website listed providers by organization, while another listed individual providers. We respectfully request the State maintain an accurate provider and network list in multiple formats, e.g. online or by phone, that are updated in real time to ensure PAP Program enrollees and providers have the most accurate and up-to-date information.

Network Adequacy

We are pleased the State shares our goal of increasing access to health care coverage while ensuring continuity of care. The Waiver states that PAP Program enrollees will have access to the QHP networks, which are the same networks individuals who purchase coverage in the individual market have.[39] While this might comply with the requirements of Section 1902(a)(30)(A) of the Social Security Act, it is unclear at this time if this will negatively affect potential PAP Program enrollees. We hope the State will ensure PAP Program enrollees (former Medicaid managed care enrollees) have access to necessary providers, providers that they have an established history with, and providers skilled in treating low-income patients with complex socioeconomic needs. We respectfully request network adequacy be continuously monitored to ensure the health outcomes of the PAP Program enrollees are not affected by network adequacy.

Waiver of 90-day Retroactivity

The State seeks to permission to waive the Medicaid 90-day retroactive coverage requirement and limit coverage to the "beginning of Medicaid coverage with the date of the application."[40] The reason given by the State for this request is that the majority of the enrollees will be moved from Medicaid care management into the PAP Program. This assumption presents a number of problems not only for the patients but also providers, including: 1) there will be a number of PAP Program enrollees who were not included in Medicaid managed care and would benefit from having 90-day retroactive coverage; 2) the population the PAP Program is designed to serve often have complex socioeconomic backgrounds that will inhibit them from seeking coverage when they initially present to a provider, even if eligible at the time of service; and 3) if a provider serves an uninsured patient who is eligible for coverage under the PAP Program prior to the application date, the provider will not receive reimbursement for the care provided. This will

[38] *Id.* at 24.
[39] *Id.* at 20.
[40] Waiver at 28.

unnecessarily increase that provider's level of uncompensated care, which is in direct conflict with the goals as outlined in the Waiver.[41] Medical debt is the most cited reason as to why a person files for bankruptcy in the US.[42] The number of individuals that will be uninsured prior to participation in the PAP Program is likely small; therefore, the 90-day retroactivity coverage requirement should not be waived given the significant financial impact it will have on the PAP Program enrollees and providers.

Waiver of Medicaid's 24-hour Prior Authorization Requirement for Prescription Drugs

We respect the crucial role the QHPs will play in providing coverage to the PAP Program enrollees and understand the desire to align prior authorization standards for PAP Program enrollees with those of the standard QHPs. However, the population that will receive health insurance coverage through the PAP Program are Medicaid recipients with more complex health needs than the typical privately insured consumer. The Waiver requests prior authorization for prescriptions be addressed within 72 hours rather than 24 hours as currently required by Medicaid.[43] The Waiver also seeks permission to issue a 72-hour supply of the requested prescription medication in the event of an emergency, but does not define an "emergency."[44] The Waiver also does not indicate who makes the determination as to whether there is an emergency: whether it is the QHP, the pharmacist, the provider, or the patient.[45] We respectfully request that the Waiver be clarified to indicate who makes the determination as to whether an emergency exists and how that determination is to be made.

340B Drug Pricing Program

The 340B Drug Pricing Program is a program administered by the Office of Pharmacy Affairs within the Health Resources and Services Administration.[46] Participating manufacturers provide outpatient drugs to participating providers (covered entities) at a reduced price, which then allows the covered entities, including FQHCs and critical access hospitals, to provide outpatient drugs to patients at a significantly discounted price.[47] Covered entities are limited to nonprofit health care organizations funded through certain federal programs.[48] If a covered entity provides prescription medicine purchased through the 340B Drug Pricing Program to a patient, the State cannot seek a Medicaid rebate for the patient because of the prohibition on duplicate discounts and vice versa. It is unclear if the State has the burden to notify the covered entity that the entity can use 340B prescription medicine.

Also, the Waiver is unclear as to how the State will manage the PAP Program with regards to the 340B Drug Pricing Program: will FQHCs and other 340B Drug Pricing Program providers be able to seek reimbursement for drugs provided to PAP Program enrollees? How will the providers know whether or not the State chooses to seek a Medicaid rebate for that enrollee? What systems will the State put in place to ensure a duplicate discount is avoided? The FQHCs' continued participation in the 340B Drug Pricing Program is crucial to the financial health of the

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[41] *See id.* at 2.
[42] Karen Pollitz and Cynthia Cox, Medical Debt Among People with Health Insurance, 18 (January 2014).
[43] Waiver at 28.
[44] *Id.*
[45] *See id.*
[46] HRSA http://www.hrsa.gov/OPA/ (last accessed in October 2014).
[47] *Id.*
[48] HRSA http://www.hrsa.gov/OPA/.

FQHCs: "The 340B Program enables covered entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[49] We respectfully request the covered entities retain the ability to provide prescription medicine purchased through the 340B Drug Pricing Program to PAP Program enrollees.

Proposed Timeframe for the Waiver

The PAP Program was authorized by the New Hampshire Legislature from January 1, 2016 to December 31, 2016 and thus the Waiver proposes a demonstration timeframe of one year.[50] If the Legislature does not reauthorize the PAP Program, the PAP Program ceases to exist. Because of the time and effort requirements associated with a waiver application, not to mention the administrative costs and burdens incurred by the State in filing a waiver application and subsequent extensions, we respectfully request the Waiver extend the demonstration to a minimum of three years.

Conclusion

We are grateful that our State is in the position to seek a Waiver authorizing Medicaid recipients be placed in QHPs. Our State has made great strides in improving our low-income population's access to health care coverage in the last year. We appreciate the work by DHHS and the New Hampshire Insurance Department in developing this Waiver and look forward to continuing to partner with the State going forward.

Thank you again for giving us the opportunity to provide you comments on such an important program.

Sincerely,

[redacted]

Janet Laatsch, CEO

Email: jlaatsch@goodwinch.org
Phone: (603) 516-2550

[49] *Id.*
[50] N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014); *see* Waiver at 6.

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October 29, 2014

Jeffrey A. Meyers
Director of Intergovernmental Affairs
New Hampshire Department of Health and Human Services
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PAP1115Waiver@dhhs.state.nh.us

Dear Jeffrey:

Thank you for the opportunity to provide comments on the New Hampshire Health Protection Program Premium Assistance Section 1115 Research and Demonstration Waiver (Waiver). Bi-State is a non-profit, two-state organization that represents 15 non-profit Community Health Centers (CHCs) with 39 locations in New Hampshire. Bi-State advocates for access to health care for all New Hampshire citizens, with a special emphasis on medically underserved areas. New Hampshire's CHCs serve over 100,000 residents annually, of which 30,000 are uninsured. Bi-State and our members are thrilled to see the State is taking steps to expand health care coverage to low-income New Hampshire residents. If approved, the Waiver will allow the State to provide health insurance coverage to adults between the ages of 19 and 65 with incomes at or below 133% of the Federal Poverty Level through the Premium Assistance Program (PAP Program).[1] We appreciate and support the State's goals of: 1) addressing the continuity of coverage for the newly eligible adult Medicaid population; 2) rationalizing provider reimbursement; 3) promoting overall health of our low-income citizens; and 4) relieving the burden of uncompensated care affecting providers statewide. Our comments below address the concerns of Bi-State and our members as to how the Waiver may affect New Hampshire's low-income population's access to health care.

Cost-sharing

Bi-State and our members understand that our comments must be directed at the Waiver, however, we feel it is important to provide input on the Proposed Standard Cost-sharing Plan (Plan) included on the NH Department of Health and Human Services' Premium Assistance Program Section 1115 Demonstration Waiver website.[2] The Waiver specifies that the State will amend its State Plan Amendment to include cost-sharing measures for individuals living between 100% and 133% of the federal poverty level (FPL) and caps the cost-sharing at 5% of quarterly household income.[3] The comments outlined below address the cost-sharing included in the Plan.

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[1] NH DHHS, NH Health Protection Program Premium Assistance, §1115 Research and Demonstration Waiver, 1 (October 2014).

[2] *See* Proposed Standard Cost-sharing Plan, http://www.dhhs.state.nh.us/pap-1115-waiver/documents/cost-sharing-10012014.pdf (October 2014).

[3] Waiver at 14.

The Waiver hypothesizes that enrollees "will have equal or greater timely access to primary, specialty, and behavioral health care services."[4] The Waiver also states that enrollees will have equal or lower rates of emergency department use, and avoidable ambulatory care sensitive hospital admissions.[5] The Waiver indicates that the co-payments envisioned in the waiver "will not pose a barrier to accessing care."[6] These are admirable goals that we support, however, Bi-State and our members believe that the cost-sharing structure included in the Plan will negatively affect enrollees' access to care because cost-sharing inhibits low-income patients from accessing not only primary and preventive care, but behavioral health services as well.[7]

Prescription Co-pays

We believe personal responsibility measures can be effective if employed correctly, but the cost-sharing measures included in the Plan will discourage low-income residents from accessing necessary care.[8] Individuals living between 100% and 133% of the FPL earn between $11,670 and $15,521 annually. This population includes individuals with complex socioeconomic backgrounds and individuals who are more likely to have chronic conditions that require pharmaceutical treatment and monitoring by a health care provider than an individual with a higher income.[9] In addition, this population is more likely to experience barriers to care due to cost than a person with traditional private insurance.[10] If PAP Program enrollees did not participate in the Bridge Program, it is likely this population was uninsured and paid out of pocket for their health care needs prior to participation in the PAP Program. As a result, those PAP Program enrollees are less likely to have accessed a primary care provider.[11] The Plan includes pharmaceutical co-payments as high as $6 despite evidence that co-payments as low as $2 to $3 for prescription medications decrease adherence to prescription regimens.[12] In contrast, studies show that decreased cost-sharing improves health outcomes, including for those with chronic conditions.[13]

Decreasing adherence to treatment plans contradicts the hypothesis stated in the Waiver: "[t]he co-payments will not pose a barrier to accessing care" and has the potential impact of negatively affecting those with chronic conditions such as mental illness.[14] "One multistate study of Medicaid claims data found generic co-pays of only $2 or $3 correlated with significantly lower adherence to medications for schizophrenia as compared with no co-pays."[15] Delayed or discontinued prescription use has a greater impact on the low-income population and results in an increase of low-income patients foregoing prescription treatment.[16] Combined with the

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[4] Waiver at 4.
[5] Waiver at 5.
[6] Waiver at 6.
[7] *See* Danny McCormick, Assaad Sayah, Hermione Lokko, et al., Access to Care After Massachusetts' Health Care Reform: A safety Net Hospital Patient Survey, 1552 (July 2012).
[8] *See* National Health Law Program, Medicaid Premiums and Cost-sharing, 1 (March 2014).
[9] *See id.* at 5, 11.
[10] *See* McCormick at 1550; *see also* Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, 6 (February 2013).
[11] *See* McCormick at 1550.
[12] Plan; *see* National Health Law Program at 6, 9.
[13] National Health Law Program at 3, 6.
[14] *See* Waiver at 6.
[15] National Health Law Program at 9.
[16] *Id.* at 5.

behavioral health inpatient co-pay of $50, the Plan has the potential to reduce access within an already fragile behavioral health care delivery system in New Hampshire.[17] If patients are able to access the care they need when the symptoms are acute and manageable, New Hampshire's health care systems will save money because adverse health outcomes will be avoided.[18]

In addition to affecting the ability of patients to comply with prescription treatments, the cost-sharing included in the Plan will negatively affect the ability of patients to access outpatient services for behavioral health and other health care needs.[19] The Plan includes cost-sharing for imaging services, behavioral health inpatient services, hospital inpatient services, and "other medical professionals."[20] Studies show that patients are likely to reduce utilization of these services in particular because of cost-sharing.[21] This will negatively affect patients with chronic illnesses, such as cancer and mental illness, as evidence suggests a likelihood patients will discontinue necessary services, especially those who need access to behavioral health services.[22] In addition, the term "other medical professionals" is not defined in the Waiver or Plan.[23] If this term includes services that are accessed on a daily basis, such as home health care services, PAP Program participants will experience exponential costs; making it less likely that the participant will access necessary care that delays more expensive medical intervention.

Cost Shifting

The level of cost-sharing included in the Plan will negatively affect providers because of cost shifting.[24] The Waiver requires providers collect "all applicable co-payments at the point of care."[25] FQHCs and CHCs cannot deny a patient care because of the patient's inability to pay. If the provider cannot collect payment from the patient, the provider will not only lose the amount of the co-payment, but also the administrative costs of trying to collect the co-payment. This will increase the uncompensated care burden on providers. Further, patients who cannot afford co-payments are more likely to rely on the services of safety net primary care providers such as the FQHCs and CHCs, which will place more financial burden on these small, non-profit businesses.[26] Cost shifting due to co-payments may result in an inability of safety net providers to continue to provide services at the level currently seen statewide.[27]

Alternatives to cost-sharing

Personal responsibility can take many forms, including participation in care management programs, many of which are offered by providers, participation in group therapy for chronic illnesses, and wellness programs. For example, like many chronic diseases, diabetes requires prescription treatment and provider monitoring. It is also a disease that can lead to more costly

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[17] *See* Plan.
[18] *See* Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, 1 (February 2013).
[19] *See* National Health Law Program at 8; *see also* Kaiser Commission on Medicaid and the Uninsured at 6.
[20] *See* Plan.
[21] National Health Law Program at 8.
[22] *See id.* at 8, 9.
[23] *See* Plan.
[24] *See* National Health Law Program at 3.
[25] Waiver at14.
[26] *See* Kaiser Commission on Medicaid and the Uninsured at 1.
[27] *See* McCormick at 1553.

interventions if not managed correctly. Similar to other chronic conditions, chronic disease management is shown to reduce overall health care costs in patients with diabetes and improve the quality of care.[28] As currently written, the Plan discourages adherence to a provider's recommended course of treatment for chronic and non-chronic conditions through the use of cost-sharing. Therefore, we ask the State to consider requiring participation in programs that educate and encourage chronic disease self-management and overall wellness rather than employing cost-sharing measures. These programs "more strongly govern" health care costs than cost-sharing, especially for our low-income residents.[29]

Calculating and Collecting Cost-sharing

The Waiver requires aggregate quarterly cost-sharing and places an annual cap on cost-sharing at 5% of quarterly household income.[30] In addition, PAP Program enrollees must notify the State within 10 days of any changes in financial eligibility.[31] The Waiver also states that the enrollees' aggregate amount of co-payments will be monitored to ensure the enrollee does not exceed the annual limit.[32] However, it is unclear who will conduct the monitoring of these co-payments and how often.[33] This could potentially negatively affect PAP Program enrollees, especially those whose incomes fluctuate frequently. A large number of the adults who are eligible for health insurance coverage through the PAP Program work in the service industries, including restaurants, hotels, construction, and grocery stores, and their employment is often seasonal.[34] Their incomes are likely to frequently fluctuate given the nature of employment. Tracking of enrollees' income in order to ensure an individual's costs do not exceed that cap will be a costly endeavor, regardless of whether the State or the QHP collects this information. As currently written, it is unclear what the notification process will be for ensuring a PAP Program enrollee receives notice that the cap has been met. It is also unclear how providers will be notified as to whether or not to collect payment from the patient at the time of service and how quickly the PAP Program will respond to enrollees' notification of change in income. A patient with a chronic condition could potentially pay in excess of the 5% cap for an entire quarter unless the State's monitoring system is in real time. Minimal cost-sharing results in the delay of accessing necessary care and a reduction in the utilization of less costly health care services.[35]

Grievance and Appeals Process

The Waiver creates a bifurcated grievance and appeals process based on the service at issue for the PAP Program enrollee.[36] Bi-State and our members were pleased to see the Waiver include notification to enrollees of the QHP appeals process governed by statute, which services are covered by the QHP appeals process, and notification of the services that will be subject to the

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[28] *See* Jaan Sidorov, Robert Shull, Janet Tomcavage, et al., Does Diabetes Disease Management Save Money and Improve Outcomes?, 684 (April 2002).
[29] *See* National Health Law Program at 4.
[30] Waiver at 14.
[31] N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014).
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Medicaid appeals process.[37] We understand that PAP Program enrollees are QHP consumers, however, this population has different needs, socioeconomic backgrounds, and education levels than a typical privately insured consumer. While notification from the State as to which services are covered by which appeals process is beneficial, Bi-State and our members do not believe this will adequately meet the needs of this population. We respectfully request the State consider a monthly grievance and appeals process review program to ensure the appellate process established by statute for the QHPs is as effective for the PAP Program enrollees as that of the Medicaid appeals process. In addition, we ask the State to create and appoint an Ombudsman to assist PAP Program enrollees with the navigation of not only the QHP appellate process, but also the Medicaid fair hearing process.

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[37] Waiver at 23.
[38] *Id.* at 24.
[39] *Id.* at 20.

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Bi-State and our members respect the crucial role the QHPs will play in providing coverage to the PAP Program enrollees and understand the desire to align prior authorization standards for PAP Program enrollees with those of the standard QHPs. However, the population that will receive health insurance coverage through the PAP Program are Medicaid recipients with more complex health needs than the typical privately insured consumer. The Waiver requests prior authorization for prescriptions be addressed within 72 hours rather than 24 hours as currently required by Medicaid.[43] The Waiver also seeks permission to issue a 72-hour supply of the requested prescription medication in the event of an emergency, but does not define an "emergency."[44] The Waiver also does not indicate who makes the determination as to whether there is an emergency: whether it is the QHP, the pharmacist, the provider, or the patient.[45] Bi-State and our members respectfully request that the Waiver be clarified to indicate who makes the determination as to whether an emergency exists and how that determination is to be made.

340B Drug Pricing Program

The 340B Drug Pricing Program is a program administered by the Office of Pharmacy Affairs within the Health Resources and Services Administration.[46] Participating manufacturers provide outpatient drugs to participating providers (covered entities) at a reduced price, which then allows the covered entities, including FQHCs and critical access hospitals, to provide outpatient drugs to patients at a significantly discounted price.[47] Covered entities are limited to nonprofit

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[40] Waiver at 28.
[41] *See id.* at 2.
[42] Karen Pollitz and Cynthia Cox, Medical Debt Among People with Health Insurance, 18 (January 2014).
[43] Waiver at 28.
[44] *Id.*
[45] *See id.*
[46] HRSA http://www.hrsa.gov/OPA/ (last accessed in October 2014).
[47] *Id.*

health care organizations funded through certain federal programs.[48] If a covered entity provides prescription medicine purchased through the 340B Drug Pricing Program to a patient, the State cannot seek a Medicaid rebate for the patient because of the prohibition on duplicate discounts and vice versa. It is unclear if the State has the burden to notify the covered entity that the entity can use 340B prescription medicine.

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Proposed Timeframe for the Waiver

The PAP Program was authorized by the New Hampshire Legislature from January 1, 2016 to December 31, 2016 and thus the Waiver proposes a demonstration timeframe of one year.[50] If the Legislature does not reauthorize the PAP Program, the PAP Program ceases to exist. Because of the time and effort requirements associated with a waiver application, not to mention the administrative costs and burdens incurred by the State in filing a waiver application and subsequent extensions, we respectfully request the Waiver extend the demonstration to a minimum of three years.

Conclusion

Bi-State and our members are grateful that our State is in the position to seek a Waiver authorizing Medicaid recipients be placed in QHPs. Our State has made great strides in improving our low-income population's access to health care coverage in the last year. We appreciate the work by DHHS and the New Hampshire Insurance Department in developing this Waiver and look forward to continuing to partner with the State going forward.

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[48] HRSA http://www.hrsa.gov/OPA/.
[49] *Id.*
[50] N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014); *see* Waiver at 6.

Thank you again for giving us the opportunity to provide you comments on such an important program.

Sincerely,

[redacted]

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October 29, 2014

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Dear Jeffrey:

Thank you for the opportunity to provide comments on the New Hampshire Health Protection Program Premium Assistance Section 1115 Research and Demonstration Waiver (Waiver). Manchester Community Health Center (MCHC) is a Federally Qualified Health Center. Our mission is:

> To improve the health and well-being of our patients and the communities we serve by leading the effort to eliminate health disparities by providing exceptional primary and preventive healthcare and support services which are accessible to all.

MCHC was started in 1993 in downtown Manchester. We now have three locations of care and approximately 15,000 patients. Over 40% of our patients have Medicaid, and about the same percentage are uninsured. We serve a very diverse community, with about 45% of our daily visits requiring interpreters for one of the 62 languages spoken at our health center.

MCHC is very happy to see the State is taking steps to expand health care coverage to low-income New Hampshire residents. If approved, the Waiver will allow the State to provide health insurance coverage to adults between the ages of 19 and 65 with incomes at or below 133% of the Federal Poverty Level through the Premium Assistance Program (PAP Program).[1] We appreciate and support the State's goals of: 1) addressing the continuity of coverage for the newly eligible adult Medicaid population; 2) rationalizing provider reimbursement; 3) promoting overall health of our low-income citizens; and 4) relieving the burden of uncompensated care affecting providers statewide. Our comments below address our concerns as to how the Waiver may affect New Hampshire's low-income population's access to health care.

Cost-sharing

MCHC understands that our comments must be directed at the Waiver, however, we feel it is important to provide input on the Proposed Standard Cost-sharing Plan (Plan) included on the NH Department of Health and Human Services' Premium Assistance Program Section 1115

[1] NH DHHS, NH Health Protection Program Premium Assistance, §1115 Research and Demonstration Waiver, 1 (October 2014).

Demonstration Waiver website.[2] The Waiver specifies that the State will amend its State Plan Amendment to include cost-sharing measures for individuals living between 100% and 133% of the federal poverty level (FPL) and caps the cost-sharing at 5% of quarterly household income.[3] The comments outlined below address the cost-sharing included in the Plan.

The Waiver hypothesizes that enrollees "will have equal or greater timely access to primary, specialty, and behavioral health care services."[4] The Waiver also states that enrollees will have equal or lower rates of emergency department use, and avoidable ambulatory care sensitive hospital admissions.[5] The Waiver indicates that the co-payments envisioned in the waiver "will not pose a barrier to accessing care."[6] These are admirable goals that we support, however, we believe that the cost-sharing structure included in the Plan will negatively affect enrollees' access to care because cost-sharing inhibits low-income patients from accessing not only primary and preventive care, but behavioral health services as well.[7]

Prescription Co-pays

We believe personal responsibility measures can be effective if employed correctly, but the cost-sharing measures included in the Plan will discourage low-income residents from accessing necessary care.[8] Individuals living between 100% and 133% of the FPL earn between $11,670 and $15,521 annually. This population includes individuals with complex socioeconomic backgrounds and individuals who are more likely to have chronic conditions that require pharmaceutical treatment and monitoring by a health care provider than an individual with a higher income.[9] In addition, this population is more likely to experience barriers to care due to cost than a person with traditional private insurance.[10] If PAP Program enrollees did not participate in the Bridge Program, it is likely this population was uninsured and paid out of pocket for their health care needs prior to participation in the PAP Program. As a result, those PAP Program enrollees are less likely to have accessed a primary care provider.[11] The Plan includes pharmaceutical co-payments as high as $6 despite evidence that co-payments as low as $2 to $3 for prescription medications decrease adherence to prescription regimens.[12] In contrast, studies show that decreased cost-sharing improves health outcomes, including for those with chronic conditions.[13]

Decreasing adherence to treatment plans contradicts the hypothesis stated in the Waiver: "[t]he co-payments will not pose a barrier to accessing care" and has the potential impact of negatively

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[2] *See* Proposed Standard Cost-sharing Plan, http://www.dhhs.state.nh.us/pap-1115-waiver/documents/cost-sharing-10012014.pdf (October 2014).

[3] Waiver at 14.

[4] Waiver at 4.

[5] Waiver at 5.

[6] Waiver at 6.

[7] *See* Danny McCormick, Assaad Sayah, Hermione Lokko, et al., Access to Care After Massachusetts' Health Care Reform: A safety Net Hospital Patient Survey, 1552 (July 2012).

[8] *See* National Health Law Program, Medicaid Premiums and Cost-sharing, 1 (March 2014).

[9] *See id.* at 5, 11.

[10] *See* McCormick at 1550; *see also* Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, 6 (February 2013).

[11] *See* McCormick at 1550.

[12] Plan; *see* National Health Law Program at 6, 9.

[13] National Health Law Program at 3, 6.

affecting those with chronic conditions such as mental illness.[14] "One multistate study of Medicaid claims data found generic co-pays of only $2 or $3 correlated with significantly lower adherence to medications for schizophrenia as compared with no co-pays."[15] Delayed or discontinued prescription use has a greater impact on the low-income population and results in an increase of low-income patients foregoing prescription treatment.[16] Combined with the behavioral health inpatient co-pay of $50, the Plan has the potential to reduce access within an already fragile behavioral health care delivery system in New Hampshire.[17] If patients are able to access the care they need when the symptoms are acute and manageable, New Hampshire's health care systems will save money because adverse health outcomes will be avoided.[18]

In addition to affecting the ability of patients to comply with prescription treatments, the cost-sharing included in the Plan will negatively affect the ability of patients to access outpatient services for behavioral health and other health care needs.[19] The Plan includes cost-sharing for imaging services, behavioral health inpatient services, hospital inpatient services, and "other medical professionals."[20] Studies show that patients are likely to reduce utilization of these services in particular because of cost-sharing.[21] This will negatively affect patients with chronic illnesses, such as cancer and mental illness, as evidence suggests a likelihood patients will discontinue necessary services, especially those who need access to behavioral health services.[22] In addition, the term "other medical professionals" is not defined in the Waiver or Plan.[23] If this term includes services that are accessed on a daily basis, such as home health care services, PAP Program participants will experience exponential costs; making it less likely that the participant will access necessary care that delays more expensive medical intervention.

Cost Shifting

The level of cost-sharing included in the Plan will negatively affect providers because of cost shifting.[24] The Waiver requires providers collect "all applicable co-payments at the point of care."[25] FQHCs and CHCs cannot deny a patient care because of the patient's inability to pay. If the provider cannot collect payment from the patient, the provider will not only lose the amount of the co-payment, but also the administrative costs of trying to collect the co-payment. This will increase the uncompensated care burden on providers. Further, patients who cannot afford co-payments are more likely to rely on the services of safety net primary care providers such as the FQHCs and CHCs, which will place more financial burden on these small, non-profit

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[14] *See* Waiver at 6.
[15] National Health Law Program at 9.
[16] *Id.* at 5.
[17] *See* Plan.
[18] *See* Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, 1 (February 2013).
[19] *See* National Health Law Program at 8; *see also* Kaiser Commission on Medicaid and the Uninsured at 6.
[20] *See* Plan.
[21] National Health Law Program at 8.
[22] *See id.* at 8, 9.
[23] *See* Plan.
[24] *See* National Health Law Program at 3.
[25] Waiver at14.

66

businesses.[26] Cost shifting due to co-payments may result in an inability of safety net providers to continue to provide services at the level currently seen statewide.[27]

Alternatives to cost-sharing

Personal responsibility can take many forms, including participation in care management programs, many of which are offered by providers, participation in group therapy for chronic illnesses, and wellness programs. For example, like many chronic diseases, diabetes requires prescription treatment and provider monitoring. It is also a disease that can lead to more costly interventions if not managed correctly. Similar to other chronic conditions, chronic disease management is shown to reduce overall health care costs in patients with diabetes and improve the quality of care.[28] As currently written, the Plan discourages adherence to a provider's recommended course of treatment for chronic and non-chronic conditions through the use of cost-sharing. Therefore, we ask the State to consider requiring participation in programs that educate and encourage chronic disease self-management and overall wellness rather than employing cost-sharing measures. These programs "more strongly govern" health care costs than cost-sharing, especially for our low-income residents.[29]

Calculating and Collecting Cost-sharing

The Waiver requires aggregate quarterly cost-sharing and places an annual cap on cost-sharing at 5% of quarterly household income.[30] In addition, PAP Program enrollees must notify the State within 10 days of any changes in financial eligibility.[31] The Waiver also states that the enrollees' aggregate amount of co-payments will be monitored to ensure the enrollee does not exceed the annual limit.[32] However, it is unclear who will conduct the monitoring of these co-payments and how often.[33] This could potentially negatively affect PAP Program enrollees, especially those whose incomes fluctuate frequently. A large number of the adults who are eligible for health insurance coverage through the PAP Program work in the service industries, including restaurants, hotels, construction, and grocery stores, and their employment is often seasonal.[34] Their incomes are likely to frequently fluctuate given the nature of employment. Tracking of enrollees' income in order to ensure an individual's costs do not exceed that cap will be a costly endeavor, regardless of whether the State or the QHP collects this information. As currently written, it is unclear what the notification process will be for ensuring a PAP Program enrollee receives notice that the cap has been met. It is also unclear how providers will be notified as to whether or not to collect payment from the patient at the time of service and how quickly the PAP Program will respond to enrollees' notification of change in income. A patient with a chronic condition could potentially pay in excess of the 5% cap for an entire quarter unless the

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[26] *See* Kaiser Commission on Medicaid and the Uninsured at 1.
[27] *See* McCormick at 1553.
[28] *See* Jaan Sidorov, Robert Shull, Janet Tomcavage, et al., Does Diabetes Disease Management Save Money and Improve Outcomes?, 684 (April 2002).
[29] *See* National Health Law Program at 4.
[30] Waiver at 14.
[31] N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014).
[32] Waiver at 14.
[33] *Id.*
[34] *See* Fact Sheet: Impact of Medicaid Expansion by Industry, http://www.nhfpi.org/research/fact-sheet-impact-medicaid-expansion-industry.html (October 2013).

67

State's monitoring system is in real time. Minimal cost-sharing results in the delay of accessing necessary care and a reduction in the utilization of less costly health care services.[35]

Grievance and Appeals Process

The Waiver creates a bifurcated grievance and appeals process based on the service at issue for the PAP Program enrollee.[36] MCHC is pleased to see the Waiver include notification to enrollees of the QHP appeals process governed by statute, which services are covered by the QHP appeals process, and notification of the services that will be subject to the Medicaid appeals process.[37] We understand that PAP Program enrollees are QHP consumers, however, this population has different needs, socioeconomic backgrounds, and education levels than a typical privately insured consumer. While notification from the State as to which services are covered by which appeals process is beneficial, we do not believe this will adequately meet the needs of this population. We respectfully request the State consider a monthly grievance and appeals process review program to ensure the appellate process established by statute for the QHP's is as effective for the PAP Program enrollees as that of the Medicaid appeals process. In addition, we ask the State to create and appoint an Ombudsman to assist PAP Program enrollees with the navigation of not only the QHP appellate process, but also the Medicaid fair hearing process.

Auto-Assignment of PAP Program Enrollees to QHPs

The Waiver prescribes an auto-assignment process for individuals transitioning from Medicaid Care Management to the PAP Program, allows individuals to select a different QHP than the auto-assignment if they desire with 60 days, and allows individuals who were not auto-assigned to select a QHP.[38] We appreciate that the notice sent to enrollees will include guidance on how to select a QHP, however, we hope enrollees will have access to information such as network adequacy and provider participation. The FQHCs and CHCs experienced significant financial and administrative burdens due to the auto-assignment of their patients during the rollout of Medicaid Managed Care. One FQHC noted that over 1000 of their patients were auto-assigned to another provider. In addition, our patients and staff experienced difficulty in determining which providers were covered by which Managed Care Organization (MCO). One MCO's website listed providers by organization, while another listed individual providers. We respectfully request the State maintain an accurate provider and network list in multiple formats, e.g. online or by phone, that are updated in real time to ensure PAP Program enrollees and providers have the most accurate and up-to-date information.

Network Adequacy

We are pleased the State shares our goal of increasing access to health care coverage while ensuring continuity of care. The Waiver states that PAP Program enrollees will have access to the QHP networks, which are the same networks individuals who purchase coverage in the individual market have.[39] While this might comply with the requirements of Section 1902(a)(30)(A) of the Social Security Act, it is unclear at this time if this will negatively affect potential PAP Program enrollees. We hope the State will ensure PAP Program enrollees (former

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[35] Kaiser Commission on Medicaid and the Uninsured at 6.
[36] Waiver at 11.
[37] Waiver at 23.
[38] *Id.* at 24.
[39] *Id.* at 20.

Medicaid managed care enrollees) have access to necessary providers, providers that they have an established history with, and providers skilled in treating low-income patients with complex socioeconomic needs. We respectfully request network adequacy be continuously monitored to ensure the health outcomes of the PAP Program enrollees are not affected by network adequacy.

Waiver of 90-day Retroactivity

The State seeks to permission to waive the Medicaid 90-day retroactive coverage requirement and limit coverage to the "beginning of Medicaid coverage with the date of the application."[40] The reason given by the State for this request is that the majority of the enrollees will be moved from Medicaid care management into the PAP Program. This assumption presents a number of problems not only for the patients but also providers, including: 1) there will be a number of PAP Program enrollees who were not included in Medicaid managed care and would benefit from having 90-day retroactive coverage; 2) the population the PAP Program is designed to serve often have complex socioeconomic backgrounds that will inhibit them from seeking coverage when they initially present to a provider, even if eligible at the time of service; and 3) if a provider serves an uninsured patient who is eligible for coverage under the PAP Program prior to the application date, the provider will not receive reimbursement for the care provided. This will unnecessarily increase that provider's level of uncompensated care, which is in direct conflict with the goals as outlined in the Waiver.[41] Medical debt is the most cited reason as to why a person files for bankruptcy in the US.[42] The number of individuals that will be uninsured prior to participation in the PAP Program is likely small; therefore, the 90-day retroactivity coverage requirement should not be waived given the significant financial impact it will have on the PAP Program enrollees and providers.

Waiver of Medicaid's 24-hour Prior Authorization Requirement for Prescription Drugs

We respect the crucial role the QHPs will play in providing coverage to the PAP Program enrollees and understand the desire to align prior authorization standards for PAP Program enrollees with those of the standard QHPs. However, the population that will receive health insurance coverage through the PAP Program are Medicaid recipients with more complex health needs than the typical privately insured consumer. The Waiver requests prior authorization for prescriptions be addressed within 72 hours rather than 24 hours as currently required by Medicaid.[43] The Waiver also seeks permission to issue a 72-hour supply of the requested prescription medication in the event of an emergency, but does not define an "emergency."[44] The Waiver also does not indicate who makes the determination as to whether there is an emergency: whether it is the QHP, the pharmacist, the provider, or the patient.[45] We respectfully request that the Waiver be clarified to indicate who makes the determination as to whether an emergency exists and how that determination is to be made.

340B Drug Pricing Program

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[40] Waiver at 28.
[41] *See id.* at 2.
[42] Karen Pollitz and Cynthia Cox, Medical Debt Among People with Health Insurance, 18 (January 2014).
[43] Waiver at 28.
[44] *Id.*
[45] *See id.*

The 340B Drug Pricing Program is a program administered by the Office of Pharmacy Affairs within the Health Resources and Services Administration.[46] Participating manufacturers provide outpatient drugs to participating providers (covered entities) at a reduced price, which then allows the covered entities, including FQHCs and critical access hospitals, to provide outpatient drugs to patients at a significantly discounted price.[47] Covered entities are limited to nonprofit health care organizations funded through certain federal programs.[48] If a covered entity provides prescription medicine purchased through the 340B Drug Pricing Program to a patient, the State cannot seek a Medicaid rebate for the patient because of the prohibition on duplicate discounts and vice versa. It is unclear if the State has the burden to notify the covered entity that the entity can use 340B prescription medicine.

Also, the Waiver is unclear as to how the State will manage the PAP Program with regards to the 340B Drug Pricing Program: will FQHCs and other 340B Drug Pricing Program providers be able to seek reimbursement for drugs provided to PAP Program enrollees? How will the providers know whether or not the State chooses to seek a Medicaid rebate for that enrollee? What systems will the State put in place to ensure a duplicate discount is avoided? The FQHCs' continued participation in the 340B Drug Pricing Program is crucial to the financial health of the FQHCs: "The 340B Program enables covered entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[49] We respectfully request the covered entities retain the ability to provide prescription medicine purchased through the 340B Drug Pricing Program to PAP Program enrollees.

Proposed Timeframe for the Waiver

The PAP Program was authorized by the New Hampshire Legislature from January 1, 2016 to December 31, 2016 and thus the Waiver proposes a demonstration timeframe of one year.[50] If the Legislature does not reauthorize the PAP Program, the PAP Program ceases to exist. Because of the time and effort requirements associated with a waiver application, not to mention the administrative costs and burdens incurred by the State in filing a waiver application and subsequent extensions, we respectfully request the Waiver extend the demonstration to a minimum of three years.

Conclusion

We are grateful that our State is in the position to seek a Waiver authorizing Medicaid recipients be placed in QHPs. Our State has made great strides in improving our low-income population's access to health care coverage in the last year. We appreciate the work by DHHS and the New Hampshire Insurance Department in developing this Waiver and look forward to continuing to partner with the State going forward.

Thank you again for giving us the opportunity to provide you comments on such an important program.

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[46] HRSA http://www.hrsa.gov/OPA/ (last accessed in October 2014).
[47] *Id.*
[48] HRSA http://www.hrsa.gov/OPA/.
[49] *Id.*
[50] N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014); *see* Waiver at 6.

Sincerely,

[redacted]

Kris McCracken, President/CEO

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October 30, 2014

Jeffrey A. Meyers, Director
Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street – Thayer Building
Concord, NH 03301-3857

Via Email Only to PAP1115Waiver@dhhs.state.nh.us

RE: New Hampshire Health Protection Program
Premium Assistance Section 1115 Research and Demonstration Waiver
Comments of New Hampshire Legal Assistance

Dear Mr. Meyers:

New Hampshire Legal Assistance (NHLA) submits these comments regarding the draft Premium Assistance Section 1115 Research and Demonstration Waiver ("draft Waiver").[1] Please consider these comments in addition to those we submitted on October 8, 2014, and October 20, 2014.

NHLA is a non-profit law firm. We represent low-income and elderly clients in civil cases impacting their basic needs. Healthcare is a fundamental human need, and our law firm prioritizes representation of people who need access to healthcare and health insurance coverage. We applaud the Department of Health and Human Services ("DHHS") and the Insurance Department ("NHID") for your efforts to implement the New Hampshire Health Protection Program. This expansion of health insurance coverage is a magnificent step toward improved access to healthcare for low-income Granite Staters.

NHLA supported SB 413, which created the Health Protection Program, and we support your efforts to stand up the Premium Assistance Program. We do have substantial concerns about two components of the draft Waiver: (1) the

[1] NHLA submits these comments without prejudice to the right of our law firm and/or our current or future clients to make any claims in any current or future litigation. Absence of comment regarding any provision in the draft Waiver should not be construed as support for that provision nor agreement that it is lawful.

72

elimination of the Medicaid appeal process for enrollees; and (2) the mechanism for tracking enrollees' maximum cost-sharing obligations.

Appeals

The draft Waiver's list of specific waiver requests does not include waiver of the Medicaid appeal process for Premium Assistance Program enrollees. It is however apparent that DHHS is indeed proposing to eliminate Medicaid appeals in many circumstances. See Draft Waiver at 27-28. According to Section III of the draft Waiver, Premium Assistance Program enrollees will be entitled to use the Qualified Health Plan ("QHP") appeal process for coverage determinations related to services provided through the QHP. (As we understand the draft Waiver and related information received from DHHS and NHID, the Medicaid appeal process will remain available for all eligibility-related determinations and coverage determinations for so-called "wrapped" services.) See Draft Waiver at 11-12.

Although Premium Assistance Program enrollees will have their health insurance delivered through QHPs, they will remain Medicaid beneficiaries entitled to the rights afforded them under the Medicaid statute and regulations. Medicaid law has been carefully crafted to meet the specific healthcare and health insurance coverage needs of low-income people. Its appeal provisions are designed to ensure that low-income people never lose their critically important health insurance benefits without a lawful reason. These essential protections derive from the Due Process Clause of the U.S. Constitution as interpreted in the Supreme Court's landmark decision in Goldberg v. Kelly, 397 U.S. 254 (1970). Medicaid regulations require that state Medicaid agencies provide appeal processes that comply with Goldberg. 42 C.F.R. 431.205(d) ("The [Medicaid] hearing system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970) . . . .).

Two cornerstone principles of Medicaid appeal law are that beneficiaries must have an opportunity for a hearing before their benefits are reduced or terminated, and that those beneficiaries who choose to appeal must have the option to continue receiving benefits while the appeal is pending. These concepts are generally known as "pre-termination review" and "aid paid pending appeal," respectively. (There are numerous other procedural requirements going to the nature of the appeal process, as well.)

The QHP appeal process fails to provide adequately either pre-termination review or aid paid pending appeal. Although somewhat heightened procedural protections in the vein of pre-termination review and aid paid pending appeal are available for so-called "expedited" internal and external appeals under RSA 420-J and the applicable NHID regulations, they do not fully comply with Medicaid appeal law. And even those protections are not available at all for non-expedited internal and external appeals. Many QHP internal and external appeals will

involve coverage determinations that do not qualify for the expedited appeal processes. Premium Assistance Program enrollees will therefore lose their right to pre-termination review and aid paid pending appeal in many circumstances. Medicaid law simply does not permit a distinction between appeals in the nature of expedited appeals and those in the nature of non-expedited appeals. Any waiver of enrollees' rights to pre-termination review and/or aid paid pending appeal – as contemplated by the draft Waiver – would likely fail constitutional scrutiny.

The Premium Assistance Program will offer to enrollees a number of "wrapped" benefits – services that are required under Medicaid law but are not Essential Health Benefits provided by QHPs. The Medicaid appeal process should be extended to all QHP coverage determinations, essentially in the form of a wrapped benefit. This will ensure compliance with the Due Process Clause and the Supreme Court's Goldberg decision. It will also mean that Premium Assistance Program enrollees – who may face obstacles such as limited English proficiency, illiteracy, and learning disability, among others – will not have to navigate a multi-venue appeal structure in which they must invoke the Medicaid appeal process for eligibility-related determinations and coverage determinations for wrapped benefits, and the QHP appeal process for coverage determinations made by the QHP.

Cost-Sharing Tracking

As a threshold matter, NHLA offers our wholehearted support for the absence of premiums and coinsurance in the draft Waiver's cost-sharing scheme. That being said, we wish to note that the co-payments proposed for Premium Assistance Program enrollees with incomes between 100 and 138 percent of the federal poverty level will work a substantial burden on people who have little, if any, disposable income to spend on healthcare. Abundant research demonstrates that co-payments – even those in relatively small amounts – discourage people from accessing healthcare that they need. See National Health Law Program, "Medicaid Premiums and Cost Sharing" (March 26, 2014), available at www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing. The central purpose of SB 413, which created the New Hampshire Health Protection Program, was to "promote the improvement of overall health." That goal simply cannot be achieved if enrollees can't afford co-payments and therefore forego or delay healthcare. We encourage DHHS and NHID to explore every possible avenue for reducing or eliminating copayments.

The significance of the cost-sharing burden underscores the importance of tracking enrollees' co-payments to ensure that they do not exceed their maximum cost-sharing obligations. The draft Waiver caps cost-sharing at 5 percent of quarterly household income. See Draft Waiver at 14. We note that capping cost-sharing at 5 percent of monthly household income, which appears to be permissible under Medicaid law, would likely reduce the overall cost-sharing

burden on enrollees, and we encourage DHHS and NHID to consider giving enrollees the option to select either a quarterly or a monthly approach.

The draft Waiver is also virtually silent on how the cost-sharing cap will be enforced. DHHS and NHID have not identified their plans to address the following significant issues:

1. Enrollees' quarterly household income may fluctuate not only from quarter to quarter, but within quarters. Their maximum quarterly cost-sharing obligations should be capable of immediate adjustment upon notice to DHHS of a change income.
2. Enrollees may also suffer sharp declines in income sufficient to move them below 100 percent of the federal poverty level. The cost-sharing tracking mechanism should be capable of immediately eliminating their obligation to make co-payments, even within a particular quarter.
3. The "shoebox method" – requiring enrollees to track their own co-payments – should be avoided at all costs.
4. There should be a simple way for DHHS and NHID to make enrollees whole when they pay co-payments exceeding 5 percent of quarterly household income. Refunds should be processed promptly and automatically, without requiring enrollees to request them.

Once again, we thank you for your efforts to implement the New Hampshire Health Protection Program consistent with the objectives of SB 413. NHLA would welcome the opportunity to continue working with you as you move forward.

Very truly yours,

[redacted]

Sarah Mattson Dustin, Esq.
Policy Director

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October 30, 2014

Jeffrey A. Meyers
Director, Intergovernmental Affairs
NH Department of Health and Human Services
Office of Medicaid Business and Policy Legal and Policy Unit
129 Pleasant Street Thayer Building
Concord, NH 03301

Re: New Hampshire Health Protection Program

Dear Director Meyers:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the New Hampshire Health Protection Program demonstration project. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN strongly supports expanded access to Medicaid. Over 8,450 New Hampshirites are expected to be diagnosed with cancer this year[1] – many of whom will rely on Medicaid for their care. Our comments on the proposal are intended to ensure that cancer patients in New Hampshire (including the newly diagnosed, those in active treatment, and survivors) will have adequate access and coverage under the New Hampshire Health Protection Program and that specific requirements do not have the effect of creating barriers to care for low-income cancer patients.

Medically Frail

New Hampshire proposes excluding individuals who are identified as medically frail from enrollment in the qualified health plan (QHP) premium assistance program, allowing them to enroll in coverage under Title XIX, with either the Alternative Benefit Plan (ABP) or standard Medicaid benefit package.

While we support the state's intention to provide the medically frail with more health care coverage options, we request additional information on a few items related to their exemption from the QHP premium assistance program. Specifically, we would like clarification on the cost sharing responsibilities for those between 100 and 133 percent of the federal poverty level that are determined to be medically frail. Will the medically frail be required to pay the same cost sharing amounts as those non-medically frail QHP premium assistance enrollees of the same income level?

[1] American Cancer Society, Cancer Facts & Figures 2014.

Cancer treatment causes a number of side effects, some of which can be serious and debilitating. Cancer patients undergoing chemotherapy, radiation and/or related surgical procedures may temporarily meet the criteria for medically frail status depending on how that term is defined. We urge the Department to provide greater clarification on the term "medically frail" and whether New Hampshire will allow enrollees the option of temporary medical frailty. In addition, we also ask the Department to detail the evaluation and/or selection criteria that will be used to allow an individual to qualify for medically frail status.

Cost Sharing

New Hampshire proposes to impose cost sharing up to the federal limit of 5 percent for those between 100 and 133 percent of the federal poverty level. However, we encourage the Department to re-consider the proposed aggregate quarterly out-of-pocket (OOP) cost-sharing limit, and instead impose an aggregate monthly out-of-pocket limit. Newly diagnosed cancer patients and those in active treatment often have higher rates of utilization, particularly during and immediately following the initial diagnosis. As such, these individuals would benefit from monthly OOP cost limitations, as it will protect them from high-cost, front-loaded services and care, allowing them to more equitably spread out their cost-sharing over a period of time. The following chart provides an example of how a cancer care becomes more affordable under a monthly out-of-pocket limit.

	Individual at 138% FPL ($16,105 annual income)	
	Monthly: $67.10	Quarterly: $201.31
Month 1	3 CT Scans @25= $75	3 CT Scans @25= $75
	1 Hospital Inpatient Stay= $50	1 Hospital Inpatient Stay= $50
	3 Specialty Physician visits@8= $24	3 Specialty Physician visits@8= $24
	1 Generic Drug= $2	1 Generic Drug= $2
	2 Brand Drug= $12	2 Brand Drug= $12
	Total: $67.10	Total: $163.00
Month 2	1 Physician visit- $0	1 Physician visit- $0
	2 Specialist Visits- $16	2 Specialist Visits- $16
	2 Brand Drugs- $12	2 Brand Drugs- $12
	Total: $28	Total: $28
Month 3	2 Specialist Visits- $16	2 Specialist Visits- $16
	2 Brand Drugs- $12	2 Brand Drugs- $12
	Total: $28.00	Total: $10.31
3 Month TOTAL	$123.10	$201.31

*** The service utilization example provided above is for illustrative purposes only and does not reflect a specific treatment protocol.

New Hampshire proposes imposing copayment of $25 for imaging services and a $50 copayment for hospitals inpatient services. For a patient with a serious, chronic condition such as cancer, the proposed cost sharing for imaging and inpatient hospitalization could pose a significant barrier to care. Cancer patients often need multiple imaging tests to diagnose their cancer and evaluate if the cancer treatment is working. Additionally, cancer patients may need to undergo inpatient surgical procedures to treat their cancer. The co-payments associated with these procedures, in addition to the other related cost sharing requirements, such as prescription drug and specialty care visits could create considerable financial hardship for an individual or family fighting cancer. We ask the Department to consider reducing the co-payments for imaging tests and inpatient hospitalization.

Retroactive Eligibility

We appreciate New Hampshire taking the proactive step to provide low-income New Hampshirites early access to health care coverage through either the HIPP or bridge program during the premium assistance waiver process. However, we are very concerned about the Department's assumption that all individuals eligible for the NH Health Protection Program will have been enrolled in one of these coverage options eliminating the need for the state to continue providing retroactive eligibility for this coverage group. We urge the Department to reconsider its request for permission to eliminate retroactive eligibility.

In 2012, there were an estimated 120,000 uninsured New Hampshirites and while the Affordable Care Act and Medicaid expansion will significantly reduce the number of uninsured, a number of state residents will not learn about their coverage options until they experience a health event that forces them to seek medical attention. For example, it is unclear whether an uninsured individual who seeks emergency/urgent care that results in a significant amount of medical care prior to them being determined eligible for coverage under the QHP premium assistance program would be financially responsible for the cost of those services. We urge the Department to clarify that in such situations, the individual would not bear personal responsibility for those costs.

Appeals Determinations

The draft waiver indicates that appeals determinations will vary depending on whether services are defined as urgent or non-urgent. We ask the Department provide definitions of urgent and non-urgent services, specifically indicating whether chemotherapy, radiation and cancer related surgery would be considered an urgent service. Further, we ask the Department to consider the following circumstances in its response: if chemotherapy is considered non-urgent, whether a patient be allowed to receive another round of treatment services while the 30 day appeal determination is being made. In addition, if chemotherapy is considered non-urgent, after diagnosis whether the patient would have to wait (at least) 60 days before beginning their cancer treatment.

Provider Networks

We ask the Department to indicate if the newly eligible population will have access to out-of-network providers. Most private insurance plans have a process by which enrollees can request in-network coverage for an out-of-network provider. If a QHP premium assistance plan's current provider network does not include a specific type of specialist or if the in-network provider appointment wait time/distance is too great, we urge the Department to clarify that QHP premium assistance enrollees

will have the ability to request access to an out-of- network provider. In addition, the Department should clarify that the QHP enrollee will not face higher OOP cost sharing as a result of them accessing an out-of-network provider.

On behalf of the American Cancer Society Cancer Action Network we appreciate the opportunity to provide comments on the state's waiver application. If you have any questions, please feel free to contact me at mike.rollo@cancer.org or 603.471.4115.

Sincerely,

[redacted]

Mike Rollo
Government Relations Director, New Hampshire
American Cancer Society Cancer Action Network

Planned Parenthood
of Northern New England

Maine
New Hampshire
& Vermont

October 31, 2014

Jeffrey A. Meyers, Director, Intergovernmental Affairs
Department of Health and Human Services
Office of Medicaid Business Policy
Legal Policy Unit
129 Pleasant Street – Thayer Building
Concord, NH 03301-3857

VIA ELECTRONIC SUBMISSION

Dear Mr. ~~Meyers~~, Jeff

Planned Parenthood of Northern New England ("Planned Parenthood") is pleased to submit comments on the New Hampshire Health Protection Program Premium Assistance Section 1115 Research and Demonstration Waiver draft application ("draft application"). As a trusted women's health care advocate, Planned Parenthood appreciates the opportunity to provide the Department of Health and Human Services ("Department") feedback on this important proposal.

Planned Parenthood is the largest provider of reproductive and sexual health care for women, men and teens across the State of New Hampshire. For many women of reproductive age, we serve as their primary source of medical care. We serve New Hampshire residents through 6 health centers in Claremont, Derry, Exeter, Keene, Manchester and West Lebanon. Last year we saw nearly 16,000 patients at these sites.

We strongly support the Department's continued efforts to expand Medicaid coverage to individuals with incomes up to 138 percent of the federal poverty level. Medicaid is a vital part of the health care system and plays a major role in ensuring access to essential primary and preventive care services for women and men. Low-income women, in particular, benefit from the expansion of Medicaid. Greater access to coverage enables hardworking women across the state to obtain the women's health services that are critical to their health and lives such as birth control, life-saving cancer screenings, and prenatal care.

As New Hampshire moves forward to formalize this proposal and seek federal approval, we strongly urge the Department to ensure the Premium Assistance Program meets the unique health needs of women. Specifically, we urge the Department to implement the program in a manner that will provide women coverage for comprehensive health care services, including family planning and pregnancy-related services, and ensure patient access to the providers they trust. Properly implemented, the Premium Assistance Program will enable women to access the services they need, resulting in better health outcomes for women and their families.

I. **The Department Should Explicitly Clarify that Premium Assistance Program Enrollees Retain Freedom of Choice for Family Planning Providers.**

The draft application seeks to waive freedom of choice broadly (1902(a)(23) of the Social Security Act) so that enrollees can receive services only from in-network providers that participate in select qualified health plans (QHPs). Yet multiple provisions of federal law and policy unequivocally protect an enrollee's ability to receive family planning services from any qualified Medicaid provider – even if the

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provider is out-of-network and without referral.[1] Indeed, the Centers for Medicare and Medicaid Services (CMS) has rightly enforced the "family planning freedom of choice" protection with 1115 demonstration waivers, including 1115 demonstration waivers to expand Medicaid coverage via premium assistance, to ensure enrollees' access to family planning services from trusted providers.[2] While we assume that the Department did not intend to undermine women's access to family planning and sought to waive 1902(a)(23)(A) instead of 1902(a)(23), we urge the Department clarify that it will preserve 1902(a)(23)(B) (family planning freedom of choice) and operate its proposed Premium Assistance Program in line with federal law and policy.

II. The Department Should Ensure Participating QHPs Provide Women Sufficient and Direct Access to Women's Health Providers.

To ensure that the new adult group receives quality care, it is important that the Department continue to limit care delivery to QHPs and not broaden premium assistance participation to other carriers in the individual market. Unlike other private plans, federal law requires QHPs to meet certain network adequacy standards,[3] in addition to having a sufficient number and geographic distribution of Essential Community Providers (ECPs).[4] These standards are critical for women's health care access, particularly for low-income women who rely on family planning ECPs for essential reproductive health services. In addition, the Department must ensure that QHPs provide female enrollees with direct access to a women's health specialist or OB/GYN within the network for coverage necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not otherwise a women's health specialist.[5]

When health insurance coverage is significantly expanded, women's health providers are the first to be overwhelmed with increased demand. In fact, when Massachusetts initially implemented health reform, wait times for OB/GYN appointments in Boston increased from 45 days to 70 days. Likewise, OB/GYN providers had the longest wait time of any health care provider primarily because there were not enough women's health providers in provider networks.

Safeguarding access to women's health providers will also help ensure that the Premium Assistance Program reflects the unique ways low-income women access health care. According to a recent survey,

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[1] 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(4); CMS, *State Medicaid Manual* § 2088.5; *see also* CMS, *Informational Bulletin* (Jun. 1, 2011) (reiterating the federal requirement that states must provide Medicaid enrollees freedom of choice of family planning providers); U.S. Statement of Interest at 4, 8-9, *Planned Parenthood of Indiana v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012) (cert denied) (asserting that freedom of choice is a longstanding provision, and that a State may not exclude certain providers from the Medicaid program because of a provider's scope of practice).

[2] CMS, Special Terms and Conditions Iowa Marketplace Choice Plan (2013) ("The state Medicaid program will ensure payment at state plan rates of family planning services that the QHP considers to be out-of-network, subject to all third party liability rules"); CMS, Letter to Billy Millwee, Deputy Executive Commissioner of the Texas Health and Human Services Commission (Dec. 12, 2011) (notifying the State of Texas that CMS will not renew the 1115 family planning demonstration waiver because Texas sought to waive freedom of choice of family planning providers).

[3] Affordable Care Act ("ACA") § 1311(c)(1)(B).

[4] ACA § 1311(c)(1)(C); 45 C.F.R. § 156.235; CMS and CCIIO, 2015 Letter to Issuers in the Federally-facilitated Marketplaces (March 14, 2014), available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf (listing family planning providers as a unique ECP category and requiring issuers to offer contracts in good faith to at least one ECP in each ECP category in each county in the service area).

[5] 42 C.F.R. §438.206(b)(2).

41 percent of low-income women report relying on their OB/GYN providers as their main source of care. Therefore, ensuring QHPs have a sufficient number of in-network women's health care providers will help improve women's access to the broader health care system.

In addition, we encourage the Department to implement a network adequacy exceptions process to complement wrap-around services so that individuals can go out-of-network if a provider is not geographically accessible or cannot provide a Medicaid-covered service in a reasonable time. In particular, an exceptions process is important with respect to abortion services. Under federal law, Medicaid programs must cover abortion when continuing the pregnancy will endanger the life of the woman or when a woman's pregnancy results from rape or incest.[6] However, QHPs have no legal obligation to cover abortion under any circumstances.[7] Likewise, the exceptions process may be necessary for other reproductive health care that an individual provider may object to or may lack the expertise to provide such as miscarriage management.

III. The Department Must Ensure Sufficient Coverage Mechanisms for Women who Become Pregnant after Enrolling in the Premium Assistance Program to Ensure Their Access to Pregnancy-Related Care in a Timely Manner and Without Cost-Sharing.

The draft application does not detail how women who become pregnant after enrolling in the Premium Assistance Program will access care. While we assume this was an oversight, we urge the Department to clarify that women who become pregnant after enrolling in the Premium Assistance Program will be able to choose to remain in their current QHP or receive pregnancy-only coverage through the traditional Medicaid program. In addition, we ask the Department to reinforce that pregnant women will receive all covered pregnancy-related services, including wrap-around services,[8] without cost-sharing, regardless of how they receive their coverage.[9] Moreover, we encourage the Department to ensure that the state's existing pregnancy-reporting mechanisms are sufficient to meet enrollees' needs.

Federal guidance provides pregnant women the choice to remain in the newly eligible group or transfer to traditional Medicaid coverage until the next eligibility determination.[10] Consistent with that guidance, we urge the Department to provide pregnant women the choice to remain in their selected QHP or transfer to pregnancy-only coverage via the traditional Medicaid program. Providing this option is ideal because it empowers each pregnant woman to make decisions about her own pregnancy, including the ability to maintain her current network of providers. If the Department implements such a standard, it

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[6] CMS, Dear State Health Official Letter (Feb. 12, 1998).

[7] ACA § 1303(b)(1); 45 C.F.R. § 156.280(c)(2).

[8] If a state permits a pregnant woman to remain in the new adult group, the state must ensure she receives all covered pregnancy-related services provided to pregnant women. In addition, individuals enrolled in premium assistance are entitled to all Medicaid-covered services and cost-sharing protections. 42 C.F.R. § 435.1015(a)(2), (b); CMS, *Medicaid and the Affordable Care Act: Premium Assistance* (Mar. 2013), *available at* http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf; CMS, *What FMAP Applies to Women Enrolled in the New Adult Group Who Become Pregnant? FAQ 9602, available at* https://questions.medicaid.gov/faq.php?id=5010&faqId=9602.

[9] 42 U.S.C. §§ 1396o(a)(2)(B), 1396o(b)(2)(B), 1396o-1(b)(3)(B)(iii); 42 C.F.R. § 447.53(b)(2); 78 Fed. Reg. at 42311 (to be codified at 42 C.F.R. § 447.56(a)(1)(vii)). In addition, the state may not impose premiums on pregnant women who have incomes less than 150 percent FPL. 78 Fed. Reg. at 42310 (to be codified at 42 C.F.R. § 447.55(a)(1)).

[10] CMS, *Medicaid/CHIP Affordable Care Act Implementation Frequently Asked Questions* (May 22, 2012), *available at* http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf.

is critical that the Medicaid program notify pregnant women of their right to transfer coverage and provide pregnant women the information necessary to make an informed choice.

Additionally, we urge the Department to confirm its current mechanisms used to identify pregnant women are sufficient and will be integrated into the premium assistance framework. Efficient and effective mechanisms are necessary to ensure pregnant women receive care in a timely manner without cost-sharing. Moreover, the Department must make sure that each pregnant woman receives the full range of pregnancy-related care she is entitled to, regardless of whether she remains in her premium assistance QHP or enrolls in pregnancy-related coverage.

IV. The Department Should Provide Retroactive Coverage for Premium Assistance Program Enrollees.

We appreciate the Department's proposal to transition individuals from Medicaid managed care to premium assistance QHPs so that individuals currently enrolled in Medicaid do not experience gaps in coverage. In addition, we support the Department's plan to auto-enroll individuals in QHP coverage if they fail to select a plan within 60 days (while still providing a period to switch their QHP coverage) so that eligible individuals are guaranteed access to coverage.

However, we are very concerned that the draft application seeks to waive retroactive coverage for new applicants that would be enrolled in the Premium Assistance Program, and we strongly urge the Department to clarify that premium assistance enrollees, like all other Medicaid enrollees, will receive retroactive coverage. Retroactive coverage is required under federal law,[11] and it is sound public policy to ensure that all Medicaid enrollees remain entitled to this important federal protection. Providing a retroactive period reduces uncompensated care costs and alleviates financial burdens on health care providers. In addition, retroactive coverage acts an incentive for provider participation in the Medicaid program, as it increases the likelihood that medical providers and health care entities will receive reimbursement for medical costs. Given that the Department estimates that 45,000 individuals will enroll in the Premium Assistance Program, it is critical that the state ensure sufficient provider participation to ensure patients' timely access to care.

V. The Department Should Continue to Provide a Presumptive Eligibility Period to the New Adult Group.

We thank the Department for adopting the state option to provide the new adult group a presumptive eligibility period and for enabling licensed Medicaid providers to make presumptive eligibility determinations.[12] Presumptive eligibility is a "win-win": patients are able to receive care in a timely manner and providers are guaranteed reimbursement for the care they provide to patients who have been determined presumptively eligible. Moreover, enabling providers to make presumptive eligibility determinations helps facilitate public education and outreach about health care coverage options at a time when individuals are receptive to hearing about the care they need and any costs associated with such care.

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[11] States must pay for covered services provided to individuals during the three month period prior to the date of application, if the applicant would have been eligible at the date of the application. 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914.

[12] New Hampshire State Plan Amendment # 14-004, http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NH/NH-14-0004.pdf.

Because presumptive eligibility is crucial to health care access, we ask the Department to confirm that presumptive eligibility for the new adult group will continue in the premium assistance framework. Specifically, we ask the Department to clarify that licensed Medicaid providers will continue to be able to make presumptive eligibility determinations and that those determinations will be effectively communicated to premium assistance QHPs.

VI. The Departments Should Maintain Cost Protections for Premium Assistance Enrollees.

We thank the Department for proposing to implement a premium assistance framework that will exempt individuals with incomes less than 100 percent FPL from premium and cost-sharing obligations. Beyond that framework, we ask the Department to reinforce the federal requirement that cost-sharing must be withheld from family planning services for all individuals, including those between 100 and 138 percent FPL.[13] These limitations on cost-sharing are consistent with federal law, both under Medicaid and the Affordable Care Act's no cost-sharing provisions and reflect the reality that even minimal co-pays or premium obligations can be an access barrier for low-income individuals and families.

VII. The Department Should Clarify that Family Planning Related Prescription Drugs and Devices May Not Be Subject to Prior Authorization Requirements

While the draft application seeks to waive the existing requirement that prior authorization decisions must be made within 24 hours for prescription drugs, the application, and subsequent communications with QHPs, should clarify that family planning-related prescription drugs or devices (hormonal implants, IUDs, etc.) may not be subjected to prior authorization requirements. Federal Medicaid regulations surrounding managed care provide that "[f]or recipients eligible for family planning services, [the MCO] must provide that each recipient is ..... *free to choose* the method of family planning to be used."[14] At least one of the Medicaid MCOs in New Hampshire had imposed requirements in violation of this prohibition suggesting that this protection needs to be explicitly articulated in the Department's application.

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We thank the Department for the opportunity to submit these comments, and we look forward to working together toward our shared goal of improving health care access and coverage. If you have any questions, please do not hesitate to contact me at 603.513.5334 or jennifer.frizzell@ppnne.org .

Sincerely,

[redacted]

Jennifer Frizzell
Vice President for Public Policy

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[13] 42 U.S.C. § 1396o(a)(20(D), 1396o(b)(2)(D), 1396o-1(b)(3)(B)(vii); 42 C.F.R. § 447.53(b)(5); 78 Fed. Reg. 42160, 42311 (Jul. 15, 2013) (to be codified at 42 C.F.R. § 447.56(a)(2)(ii)).

[14] 42 CFR § 441.20.

WELL SENSE.
HEALTH PLAN

October 31, 2014

Via Email

Jeffrey A. Meyers, Esq.
Director, Intergovernmental Affairs
New Hampshire Department of Health and Human Services
Office of Medicaid Business and Policy, Legal and Policy Unit
129 Pleasant Street-Thayer Building
Concord, NH 03301

Re: Well Sense Comments on Section 1115 Premium Assistance Program Waiver

Dear Mr. Meyers:

Well Sense Health Plan appreciates the opportunity to comment on the New Hampshire Department of Health and Human Services' (DHHS) Premium Assistance Program (PAP) Section 1115 Demonstration Waiver Application (Waiver). As a Medicaid managed care organization (MCO) currently serving members in New Hampshire, Well Sense supports New Hampshire's efforts to expand and maintain healthcare coverage to individuals with incomes up to 138% of the federal poverty level (FPL). We appreciate the challenges associated with maintaining a program that aligns with the federal marketplace and support DHHS's efforts to provide coverage for this population.

As you know, Well Sense participates in New Hampshire's Medicaid program by serving as a managed care partner to the State under the Medicaid Care Management Program. We have also worked more recently with New Hampshire to launch the New Hampshire Health Protection Program, also known as the Voluntary Bridge to Marketplace Premium Assistance Program (Bridge Program). Between the Medicaid Step 1 and the Bridge Program, Well Sense currently covers over 70,000 enrollees.

Well Sense is pleased to build on these programs' success and offers the following comments on the PAP Section 1115 Demonstration Waiver.

Continuity of Coverage

Well Sense supports the emphasis in the Waiver on the importance of coverage continuity for Bridge Program individuals and families. To advance coverage continuity for members, Well Sense supports the provision within the law establishing the auto assignment of Bridge Program members to their existing MCO if that MCO is a qualified health plan (QHP) on the federal exchange unless the individual opts to select a different QHP. Well Sense agrees with this approach based on its experience that open enrollment

processes without auto assignment for these populations can result in coverage gaps as many individuals fail to choose plans and lose this coverage.

While Well Sense is immediately focused on promoting coverage continuity for members as they transition from the Bridge Program to a QHP on the federal exchange in 2016, we also encourage the State to extend subsidized coverage for current Bridge Program individuals for 2017 and beyond. In particular, Well Sense supports the State's intention to seek an extension of the Section 1115 Waiver.

Continuity of Care

Well Sense also believes that continuity of care for Bridge Program enrollees is essential. As an MCO currently serving Bridge Program members, Well Sense has developed and implemented care management strategies that help to meet the unique needs of lower income members. We have established relationships with diverse partner-providers who have the capacity and capability to meet the specific needs of our members. These providers are adept at caring for lower-income patients and likely have cared for many individuals while uninsured. Well Sense encourages the State to support MCOs in their efforts to maintain this network for members as they transition from the Bridge Program to the marketplace by supporting flexibility in network designs.

QHP Selection Support

Well Sense encourages the State to work with MCOs and other carriers to support individuals who are eligible for premium assistance as they attempt to select a QHP under the federal marketplace. For example, we believe suitable coverage options should be highlighted for this population. It may be appropriate to identify individuals eligible for premium assistance once they begin shopping at the federal marketplace or NH Easy and direct them to the appropriate actuarially valued silver plan. To the extent possible, New Hampshire should also consider selecting a sub-set of silver plans that are cost-effective and equipped with a provider network that can provide necessary services to this unique population.

Risk and the PAP Population

Well Sense urges DHHS to consider the risk profile of the PAP population, which is likely to include higher acuity patients than current marketplace enrollees due to their new insured status. While expanding the number of marketplace customers may increase plan competition and options for consumers, carriers that provide coverage must incorporate the risk of the new PAP population into their 2016 rates. As such, a process to define and identify the medically frail and exempt them from marketplace coverage should be developed. We recommend that New Hampshire have flexibility under the Waiver to define these medically frail individuals. Without this process, individuals who do not receive premium assistance on the marketplace may see premium increases.

As Well Sense continues to evaluate the opportunity to participate on the federal marketplace, it appreciates its ongoing partnership with New Hampshire in providing coverage to its citizens. We look forward to continuing this discussion. Please feel free to contact me at 617-748-6000 if you have questions or would like to discuss the issues raised here.

Sincerely,

[redacted]

Matthew H. Herndon
Interim Chief Legal Officer and VP of Government Affairs

NH Community Behavioral Health Association

1 Pillsbury Street, Suite 200 Concord, NH 03301-3570 603-225-6633 FAX 603-225-4739

Department of Health and Human Services
Office of Medicaid Business and Policy, Legal and Policy Unit
129 Pleasant Street-Thayer Building
Concord, NH 03301-3857
PAP1115Waiver@dhhs.state.nh.us

October 31, 2014

RE: Comments on the 1115 Draft Premium Assistance Waiver application

The NH Community Behavioral Health Association, representing the state's ten community mental health centers (CMHCs), wishes to submit comments on the 1115 Draft Premium Assistance Waiver application on behalf of our centers and the more than 50,000 adults and children we provide care for annually. The following are our primary concerns:

1. Proposed cost-sharing:
    - The presumption is that cost-sharing increases a sense of personal responsibility. While this may be a valid proposition in many health care settings, it is a much more challenging proposition for the population we serve, namely, those with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). Any potential cost benefits need to be balanced with the creation of a new disincentive for those who already have a hard time managing chronic conditions.
    - As a general matter, the CMHCs do not collect co-pays now from Medicaid consumers. Adding the technology required for collection of co-pays from a small group of consumers will create not only a new administrative set of costs, but also will have the undesired effect of diverting dollars away from direct care. While the waiver language applies to in-patient care, and most CMHCs have limited in-patient facilities, this remains a concern for the CMHCs that will be burdened with this new requirement, such as the Mental Health Center of Greater Manchester, which operates the Cypress Center.

2. The proposed waiver of Medicaid's 24-hour prior authorization requirement for prescription drugs and replacement with a 72-hour standard:
    - We do not understand the rationale for this change.
    - Extending prior authorization requirements for necessary medications from one day to three days creates significant problems for those with a Serious Mental Illness or a

Serious and Persistent Mental Illness, even with the allowance of a 72-hour supply "in the event of an emergency." How is an emergency defined?

- We need to emphasize that the population we serve, in particular, find it difficult to manage their chronic conditions, to make and keep appointments, to fill and take their prescriptions, and to deal with bureaucracy. Creating another barrier means more people will fall through the cracks, will experience unnecessary setbacks in their treatment, and will find it even more difficult to become contributing members of the community.
- We suggest that prescription drugs for those with a Serious Mental Illness or a Serious and Persistent Mental Illness be exempt from this provision.

We appreciate the hard work that has gone into the waiver application by Department staff. Thank you for the opportunity to comment.

Very truly yours,

Jay Couture, President
NH Community Behavioral Health Association

newfutures
advocate • educate • collaborate
to reduce alcohol and other drug problems in New Hampshire

October 31, 2014

Commissioner Nicholas A. Toumpas
Office of the Commissioner
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

Re: Draft Premium Assistance Program 1115 Demonstration Waiver Comment

Dear Commissioner Toumpas:

New Futures appreciates the opportunity to comment on the Draft Premium Assistance Program 1115 Demonstration Waiver to be submitted to the Centers for Medicaid Services by the NH Department of Health and Human Services.

New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to prevent and reduce New Hampshire substance abuse problems. New Futures envisions a State and local communities where public policies support prevention, treatments and recovery oriented efforts to reduce alcohol and other drug problems.

For the past decade, New Futures has worked diligently to ensure the citizens of New Hampshire have access to quality behavioral health services. New Futures was thrilled by the recent passage of the New Hampshire Health Protection Plan (NHHPP), which will expand access to substance use treatment to approximately 7,000 New Hampshire residents.

With the passage of the NHHPP, the NH Department of Health and Human Services (the Department) was tasked with creating a service array for the new Substance Use Disorder (SUD) benefit. The Department recommended a comprehensive and robust SUD service array, which will ensure the residents of NH have access to high quality SUD care and treatment.

Given the particular vulnerability of New Hampshire's SUD populations, the proposed Premium Assistance Program 1115 Demonstration Waiver contains some provisions which are cause for concern and threaten access to needed SUD services. With that in mind, we offer the following comments.

Cost-Sharing Payments

The primary goal of Senate Bill 413, which established the NHHPP, was to increase access to health care coverage for low-income New Hampshire residents and to encourage individuals to take personal responsibility for their health care. The type of personal responsibility SB 413 sought to encourage was more than an individual's ability to pay co-pays; it was managing chronic conditions, going to doctors' appointments, filling necessary prescriptions and seeking care when sick or injured.

While cost-sharing requirements may force an individual to financially contribute to their health care costs, it does not encourage "personal responsibility" as the NHHPP intended. Numerous studies have shown that low-income individuals are extremely sensitive to even modest increases in costs of health care. The implementation of cost-sharing deters low-income individuals from accessing needed medical care, resulting in increased emergency room visits for conditions which could have been effectively managed through a timely visit with a primary care provider.

Individuals with SUD and co-occurring mental illness are particularly sensitive to cost-sharing requirements due to the chronic nature of their conditions. Numerous individuals with SUD rely on medication assisted treatments such as methadone or suboxone to manage their disease. Requiring co-pays for such routine visits and prescription administration may threaten the recovery of some NHHPP beneficiaries who find the co-pays excessively burdensome.

Given conflict between cost-sharing and the intent of SB 413, New Futures strongly recommends the Department eliminate the cost-sharing requirement present in the Draft Premium Assistance Program 1115 Demonstration Waiver. At the very least, New Futures encourages the Department to consider lowering the percent of cost-sharing required of this population and to create an exemption from the cost-sharing requirements for drugs designed to manage chronic conditions.

Collection of Payments & Tracking

Related to the issue of cost-sharing is the proposed method for tracking beneficiary contributions. Federal law caps cost-sharing for NHHPP beneficiaries at 5% of an individual's annual household income. It is the responsibility of the State to ensure beneficiaries are not billed in excess of this cap. The Draft Premium Assistance Program 1115 Demonstration Waiver proposes to track NHHPP beneficiaries' out-of-pocket expenditures on a quarterly basis.

Tracking expenditures in this manner is concerning. Individuals facing expensive procedures in the first month of a given quarter could be required to pay up to, or beyond, 15% of their monthly household income in the first month alone. If a beneficiary continues to incur health care expenses for the remainder of the quarter, and his or her expenditures are not reviewed in a timely manner, the beneficiary may be required to pay an even greater amount.

While refunding beneficiaries for overpayments made within a given quarter is a start, it does not address the real hardship this method of tracking may place on low-income individuals. As stated above, low income individuals are particularly sensitive to any increased costs associated with health care. Tracking expenditures on a quarterly basis may deter individuals from accessing health care or force them to make the difficult decision between paying for basic needs and receiving medical care.

New Futures strongly recommends the Department consider reviewing out-of-pocket expenditures on a monthly basis, to reduce the potential for hardship on low-income NHHPP beneficiaries.

Waiver of Medicaid's 3 Month Retroactive Coverage Period

Another area of concern for SUD populations is the proposed waiver of Medicaid's three month retroactive coverage period for NHHPP beneficiaries. The proposed waiver would limit retroactive coverage to the date an application was submitted to the Department. The Department reasoned that waiving this part of Medicaid law would only affect the small number of people

who failed to sign up for coverage under the "Bridge" program because they were "difficult to reach or engage."

Traditionally, individuals with SUD or co-occurring mental illnesses are "difficult to reach or engage." These individuals may not have a permanent address or access to technology. SUD and Mental Health providers are actively working to encourage their patient populations to enroll in NHHPP, but it is a struggle. Providers have reported having multiple contacts with clients before they are able to collect sufficient information to complete an NHHPP application.

As a result, New Hampshire SUD and Mental Health providers are heavily reliant on the three month retroactive coverage period to obtain payment for services rendered to the State's SUD and mentally ill populations. Waiving this essential feature of Medicaid would threaten the continued viability of New Hampshire's SUD and Mental Health treatment providers and limit the ability of NHHPP eligible individuals to obtain needed care. New Futures therefore strongly encourages the Department to reconsider this aspect of the Draft Premium Assistance Program 1115 Demonstration Waiver.

Grievance & Appeals

As a final note, New Futures echoes the sentiments of other advocates around the proposed grievance and appeals procedures for NHHPP beneficiaries in private Marketplace health plans. The insurance grievance and appeals process is difficult to navigate for even the most sophisticated health care consumers. NHHPP beneficiaries are particularly vulnerable to becoming lost in the complex insurance appeals system, threatening their rights as Medicaid recipients. New Futures strongly recommends the creation of an ombudsman's office to help NHHPP beneficiaries navigate the insurance appeals process and to ensure their rights under Medicaid are protected.

Thank you for the opportunity to submit these comments. New Futures looks forward to working together with the Department to ensure the successful implementation of the New Hampshire Health Protection Plan and its associated programs.

Sincerely,

[redacted]

Linda Saunders Paquette, Esq.
Executive Director
New Futures

[redacted]

Michele D. Merritt, Esq.
Policy Director
New Futures

nhfpi
New Hampshire Fiscal Policy Institute

October 31, 2014

Mr. Jeffrey A. Meyers
Director of Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street
Thayer Building
Concord, NH 03301

Dear Mr. Meyers:

I write to offer the comments of the New Hampshire Fiscal Policy Institute (NHFPI) on the Department of Health and Human Services proposed *New Hampshire Health Protection Program Premium Assistance Section 1115 Research and Demonstration Waiver* and to request that the Department respond to the following questions concerning the waiver:

- Could you please confirm that, as detailed in the Department's presentations on October 8 and October 20, 2014, no premium assistance enrollee will be required to pay either a premium or deductible for such coverage? Similarly, could you please confirm that only those enrollees with incomes between 100 and 133 percent of the federal poverty level (FPL) will be required to make copayments for certain services?

- Could you please explain how the proposed schedule of copayments, detailed in the Department's presentations on October 8 and October 20, was determined and whether such copayments were set in a manner that not only allows enrollees to access the care they need, but also will not lead to an increase total expenditures under the Health Protection Program?

  As you know, a significant body of research on the effect of premiums and copayments on low-income people suggests that even modest cost sharing may increase the barriers they encounter in accessing care and prevent them from enrolling or remaining enrolled. Moreover, such research makes clear that, while cost sharing reduces utilization of health care, it does not do so in an efficient or effective way. Rather, it reduces the utilization of both essential and non-essential health care in roughly equal proportions. Finally, research on this topic suggests that higher copayments do not effectively reduce health care expenditures, as they instead lead to decreased utilization of outpatient services and concurrent increased utilization of hospital care or hospital days. In other words, those

affected by copayments rationed needed health care and such rationing ultimately resulted in more expensive health care interventions.

- Could you please detail the procedures and systems the Department will employ to ensure that enrollees will neither make aggregate copayments in excess of the federally mandated limit of 5 percent of their quarterly household income nor face copayments should their household incomes fall below 100 percent of FPL? Similarly, could you please explain the responsibilities of various parties (e.g. enrollees, medical providers, the Department) for reporting and monitoring enrollees' income levels and copayments? Finally, can you please elaborate on the remedies that will be available to enrollees should they make a copayment or copayments in excess of the 5 percent of income limit?

- Could you please explain in greater detail how the Department will evaluate the various hypotheses listed in its waiver application, particularly those that could potentially be affected by the imposition of copayments?

NHFPI greatly appreciates the opportunity to raise these questions and concerns and looks forward to working with the Department of Health and Human Services, elected officials, and other stakeholders to ensure the successful implementation of the New Hampshire Health Protection Program.

Sincerely,

[redacted]

Jeff McLynch
Executive Director

New Hampshire Hospital Association

October 31, 2014

Jeffrey A. Meyers
Director, Intergovernmental Affairs
NH Department of Health and Human Services
Office of Medicaid Business and Policy, Legal and Policy Unit
129 Pleasant Street-Thayer Building
Concord, NH 03301-3857

Dear Mr. Meyers:

On behalf of the New Hampshire Hospital Association (NHHA) and our member hospitals, I am pleased to submit this comment letter in support of the Section 1115 Research and Demonstration Waiver to implement the Premium Assistance Program that was established by the New Hampshire Health Protection Plan.

New Hampshire's hospitals are proud supporters of the New Hampshire Health Protection Plan to extend private health insurance coverage to more low-income, uninsured residents in New Hampshire and advocated vigorously for its adoption earlier this year. Hospitals see first-hand the challenges of caring for people who have no insurance. Without insurance and access to primary, preventive and ongoing chronic care management, these uninsured patients end up in a crisis and turn to their local hospital emergency room for care. Our hospitals proudly serve all of their patients without regard to their ability to pay, but we should be working to ensure patients get the right care, at the right time and in the right setting. Statewide, hospitals provided more than $425 million in uncompensated care (valued at actual cost).

The Section 1115 Research and Demonstration Waiver to implement the Premium Assistance Program (PAP) that was established by the New Hampshire Health Protection Plan (NHHPP) seeks to build on models approved by the federal Centers for Medicare and Medicaid Services (CMS) in other parts of the country by allowing states to use federal Medicaid funds to purchase qualified health plans (QHPs) on the Marketplace in New Hampshire for those individuals with incomes below 138% of the federal poverty level (FPL). This builds on the other provisions of the NHHPP to provide coverage for these individuals below 138% of the FPL through the mandatory Health Insurance Premium Payment (HIPP) Program for those with cost-effective employer sponsored insurance, and the Bridge Program that will offer coverage through New Hampshire's existing managed care plans pending the approval of the PAP. As of today, these first two programs are covering over 20,000 individuals in New Hampshire who would otherwise have no access to health insurance coverage

New Hampshire's hospitals strongly support efforts to make the health care system better for our patients, who deserve to receive the right care, at the right place, at the right time, every time. Expanding private health insurance coverage is a major step forward for patients, families, providers, businesses and our state's economy. New Hampshire's Section 1115 Research and Demonstration Waiver Application puts us squarely on this path and we look forward to working with you and your colleagues to implement the PAP.

Thank you for the opportunity to share these comments with you.

Sincerely,

[redacted]

Steve Ahnen
President

American Heart Association | American Stroke Association
life is why

2 Wall Street | Manchester, NH 03101
www.heart.org

October 31, 2014

Jeffrey A. Meyers
Director, Intergovernmental Affairs
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

Re: New Hampshire Health Protection Program
Draft Premium Assistance Section 1115 Demonstration Waiver Application

Dear Mr. Myers:

The American Heart Association appreciates the opportunity to submit questions regarding the draft Section 1115 Waiver application, and looks forward to the NH Department of Health and Human Services (DHHS) response.

In order to promote personal responsibility, enrollees are expected to participate in "mandatory wellness programs" as part of their healthcare. How will the DHHS detail the wellness programs to be mandated and to ensure they are of a comprehensive, evidence-based program? How will participation be measured, ensuring there are no penalties for not meeting certain health metrics? Will there be alternative means of participating in a wellness program, to increase enrollees' compliance in participating?

Will the DHHS detail the 'Other Medical Professionals" listed within the Cost Sharing Plan as requiring an $8.00 copay?

How will the DHHS and/or NH Insurance Department ensure there is an adequate network of healthcare providers for enrollees available in the "network of their QHP"?

Thank you for the opportunity to submit questions and provide comment on the DHHS draft premium assistance Section 1115 Medicaid Waiver. The American Heart Association advocates for affordable, accessible healthcare for all people at risk for, or suffering from, cardiovascular diseases. Should you need clarification I may be reached at 603-518-1555.

Sincerely,

[redacted]

Nancy Vaughan
Government Relations Director – New Hampshire

Anthem.
BlueCross BlueShield

Jeffrey A. Meyers, Director
Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street, Thayer Building
Concord, NH 03301-3857

October 31, 2014
Via email

Re: New Hampshire Health Protection Program
Premium Assistance Section 1115 Research and Demonstration Waiver

Dear Mr. Meyers:

Anthem Health Plans of New Hampshire ("Anthem") appreciates the opportunity to provide comment on the NH Premium Assistance Section 1115 Research and Demonstration Waiver released on October 1, 2014. We are committed to being a valued health partner to the state and to delivering quality products and services to NH citizens and we look forward to continued discussions with the state as health reform efforts continue.

Overview: It is our hope that the comments below represent thoughtful considerations for the state as the Medicaid Premium Assistance program evolves. Timely decision making, program and process clarity, and access to critical data are key elements in ensuring issuer participation and readiness. Anthem has summarized our comments into seven main categories. Recommendations and considerations are based on a comprehensive review of the NH waiver document, our current experience offering QHP coverage through NH's marketplace, and our understanding of similar premium assistance programs across the country – programs that are either in place or planned.

Timing is critical: The premium assistance program is slated to be offered through the NH exchange for coverage year 2016. In order to offer new products by the 2016 open enrollment period, carriers will be required to develop QHP plans and rates in the first quarter of 2015 and file QHP plans and premiums in the second quarter of 2015, with certification occurring soon after. Additionally, carriers will need to implement IT system changes to add capabilities needed to participate in the program, such as the processing of enrollment transactions and financial payments from the Medicaid agency. Thus, the following items need to be finalized by December 31 of this year:

- Product parameters (i.e. plan design for the plans with eliminated and lower cost-sharing) and understanding of how the individual market risk pool will be impacted with the newly added population;

- Financial and payment parameters for premium payment and cost-sharing reductions that will be applied for the Medicaid premium assistance population;
- Access to Medicaid claims utilization data for 2014 for the expansion population to help determine cost impact to the individual market;
- Modifications to the QHP certification process to reflect the additional plan variations for the Medicaid population;
- Detailed understanding of the readiness tasks (e.g. for IT/systems) for program elements such as enrollment and financial transactions from the Medicaid agency;
- A close to final draft of the 3-way contract that would need to be in place between the issuer, Medicaid agency, and federal exchange.

Should this information be delayed and a January 1, 2016 implementation date not be achievable, the program would need to be delayed at least until January 1, 2017 due to the fact that contracts and rates for exchange coverage are fixed for the entire calendar year.

Approach to administering QHP plan variations for Medicaid beneficiaries should mirror existing process for individual market consumers eligible for cost-sharing reductions (CSRs): In order for QHP issuers to reduce or eliminate cost-sharing for Medicaid beneficiaries enrolling in QHPs, issuers must be able to load additional QHP plan variations in their systems beyond what exist today for the CSR-eligible population. Such a process is the only clean way to ensure Medicaid beneficiaries experience the lower/eliminated cost-sharing to which they are entitled. This is the same way issuers currently administer CSRs for the individual market population, and it is critical to build on this process and avoid unnecessary complexity. Enrollment in the new plan variations would be treated as an eligibility issue for the 0-138% FPL in the same way enrollment into CSR plans is treated as an eligibility issue for the 100-250% FPL population today.

Financial terms of covering Medicaid beneficiaries in QHPs: Carriers considering participation in the Medicaid Premium Assistance program require further clarity regarding how rates in the individual market will be adjusted with the addition of the Medicaid population and budget neutrality requirements, and also how cost-sharing reductions will be calculated. Specifically, the following must be considered:

- **Risk pool adjustments:** Issuers will need data for Medicaid beneficiaries and must be allowed to make appropriate adjustments to the individual market risk pool that will include Medicaid beneficiaries.
- **Induced utilization:** Just having the Medicaid agency pay premiums and cost-sharing in existing contracts will not be sufficient to cover costs due to the concept of "induced utilization" where utilization increases when cost-sharing is reduced. Thus, the "cost-sharing reductions" paid by the Medicaid agency must reflect that additional dynamic. Including "induced utilization" is consistent with how the federal government administers such reductions for the standard exchange population.

Anthem BlueCross BlueShield

As noted above, to fully understand the dynamics of the expansion population and to incorporate that dynamic into rates, complete Medicaid data would be needed from the Medicaid agency by December 31 of this year.

Carrier Participation: Offering of Medicaid Premium Assistance QHPs should be voluntary for commercial QHP carriers. Such would ensure all parties are ready to serve the low-income population.

Certification process: Clarity is needed regarding the 3-way contracting requirements and process between the issuer, Medicaid Agency, and the exchange.

Transparency around "budget neutrality" and shared responsibility: A key consideration for the state and all stakeholders will be how the state achieves "budget neutrality" in the context of the Medicaid waiver, given provider rates for Commercial products are typically higher than Medicaid. We ask that this critical part of the discussion be transparent with all stakeholders.

Administration of additional Medicaid benefits: Clarity is needed regarding the services that will continue to be covered by Medicaid (e.g. Non-emergency transportation, EPSDT, adult vision) on a fee-for-service basis through the Medicaid agency. Carriers need to understand the customer service process and appeals process for the benefits that are not administered as part of the QHP.

Thank you for this opportunity to offer our comments as the state moves forward with its efforts to establish the New Hampshire Health Protection Program, and specifically the Medicaid Premium Assistance Program. We look forward to working with the state as the specific elements of the program are refined. Should you have any questions or wish to discuss our comments further, please contact Sherri Panaro, Director Change Management; 603-541-2114; sherri.panaro@wellpoint.com.

Sincerely,

[redacted]

Sherri Panaro
Director, Change Management
Anthem Blue Cross Blue Shield

NEW HAMPSHIRE VOICES FOR HEALTH

October 31, 2014

Via Electronic Submission

Jeffrey A. Meyers, Esq.
Director of Intergovernmental Affairs
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3587
E-Mail: PAP1115Waiver@dhhs.state.nh.us

Re: NH Health Protection Program – Comments on Draft Premium Assistance Section 1115 Demonstration Waiver Application

Dear Mr. Meyers:

NH Voices for Health (VOICES) is pleased to submit these Comments concerning the draft Premium Assistance Section 1115 Demonstration Waiver Application. We respectfully request that you consider this formal input alongside and in addition to the Questions that we submitted to you on October 20, 2014.

VOICES is a non-partisan, statewide network of organizations and individuals allied in the commitment to quality affordable health care and coverage for residents of New Hampshire, and representing more than 380,000 members and constituents across the Granite State.

We thank the NH Department of Health and Human Services (DHHS / Department) and the NH Insurance Department (NHID) for your diligent and successful efforts to implement expanded Medicaid via the NH Health Protection Program (NHHPP).

With more than 21,000 New Hampshire residents already enrolled in the NHHPP since August 15, this expansion of health coverage is a pragmatic and sensible step toward:

- Access to essential health services for hardworking, lower-income Granite Staters;
- Reductions in uncompensated care for health care providers;
- Reduced burden on a business community that, with health care cost-shifting, has been faced with rising health coverage expenses; and, as a result,
- A healthier workforce, fortified health system, and strengthened state economy.

We have a handful of concerns and suggestions for your consideration regarding the proposed Premium Assistance Program (PAP) Waiver for the NH Health Protection Program.

1. *Cost Sharing Plan.*

We thank the Department for proposing a plan that will exempt PAP enrollees with incomes below 100% of the Federal Poverty Level (FPL) from cost-sharing. However, we are concerned about the proposed cost-sharing / copay framework for persons with incomes at 100% to 138% of FPL.

There is a rich body of research demonstrating that copays, even in relatively small amounts, discourage lower-income people from accessing the health care they need.[1] The proposed Premium Assistance Program copays risk significant financial strain for persons who have little, if any, disposable income to spend on health services.

Studies raise additional concerns for low-income individuals with chronic conditions or other significant health care needs.[2] Small and moderate copays add up quickly when multiple medications, specialists and/or intensive care are needed.[3] Due to cost-sharing, populations with otherwise manageable chronic illnesses are more likely to delay or avoid necessary care, with findings that indicate negative effects on health outcomes.[4]

While we understand that the copays proposed by the draft Waiver are within the rubric of what is permitted by federal Medicaid law – weighing the potential risk of enhanced barriers to access, increased unmet needs, and worsened health outcomes – we encourage DHHS and NHID to explore available avenues for reducing or eliminating them.

2. *Proposed Waiver of Medicaid's 90-Day Retroactive Coverage Requirement.*

The draft Waiver application proposes that PAP coverage begin on the enrollee's date of application (or on January 1, 2016, whichever is later). We remain concerned that 'date of application' is a term that is undefined in the draft Waiver request.

In any event, it is sound public policy to ensure that NHHPP Premium Assistance Program enrollees retain this important retroactive protection. The retroactive coverage period in Medicaid law avoids unnecessary medical debt, reduces uncompensated care costs, and alleviates financial burden on patients as well as providers.

Retroactive coverage also serves as an incentive for provider participation in the NHHPP, helping to ensure sufficient provider engagement for required network adequacy and patients' timely access to care.

3. *Proposed Waiver of Medicaid's 24-Hour Prior Authorization Requirement for Prescription Drugs.*

For PAP enrollees, the draft Waiver application proposes to replace Medicaid's 24-hour prior authorization requirement for prescription drugs with a 72-hour prior authorization standard. The draft application also indicates that 'a 72-hour supply of the requested medication will be provided in the event of an emergency'. We remain very concerned that the draft application does not define 'emergency' in this context.

In New Hampshire's Medicaid Care Management Program, prior authorization has been an acknowledged and ongoing trouble spot.

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[1] "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings." Kaiser Commission on Medicaid and the Uninsured, February 2013.

[2] Newhouse, Joseph P. and the Insurance Experiment Group. Free For All? Lessons from the RAND Health Insurance Experiment. RAND, 1993.

[3] LeCouteur, Gene et al. "The Impact of Medicaid Reductions in Oregon: Focus Group Insights". Kaiser Commission on Medicaid and the Uninsured, 2004.

[4] Tamblyn R, et al. "Adverse Events Associated With Prescription Drug Cost- Sharing Among Poor and Elderly Persons." Journal of the American Medical Association. Vol. 285(4), Jan 2001.

In this instance, for PAP patients who may experience a significant health care need or needs at a given time, we are concerned that a 72-hour prior authorization period can spell hazard for patient health.

As a result, and until there is some workable and effective definition of 'emergency' in this context, we have no choice but to oppose this proposed Waiver provision.

4. *QHP Health Care Provider Network Adequacy and MCO QHP Auto-Assignment.*

In light of New Hampshire's first-year Marketplace experience of Anthem's limited health care provider network, we are concerned about how DHHS and NHID will ensure that certified QHPs (qualified health plans) provide Premium Assistance Program enrollees with access to care that is comparable to the access available to the general population in the enrollee's geographic area, as required by federal Medicaid law[5].

We generally support and appreciate the QHP auto-assignment provisions in the draft Waiver application, and we are grateful for the provision that provides PAP enrollees who have been auto-assigned to a QHP with sixty (60) days to select a different QHP, if desired.

However, from an enrollee and provider network adequacy perspective, we are concerned about an unforeseen consequence of auto-assignment as it relates to New Hampshire's Medicaid managed care organizations (MCOs).

The NHHPP authorizing statute and draft Waiver application provide that when a person is determined to be PAP eligible and is a Bridge Program enrollee, if his or her MCO is offering a certified QHP, the enrollee will be auto-assigned to the QHP offered by his or her MCO.

We understand and appreciate that the intention of this provision is to ensure that individuals currently enrolled in the Bridge Program do not experience a gap in coverage and care, but the reality is that MCO QHP auto-assignment could have the opposite effect.

Because the network adequacy standards for private insurance and the Marketplace are different than they are for Medicaid, and because the economics of private market provider networks are different than they are for Medicaid, either or both of the MCOs may offer certified QHPs with health care provider networks that are more limited than their Medicaid managed care networks.

For example, if one or both MCOs offer certified QHPs with health care provider networks that resemble Anthem's current Marketplace network, there is genuine risk that Bridge Program enrollees could be auto-enrolled in an MCO-offered QHP that does not include their health care provider/s at all.

To address this concern, VOICES has two alternative recommendations. We suggest that the Waiver require either:

- That, in order for a Medicaid Bridge Program enrollee to be auto-assigned to the QHP offered by their MCO, the MCO-offered QHP *must* have a health care provider network serving the enrollee's geographic area; or

[5] 42 U.S.C. § 1396a(a)(30)(A)

- That the notice of auto-assignment be provided to Bridge Program enrollees at least sixty (60) days in advance of January 1, 2016 so that, in the event of provider network folly, the enrollee will have sixty (60) days to select and enroll in a different certified QHP for PAP coverage that begins on January 1, 2016.

5. *Waiver Timeline.*

We respect and appreciate that the NH Health Protection Program is scheduled to sunset at the end of calendar year 2016 unless it is extended / reauthorized by the Legislature and Governor. As a result, the draft application proposes a one-year timeline for the Waiver.

We suggest that it would be more sensible and pragmatic to propose a 3-year Waiver timeframe, with a simple and straightforward circuit-breaker provision expressing that the Waiver will end in the event that the NHHPP is not reauthorized by legislative enactment.

There are three reasons for this suggestion: government efficiency; budget neutrality; and proof of the Waiver hypotheses.

First, in the event that the NH Health Protection Program is reauthorized, and with only a one-year Waiver, the Department would be required to expend the time, energy, and effort needed to pursue and secure a Section 1115 Waiver renewal with CMS. Given the availability of an alternative and workable circuit-breaker provision, at a time when government efficiency and cost-effectiveness are paramount, requiring such effort would not appear to be the most prudent option.

Second, since there are and will be start-up costs associated with getting a successful Premium Assistance Program off the ground in the first year, a one-year Waiver appears less likely to achieve the 'budget neutrality' required by federal law than a three-year Waiver, which can and would propose to spread the Program's costs and savings out over time.

And third, one year appears likely to be an insufficient time period to gather the needed and comprehensive data required to prove the proposed Waiver's thoughtful and well-crafted Demonstration hypotheses for the Premium Assistance Program.

We thank the Department and NHID for the opportunity to submit these Comments on the draft Section 1115 Waiver Application. We look forward to working together to ensure the successful implementation of the Premium Assistance Program and the continued success of the NH Health Protection Program. If you have any questions, please do not hesitate to contact me at 603.491.1924 or Tom@NHVoicesforHealth.org.

Sincerely,

[redacted]

Thomas G. Bunnell, Esq.
Policy Consultant

Responses to Comments on New Hampshire Premium Assistance Program Waiver
November 7, 2014

Cost-Sharing & Wellness

Comment 1: Several commenters expressed concerns that imposing cost-sharing on individuals with incomes from 100%-133% of the federal poverty level (FPL) will discourage individuals from receiving appropriate care. These commenters noted that even relatively low levels of cost-sharing can act as a barrier to care for low-income beneficiaries.

Response 1: The State is sensitive to the concern that cost-sharing may impose barriers to receiving care, and the State has taken steps to mitigate that risk. First, the State is proposing to impose cost-sharing only on individuals with incomes at and above 100% FPL. Additionally, the State will ensure, consistent with federal Medicaid requirements, that cost-sharing is no higher than 5% of quarterly income. Finally, the State has elected to impose only co-payments, and the State is not requesting authority to impose premiums, co-insurance, or deductibles.

Comment 2: Several commenters stated that imposing cost-sharing would increase the burden of uncompensated care on federally qualified health centers (FQHCs), since FQHCs are not permitted to deny services for failure to pay.

Response 2: The State recognizes that some individuals may seek care from FQHCs specifically because FQHCs are not permitted to deny services to individuals who are unable to make co-payments. The State encourages FQHCs to track whether a significant number of individuals enrolled in the New Hampshire Health Protection Program (NHHPP) fail to make co-payments.

Comment 3: Several commenters encouraged the State to use other mechanisms, such as wellness programs, to promote personal responsibility among NHHPP enrollees.

Response 3: Consistent with SB 413, the State intends to provide wellness programs in addition to—not in lieu of—cost-sharing to promote personal responsibility.

Comment 4: Several commenters requested clarification on how the State will track whether an individual has reached the quarterly cost-sharing cap. Several commenters also asked how the State will address fluctuations in an individual's income. Finally, one commenter asked how the State will administer a refund.

Response 4: The State is in the process of developing an approach to monitor the cost-sharing cap, but the State intends to make the process as streamlined as possible. To simplify administration and address income fluctuations, the State intends to set a fixed cap for all individuals subject to cost-sharing at 5% quarterly income for someone at or above 100% FPL. In other words, an individual with an income of 106% FPL or 126% FPL would be subject to the same cap. As a result, the fluctuations in income between 100% and 133% will have no impact on the quarterly cap. In the event that an individual reaches the cap, the State will provide a refund of any co-payments above the cap and will ensure that the beneficiary is not required to

pay any additional cost-sharing for the remainder of the quarter. The State continues to develop the process for providing the refund.

If an individual's income falls below 100% FPL, the individual will be transitioned to a plan without cost-sharing, effective at the beginning of the next coverage month after the individual notifies the State of the change in income.

Comment 5: A few commenters suggested that the State use a monthly, rather than quarterly, cost-sharing cap.

Response 5: The State has elected to impose a quarterly cap, rather than a monthly cap, to streamline administration of the cap. Given the low levels of cost-sharing imposed, the State anticipates that very few individuals will reach the cost-sharing cap in a quarter.

Comment 6: One commenter requested clarification on what constitutes an "other medical professional" and what would be defined as "imaging" under the proposed cost-sharing design.

Response 6: "Other medical professional" includes providers who are neither primary care providers nor specialty physicians, such as physical therapists. Imaging, which is subject to a copay, would include MRIs, CAT scans, and PET scans; X-rays and ultrasound would be included in the Radiology category under the proposed cost-sharing design, and would not be subject to a copay.

Comment 7: One commenter requested clarification that family planning services would not be subject to cost-sharing.

Response 7: Family planning services will not be subject to cost-sharing, since Qualified Health Plans (QHPs) are not permitted to impose cost-sharing on preventive services, including family planning services.

Comment 8: One commenter requested that the State create a list of drugs for chronic conditions that must be exempt from all cost-sharing.

Response 8: The State is purchasing QHPs that are offered on the Marketplace. Currently, QHPs are not required by state law to exempt drugs for chronic conditions from cost-sharing, and thus drugs for chronic conditions will be subject to cost-sharing. Additionally, the proposed cost-sharing amounts of $2 and $6 for generic and brand drugs, respectively, are below the amounts permitted under federal Medicaid law.

Comment 9: Commenters asked what type of cost sharing would apply to home care services and to substance use disorder residential services.

Response 9: Home health aide services will be available without cost-sharing. If an individual receives services from a professional in the "other professional" category at home, such as at

home physical therapy, the other professional cost-sharing amount would apply. The Department of Health and Human Services and the New Hampshire Insurance Department will determine whether and to what extent substance use disorder residential services will be subject to cost-sharing, consistent with federal requirements.

Comment 10: One commenter asked for clarification about how participation in wellness programs will be operationalized.

Response 10: The Department of Health and Human Services will work with the Centers for Medicare and Medicaid Services and carriers to determine the details of the wellness programs to be offered as a component of the Premium Assistance Program.

Appeals

Comment 11: Several commenters expressed concerns that individuals will not have access to the Medicaid fair hearing process for appeals involving benefits covered by the QHP.

Response 11: Although NHHPP enrollees will use the QHP appeals process, rather than the Medicaid fair hearing process, to appeal denials of coverage for benefits covered by the QHP, NHHPP enrollees will receive the full set of Medicaid-required protections throughout the appeals process. For example, NHHPP enrollees will have the ability to testify in person during the external review and NHHPP will have the protections of aid continuing.

Comment 12: Several commenters expressed concerns that there will be two separate appeals processes depending on whether the benefit is covered by the QHP or by fee-for-service Medicaid. Some commenters suggested that the State appoint an ombudsman to assist individuals in navigating through the appeals process.

Response 12: Nearly all benefits will be covered by the QHP, and thus will be appealed using the QHP process. Any benefits covered through fee-for-service Medicaid will be appealed using the Medicaid fair hearing process. The State will work closely with staff at both the Medicaid and QHP carrier call centers to ensure that all beneficiaries are directed to the correct location to make their appeal. Additionally, New Hampshire Insurance Department (NHID) consumer services personnel will be available to assist NHHPP enrollees with their QHP appeals.

Comment 13: One commenter requested clarification for what constitutes an urgent appeal, thereby qualifying for expedited review.

Response 13: Under New Hampshire statute, urgent appeals are defined as those in which the patient's life or health, or the patient's ability to regain maximum function, would be seriously jeopardized if treatment/care is not received, or a claim concerning an admission or continued stay where a person received emergency services, but has not been discharged.

Comment 14: One commenter requested clarification of whether the standard Medicaid fair hearing process would apply to appeals related to eligibility determinations, or to whether an

applicant is exempt from QHP premium assistance because of their status as medically frail, duly eligible, or pregnant.

Response 14: Individuals will have access to the Medicaid fair hearing process for all appeals related to Medicaid eligibility. The Medicaid fair hearing process will not be available for determinations of whether an individual is exempt from QHP premium assistance because the individual is a dual eligible or has indicated that she is pregnant, since such individuals are eligible for Medicaid coverage through the standard Medicaid program. Additionally, medically frail status is based on self-attestation, not a determination by DHHS, so an appeal will not be necessary for a medical frailty identification. The decision to identify as medically frail lies solely with the applicant.

Comment 15: One commenter asked whether the State will collect data on the success rate of internal appeals and external reviews filed by NHHPP enrollees covered through QHP premium assistance.

Response 15: The State will consider including this in its evaluation design.

Comment 16: One commenter asked for statistics related to the percentage of internal and external appeals under the state managed care statute that result in claim denials being reversed. The Commenter also asked for the percentage of Medicaid claim denials that result in being reversed.

Response 16: The New Hampshire Insurance Department does not presently collect data on appeals subject to internal review. The most recent annual report regarding appeals subject to external review can be found here:
http://www.nh.gov/insurance/aboutus/annualreport/documents/162nd_ann_rpt.pdf.
With respect to Medicaid appeals during SFY 11-SFY 14, among cases in which a decision was issued, 63 percent were upheld and 27 percent were reversed.

Comment 17: One Commenter asked what agency the New Hampshire Insurance Department designates to oversee the external review process.

Response 17: The NH Insurance Department is required by law to certify independent external review organizations to review external appeals. More Information relating to the external review process and certification of external review organizations can be found here:
http://www.nh.gov/insurance/consumers/appeals.htm.

Plan Selection, Auto-Assignment & Health Literacy

Comment 18: A few commenters emphasized the importance of NHHPP enrollees having access to information about the QHPs' network during the plan selection process. Some commenters suggested that QHP carriers be required to submit the network in a standardized format.

Response 18: The State agrees that it is critically important to provide individuals with sufficient information about the QHPs and their networks during the plan selection process. New Hampshire insurance carriers are required by law to provide access to information on networks and formularies in an easy-to-use format, and the NHID is committed to enforcing these requirements.

Comment 19: A few commenters requested clarification regarding how the state will ensure that NHHPP program communications will be appropriate with respect to the reading level and health literacy of enrollees.

Response 19: The State agrees that it is important to provide individuals with accessible information and will use standard, internal processes to ensure that communications to enrollees are presented at an appropriate and accessible level. In addition, New Hampshire insurance law imposes requirements on insurance carriers with respect to reading level and clarity; these requirements are applicable to carriers offering QHPs and are subject to enforcement by the NHID.

Comment 20: Several commenters expressed concerns that auto-assignment to a plan may disrupt existing provider relationships.

Response 20: The State will attempt to avoid disrupting existing provider relationships during the auto-assignment process. Since enrollees affirmatively selecting plans is the best way to maintain existing provider relationships, the State will also educate NHHPP enrollees about the importance of selecting a plan during the plan selection process. Additionally, NHHPP enrollees will be able to change plans after auto-assignment, further enabling them to maintain existing provider relationships.

Comment 21: One commenter requested clarification about family affiliation being a factor in the auto-assignment process.

Response 21: New Hampshire intends to keep families in the same plans, to the extent possible. If one individual in a household has selected a particular QHP and the other fails to do so, New Hampshire will endeavor to auto-assign the individual to the QHP selected by their family member.

Comment 22: Commenters differed on whether they supported or opposed the State's proposal, as required by SB 413, to auto-assign individuals enrolled in an MCO to the QHP offered by their MCO. Some commenters were concerned that the QHP offered by the MCO may not have an adequate network in their area.

Response 22: SB 413 requires that individuals enrolled in an MCO be auto-assigned to the QHP offered by their MCO, if one is offered. The Department of Health and Human Services has interpreted this provision as requiring that individuals be auto-assigned to the QHP offered by

their MCO, *if that QHP is offered in the individual's region*. The State will **not** auto-assign an individual to a QHP unless that QHP is approved to be offered in the individual's county.

Comment 23: One commenter suggested that NHHPP enrollees be limited to enrolling in cost-effective plans.

Response 23: Consistent with the requirements of SB 413, NHHPP enrollees will be permitted to enroll only in plans that are cost-effective.

Medically Frail

Comment 24: One commenter asked whether individuals who are medically frail will be subject to cost-sharing.

Response 24: Yes, medically frail individuals with incomes at and above 100% FPL will be subject to cost-sharing. Under federal Medicaid rules, cost-sharing that is targeted to individuals with incomes at and above 100% FPL must apply to all individuals in an eligibility category with incomes at and above 100% FPL.

Comment 25: Several commenters requested additional details on what constitutes being "medically frail," and how the State will assess whether an individual is medically frail, and whether an individual could temporarily identified themselves as medically frail.

Response 25: The term "medically frail" is defined in federal regulations as "individuals described in [42 C.F.R.] § 438.50(d)(3) . . . , children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living." See 42 C.F.R. § 440.315(f). The State will continue to use the same process that it currently uses to allow individuals to self-identify as medically frail. Specifically, the State will continue to rely on an individual's response to a question on the individual's application that asks about the need for assistance with activities of daily living. It is up to an individual to determine whether they are or are not medically frail; depending on facts and circumstances, a person could alter their status as medically frail.

Waiver Timing

Comment 26: Several commenters suggested that the State should request a three-year waiver, rather than a one-year waiver.

Response 26: SB 413 authorizes the NHHPP through 2016. The State indicates in its application that, should the legislature reauthorize the program, the State would seek an extension of the waiver.

Network Adequacy

Comment 27: Several commenters expressed concerns about whether the QHP networks would be adequate and suggested that the State continuously monitor the networks for adequacy.

Response 27: All QHP networks are subject to prior review under state and federal network adequacy standards as part of the QHP certification process. These standards require that all covered persons have access to a network of primary care, specialist and institutional providers that is sufficient in number, type and geographic location to ensure that all covered health care services are available to covered persons without unreasonable delay. Insurance carriers are responsible for maintaining adequate networks on an ongoing basis, a requirement that is enforced by the NHID. The State will ensure that the QHP networks meet the requirements of Social Security Act § 1902(a)(30)(A). As part of the State's evaluation, it will also assess whether individuals had sufficient access to care.

Comment 28: One commenter suggested that the State clarify whether individuals will be able to request a referral to an out-of-network provider if the QHP's network does not include a provider with adequate training and experience. The commenter also suggested that individuals should not incur any greater cost-sharing than if the provider had been in network.

Response 28: Under the private market network adequacy standards, if a health carrier's network is insufficient with respect to a particular service in a county where the plan is offered, the carrier must cover services provided by a non-participating provider at no greater cost to the covered person than if the services were obtained from a participating provider.

Retroactive Coverage & Presumptive Eligibility

Comment 29: Several commenters expressed concerns that the State's proposal to provide coverage effective as of the date of application would have a significant negative effect on vulnerable enrollees, such as those with serious mental illness.

Response 29: The State expects that not providing coverage prior to the date of application will affect very few beneficiaries. The State believes that the benefits of administrative simplification outweigh the potential negative impact. Further, the State will engage in widespread outreach efforts to encourage individuals to enroll in coverage.

Comment 30: One commenter asked what constitutes the date of application for the purposes of determining the coverage start date.

Response 30: The date of application is the date on which the individual submits the signed application, even if the application is missing some information or the individual has not yet submitted supporting documentation.

Comment 31: One commenter suggested that the State continue its program for presumptive eligibility.

Response 31: The State intends to continue the presumptive eligibility program in its current form.

Freedom of Choice for Family Planning & Access to Services

Comment 32: One commenter requested assurance that individuals will be able to access any family planning providers that participate in Medicaid, even if the provider is not in the network of the enrollee's QHP.

Response 32: Individuals will be able to receive services from any family planning providers that participate in Medicaid. If the provider is not in the network of the enrollee's QHP, then Medicaid will reimburse the provider directly.

Comment 33: One commenter requested that women be permitted to access obstetricians and gynecologists without a referral.

Response 33: Both federal and state law require that all non-grandfathered individual market plans, which would include all QHPs, offer access to obstetricians and gynecologists without a referral.

Evaluation

Comment 34: One commenter requested additional details on the State's evaluation plan.

Response 34: The State's proposed approach to evaluation is described on pages 4 and 5 of the draft waiver application. In the draft application, the State outlines its proposed evaluation questions, hypotheses, and data sources, as well as the waiver component being addressed by each hypothesis. The State will continue to engage with the Centers for Medicare and Medicaid Services to further define the details related to the evaluation plan.

Prescription Drugs

Comment 35: Several commenters requested clarification on the State's reasoning related to requesting a waiver of the requirement to respond to requests for prior authorization for prescription drugs within 24 hours.

Response 35: Under the NHHPP, the State is purchasing QHPs that are offered on the Marketplace, and the State is endeavoring to align Medicaid and QHP requirements to the extent possible. QHPs are not required to respond to requests for prior authorization for prescription drugs within 24 hours, but QHPs are required to cover a 72-hour emergency supply. Since NHHPP enrollees will be able to have immediate access to a needed drug, the State believes that responding to requests for prior authorization within 24 hours will provide little, if any, protection to NHHPP enrollees.

Comment 36: Several commenters also requested additional clarification on when pharmacists may dispense (and plans must cover) a 72-hour supply and who determines whether a 72-hour supply is appropriate

Response 36: Under New Hampshire law, pharmacists may dispense a 72-hour supply (and plans will cover the costs of such supply) if the drug requires prior authorization, prior

authorization has neither been approved nor denied, and the medication is determined by the pharmacist to be essential to the maintenance of life or to the continuation of therapy in a chronic condition, or the interruption of therapy might reasonably produce undesirable health consequences or may cause physical or mental discomfort. *See* RSA 318:47-i.

Comment 37: Several commenters asked whether providers would be able to use drugs purchased through the 340B program for NHHPP enrollees.

Response 37: NHHPP enrollees are covered by Medicaid, and providers should treat the NHHPP enrollees like other Medicaid beneficiaries for the purposes of the 340B program.

Comment 38: One commenter requested that the 24-hour prior authorization requirement remain in place for individuals with serious mental illness or serious and persistent mental illness.

Response 38 Although the State recognizes the unique challenges facing individuals with mental illness, the State does not intend to create specific exemptions from the waiver requirements for individuals enrolled in QHP coverage through the NHHPP. Since NHHPP enrollees may access a 72-hour emergency supply, the State expects that prior authorization requirements will not pose a barrier to individuals receiving timely access to prescription drugs

Comment 39: One commenter suggested that family planning drugs should not be subject to prior authorization.

Response 39: QHP carriers are permitted to establish their own prior authorization requirements, and the State does not intend to limit which drugs may be subject to prior authorization.

Comment 40: One commenter expressed concerns that some plans impose prior authorization requirements on prescription drugs, including requiring that individuals "fail first" on lower-cost drugs before receiving authorization for higher-cost drugs, and expressed concern that the interaction of prior authorization and copayments could potentially have a negative effect on enrollees

Response 40: QHP carriers are afforded flexibility to establish prior authorization requirements, and the State does not intend to limit that flexibility. The State will work with carriers to understand the cost-sharing implications of prior authorization requirements.

Pregnant Women

Comment 41: One commenter requested additional details on how pregnant women will be identified. This commenter also requested that women who are enrolled in a QHP and then become pregnant are given a choice of remaining in their QHP or being transferred to pregnancy-related Medicaid coverage.

Response 41: If a woman who is enrolled in a QHP becomes pregnant and notifies the State of her pregnancy, she will be given the choice between remaining in the QHP or being transferred to pregnancy-related Medicaid coverage. If the woman remains in the QHP, she will be transferred to a zero cost-sharing plan.

Operational Issues Related to Premium Assistance

Comment 42: One commenter raised several questions related to how the State will operationalize the premium assistance program. The commenter asked specific questions related to, among other things, how the State will effectuate cost-sharing reduction payments and whether the State will impose any additional QHP certification requirements on carriers. The commenter expressed that carriers need details related to operationalizing the NHHPP premium assistance program as soon as possible.

Response 42: The State acknowledges that carriers may need to make some adjustments to their internal processes to accommodate the NHHPP premium assistance program consistent with CMS –Medicaid approval and guidance, and the State intends to minimize the need for any such adjustments to the greatest extent possible. The State will work closely with carriers to identify potential operational challenges and select the simplest solution. The State will endeavor to provide additional operational information as soon as possible, and the State will ensure that carriers are updated regularly on the State's progress.

Comment 43: One commenter requested that participation in the NHHPP premium assistance program be voluntary for carriers.

Response 43: Carriers are required by state and federal law to accept all individuals who apply for coverage. Carriers are not permitted to deny coverage to a class of individuals, such as Medicaid beneficiaries. For these reasons, all carriers participating in the Marketplace in New Hampshire will be required to participate in the NHHPP premium assistance program.

Budget Neutrality Form

Section 1115 Medicaid Demonstrations should be budget neutral. This means the Demonstration cannot cost the federal government more than what would have otherwise been spent absent the Demonstration. In this section, the state must provide its explanation of how the Demonstration program will achieve budget neutrality and the data to support its rationale.

New Demonstration Request: The following form provides guidance on some of the most commonly used data elements for demonstrating budget neutrality. CMS is available to provide technical assistance to individual states to identify any other elements needed to demonstrate budget neutrality for their specific request. Use the accompanying Excel Workbook to submit supporting data, following the instructions below. All expenditure totals in the Excel Workbook are total computable expenditures (both federal and state shares combined), unless indicated otherwise.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual or Estimated Data

Provide historic data, actual or estimated, for the last five years pertaining to the Medicaid Populations or sub-Populations (Populations broken out by cost categories) in the Demonstration program.

The "Historical Data" tab from the Table Shell contains a structured template for entering these data. There are slots for three Medicaid Populations; more slots should be added as needed. The year headers "HY 1," "HY 2," etc., should be replaced with the actual historical years.

The Medicaid Populations submitted for budget neutrality purposes should correspond to the Populations reported in Section II. If not identical, a crosswalk must be provided that relates the budget neutrality Populations to the Section II populations. Use the tables below to provide descriptions of the populations defined for budget neutrality, and the cross-walk to Section II.

States that are submitting amendments or extension requests and that wish to add new Medicaid populations can use the "Historical Data" tab to provide 5 years of historical data for the new populations.

Population/Sub-Population Name:	NHHPP Bridge Program
Brief Description	Adults enrolled in the NHHPP Bridge Program as of October 2014
Relationship to Section II	N/A

Population/Sub-Population Name:	Not applicable
Brief Description	
Relationship to Section II	

Population/Sub-Population Name:	Not applicable
Brief Description	
Relationship to Section II	

Population/Sub-Population Name:	Not applicable
Brief Description	
Relationship to Section II	

Explain the sources and methodology used for the actual and/or estimated historical data. If actual data have been provided, explain the source of the data (MMIS data, other state system Medicaid data, other program data, etc.) and the program(s) and source(s) of program funding that the data represent. Indicate if the data represent all Medicaid expenditures for the population. For example, are they inclusive of long-term care expenditures? Were the expenditures reported on the CMS-64? If the data provided are a combination of actual and estimated data, provide the dates pertaining to each type of data. If any of the data are estimated, provide a detailed explanation concerning how the estimated data were developed.

B. Bridge Period

Based on the ending date of the most recent year of historic data and the proposed Demonstration implementation date, a bridge period will apply to this proposal. Estimates of Demonstration costs must be trended across this bridge period when calculating the projected first year of PMPM costs without the waiver.

In the blanks below, enter the last day of the most recent historical year, and the last day of the year immediately preceding the first Demonstration Year. The number of months between these dates is the length of the bridge period. Depending on the length of the available historical data series and data quality, each demonstration population could have its own unique bridge period.

Enter the number of months in the bridge period in the "WOW" tab of the Excel Workbook, in the grayed cell under "MONTHS OF AGING." The spreadsheet is programmed to project Demonstration Year PMPM expenditures and member month totals using historical trend rates and the length of bridge period, and assumes that the same bridge period applies to all calculations. Applicants should feel free to alter these programming features as needed.

Demonstration Bridge Period: 12/31/2015 to 12/31/2015

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

The WOW tab of the Excel Workbook is where the state displays its projections for what the cost of coverage for included Medicaid populations would be in the absence of the demonstration. A block of cells is provided to display the WOW estimates for each Medicaid population specified. Next to "Pop Type," the correct option should be selected to identify each group as a Medicaid population.

The workbook is programmed to project without-waiver (WOW) PMPM expenditures and member months using the most recent historical data, historical enrollment and per capita cost trends, and the length of bridge period specified. CMS policy is to use the lower of the state's historical trends and President's Budget trends to determine the WOW baseline.

Note that the workbook includes a projected Demonstration Year 0 (DY 00), which is an estimate of the last full year immediately prior to the projected demonstration start date. DY 00 is included to provide a common "jumping off point" for both WOW and with waiver (WW) projections.

D. Risk

CMS will provide technical assistance to states to establish an appropriate budget neutrality methodology for their demonstration request. Potential methodologies include:

PER CAPITA METHOD: The state will be at risk for the per capita (PMPM) cost of individuals served by the Demonstration, to the extent these costs exceed those that would have been incurred absent the Demonstration (based on data shown and to be agreed to above). The state shall be at risk to repay CMS for the federal share of any costs in excess of the "Without Demonstration" cost, based on historical data shown above, which are the sum of the estimated PMPM costs times the number of member months by Population. The state shall not be at risk for the number of member months of participation in the Demonstration, to the extent that they may increase above initial projections.

AGGREGATE METHOD: The state will be at risk for both the number of member months used under the Demonstration, as well as the per capita cost for Demonstration participants; to the extent these exceed the "without waiver" costs and member months that are agreed to based on the data provided above.

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The "WW" tab of the Excel Workbook is for use by the State to enter its projected WW PMPM cost and member month projections for historical populations. In general, these can be different from the proposed without-waiver baseline. If the State's demonstration is designed to reduce

PMPM costs, the number of member months by category and year should be the same here as in the without-waiver projection. (This is the default formulation used in the Excel Workbook.)

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The State must provide below a justification for the proposed with-waiver trend rate and the methodology used by the State to arrive at the proposed trend rate, estimates of PMPM costs, and number of member months.

II. Cost Projections for New Populations

This section is to report cost projections for new title XIX Populations. These could be Populations or sub-Populations that will be added to the state's Medicaid program under the Demonstration, including "Expansion Populations" that are not provided for in the Act but are created under the Demonstration.

In the table below, list all of the New Populations and explain their relationship to the eligibility groups listed in Section II.

Population Name		Brief Description	Cross-Walk to Section II
N/A			
N/A			
N/A			

Justification for New Populations' Trend Rate, PMPM and Member Month Projections

The state must provide below a justification for the proposed trend rate, estimates of PMPM costs, and number of member months for new populations, including a description of the data sources and estimation methodology used to produce the estimates. Historical data provided to support projections for new populations can be displayed in the Excel Workbook's Historic Data tab.

Some state proposals may include populations that could be made eligible through a State plan amendment, but instead will be offered coverage strictly through the Demonstration. These populations are referred to as "hypotheticals" and CMS is available to provide technical assistance to states considering whether a Demonstration population could be treated as a hypothetical population.

III. Disproportionate Share Hospital Expenditure Offset

Is the state is proposing to use a reduction in Disproportionate Share Hospital (DSH) Claims to offset Demonstration costs in the calculation of budget neutrality for the Demonstration?

☐ Yes ☑ No

If yes, the state must provide data to demonstrate that the combination of Demonstration expenditures and the remaining DSH expenditures will not exceed the lower of the state's historical DSH spending amount or the state's DSH Allotment for each year of the Demonstration. The state may provide Adjusted DSH Claim Amounts if additional DSH claims are pending due to claims lag or other reasons.

In the DSH tab of the Excel Workbook, enter the state's DSH allotments and actual DSH spending for the five most recent Federal fiscal years in Panel 1. All figures entered should represent the federal share of DSH allotments and spending.

Provide an explanation for any Adjusted DSH Claim Amounts:

In Panel 2 of the Excel Workbook, enter projected DSH allotments for the federal fiscal years that will overlap the proposed Demonstration period, and in the following row, enter projections for what DSH spending would be in the absence of the demonstration. All figures entered should represent the federal share of DSH allotments and spending.

The Excel Workbook is set up to allow for the possibility that Demonstration Years will not coincide with federal fiscal years. If this is the case, and the Demonstration is proposed to last for five full years, then the Demonstration will be in existence for parts of six federal fiscal years. FFY 00 is the federal fiscal year during which the Demonstration is proposed to begin, and FFY 05 is the federal fiscal year that contains the Demonstration's proposed end date. CMS encourages states that use DSH diversion in their budget neutrality model to define Demonstration Years so that they align with the Federal fiscal years. (If Demonstration Years do align with Federal fiscal years, it is not necessary to populate the column for FFY 00.)

In Panel 3 of the Excel Workbook, the rows are set up to be used as follows. All amounts entered in Panel 3 are Federal share.

- State DSH Allotment: Formulas in the Excel Workbook automatically enter the same DSH allotment projects as are shown in Panel 2.
- State DSH Claim Amount: Enter the amounts that the state projects will be spent on DSH payments to hospitals for each federal fiscal year that overlaps with the proposed demonstration period.
- Maximum DSH Allotment Available for Diversion: If the state wishes to propose a dollar limit on the amount of potential DSH spending that is diverted each year, enter those amounts here. If no such limit is proposed, leave blank.
- Total DSH Allotment Diverted: The Excel Workbook is structured to populate the cells in this row from amounts entered in Panel 4. CMS's default assumption is that DSH diversion spending will align with the Federal fiscal year DSH allotments based on date of service. The Excel Workbook allocates DSH diversion spending from one or two overlapping Demonstration Years to each Federal fiscal year DSH allotment.
- DSH Allotment Available for DSH Diversion Less Amount Diverted: This row provides a check to ensure that diverted DSH spending does not exceed the Maximum DSH Allotment amount specified by the State. If no Maximum DSH Allotment, delete the formulas in this row.

- DSH Allotment Projected to be Unused: This row provides a check to ensure that the combination of diverted DSH spending plus DSH payments to hospitals does not exceed the DSH allotment each year.

Panel 4 of the Excel Workbook provides space for the state to indicate amounts of DSH diversion spending are planned for each Demonstration Year, and specify how much of that amount is to be assigned to the overlapping Federal fiscal years. DSH diversion spending is entered here as a total computable expenditures. An FMAP rate is needed for each total computable spending amount entered to enable it to be converted into a federal share equivalent that will appear in Panel 3. The amounts shown in the Total Demo Spending From Diverted DSH row automatically appear in the Summary tab in the Without Waiver panel.

Explanation of Estimates, Methodology and Data

IV. Summary of Budget Neutrality

The Excel Workbook's Summary tab shows an initial assessment of budget neutrality for the Demonstration. Formulas are included that reference cells in the WOW, WW, and DSH tabs so that projected WOW and WW expenditures for each category of expenditure appear in tabular form and can be summarized by Demonstration Year, and for the entire proposed duration of the Demonstration. The Variance shown for the entire duration of the demonstration must be non-negative.

As indicated above, spending estimates for Other WOW Categories and Other WW Categories should be entered directly into the Summary tab where indicated.

V. Additional Information to Demonstrate Budget Neutrality

Provide any additional information the State believes is necessary for CMS to complete its analysis of the budget neutrality submission.

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November 17, 2014

Mr. Jeffrey A. Meyers
Director, Intergovernmental Affairs
NH Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301

Re: 1115 Budget Neutrality Projections – New Hampshire Health Protection Program Premium Assistance Program

Dear Jeff:

This letter provides the New Hampshire Department of Health and Human Services (DHHS) with budget neutrality projections for the *New Hampshire Health Protection Program Premium Assistance Program* Section 1115 Demonstration Waiver. This letter includes documentation of the budget neutrality methodology and provides CMS template forms and related worksheets. This information is appropriate for including in the waiver application to CMS.

OVERVIEW OF METHODOLOGY

New Hampshire will maintain budget neutrality over the one-year lifecycle of the *Premium Assistance Program* Section 1115 Demonstration Waiver, with total spending under the waiver not exceeding what the federal government would have spent without the waiver. New Hampshire's budget neutrality methodology includes the following components, resulting in a projected net savings of $12.0 million over the one year demonstration period:

- The "without waiver" projections reflect the current New Hampshire Health Protection Program (NHHPP) Bridge Program capitation rates and enrolled population. The September 2014 – December 2015 Bridge Program capitation rates were adjusted to reflect expected trends and population acuity for calendar year 2016.

- The "with waiver" projections reflect the expected cost of enrolling the Premium Assistance Program population in a qualified health plan (QHP) purchased on the federally facilitated New Hampshire Health Insurance Marketplace. The "with waiver" projections include the cost of the insurance premium, cost sharing subsidies, and wraparound fee-for-service (FFS) Medicaid services.

The rest of this document includes the information requested in the Budget Neutrality Form available at www.medicaid.gov regarding historical expenditure data and projected expenditures. The budget neutrality projections using the CMS template are included as Attachment A of this letter. The budget neutrality worksheet is also provided in Excel format.

HISTORICAL DATA

True historical data is not available for the NHHPP Bridge Program population because it is a newly covered population that began enrollment into Medicaid managed care organizations (MCOs) on September 1, 2014. The data presented in the "Historic Data" tab of the budget neutrality worksheet reflects the following information:

- September 2014 – December 2015 NHHPP Bridge Program capitation rates as documented in our July 7, 2014 report
- The expected impact of pharmacy rebates DHHS will collect on MCO drug expenditures
- An expected enrollment of 45,000 adults
- The demographics of the population enrolled in the NHHPP Bridge Program as of October 2014, summarized Table 1:

Table 1
Summary of NHHPP Bridge Program Enrollment
October 2014

Age Group	Female	Male	Total
19 - 24	2,107	1,796	3,903
25 - 34	3,218	2,127	5,345
35 - 44	2,180	1,506	3,686
45 - 54	1,851	1,586	3,437
55 - 64	1,344	1,136	2,480
Total	**10,700**	**8,151**	**18,851**

BRIDGE PERIOD TO BASE YEAR

The Premium Assistance Program will begin on January 1, 2016. Therefore, the data used for the historical year (calendar year 2015) is the same as the Base Year prior to the first demonstration year (calendar year 2016). Therefore, zero months of aging are used in the "WOW" tab of the budget neutrality worksheet.

WITHOUT-WAIVER PROJECTIONS

We used the following adjustments to project the "without waiver" costs assuming that the NHHPP Bridge Program would continue during calendar year 2016:

- Annual enrollment trend = 0.0%: DHHS expects approximately 45,000 adults to enroll in the Premium Assistance Program. The historical data also reflects 45,000 adults.

- PMPM annual cost trend = 4.0%: The September 2014 – December 2015 NHHPP Bridge Program capitation rates were trended for 14 months at an annual rate of 4.0% to reflect utilization and pharmacy trends. Reimbursement trends for non-pharmacy services are 0% since the NHHPP fee schedule is fixed at 2014 Medicare reimbursement rates.

- Wear-off of adverse selection = -9.1%: We removed the September 2014 – December 2015 NHHPP Bridge Program rating assumption that increased capitation rates by 10% for adverse selection (-9.1% = 1.00 / 1.10 - 1). The impact of adverse selection is expected to resolve prior to 2016.

- Wear-off of pent-up demand = -4.8%: We removed the September 2014 – December 2015 NHHPP Bridge Program rating assumption that increased capitation rates by 5% for pent up demand (-4.8% = 1.00 / 1.05 - 1). The impact of pent up demand is expected to resolve prior to 2016.

- Adjustment for actual medically frail population incidence = 4.4%: The September 2014 – December 2015 NHHPP Bridge Program capitation rates assumed that 10% of the population identified as medically frail and opted into traditional Medicaid coverage. Emerging experience shows that 8% of the population identifies as medically frail. The capitation rates would be 4.4% higher using the 8% medically frail rate.

The net impact of the "without waiver" adjustments is shown as a -5.4% trend adjustment in the "WOW" tab of the budget neutrality worksheet. The projection results in a $705.81 PMPM "without waiver" target.

Attachment B shows the "without waiver" projection in more detail.

BUDGET NEUTRALITY METHODOLOGY

New Hampshire expects to establish a "Per Capita Method" budget neutrality methodology where it will be at risk for the PMPM Cost of individuals under the Demonstration. Under a per capita method, New Hampshire will not be at risk for the number of member months of participation in the Demonstration.

WITH-WAIVER PROJECTIONS

The "with waiver" projections reflect the expected cost of enrolling the Premium Assistance Program population in a QHP purchased on the federally facilitated New Hampshire Health Insurance Marketplace. The "with waiver" projections include the cost of the insurance premium, cost sharing subsidies, and wraparound fee-for-service (FFS) Medicaid services.

We developed the "with waiver" projections using the following information and assumptions. Attachment B shows the development of the projections on a step by step basis.

- We developed an average premium rate for all Silver Plan coverage available on the Health Insurance Marketplace in 2015. Using the healthcare.gov website, we summarized the 2015 non-smoker premium rates offered by five carriers with 16 separate plans. We weighted each plan premium equally to determine the average premium rate by age, and then used the NHHPP Bridge Program demographics from Table 1 calculate the overall average premium rate of $368.15.

- The average tobacco use surcharge was about 20%. We assumed 27% of the Premium Assistance Program population would identify as a tobacco user based on New Hampshire and national tobacco use statistics. The impact of the tobacco use surcharge increases the average premium rate by 5.4% to $388.03.

- We assumed a conservative pricing trend of 10% between 2015 and 2016 based on our commercial market pricing experience, resulting in a 2016 average premium of $426.84.

- We valued the cost sharing subsidies separately for the <100% FPL and 100-138% FPL populations.

  - The <100% FPL population will be enrolled in a 100% actuarial value (AV) plan rather than the 70% Silver Plan cost sharing. We added the expected cost of covering the 30% Silver Plan cost sharing amount.

  - The 100 - 138% FPL population will be enrolled in a 94% AV plan. The proposed 94% AV plan is valued at 95% in the 2015 AV calculator. In addition, DHHS will cover the plan deductible. Therefore, we added the expected cost of covering 27% of the 30% Silver Plan cost sharing amount.

- We increased the average cost of the Health Insurance Marketplace risk pool by 3% to reflect induced utilization resulting from the reduced cost sharing levels under the Premium Assistance Program.

- We increased the average cost of the Health Insurance Marketplace risk pool by 5% to reflect the higher acuity level of the Premium Assistance Program population compared to the 2015 risk pool. While the Premium Assistance Program population is expected to be significantly younger than the current risk pool, they are expected to be slightly less healthy than currently insured members of the same age.

- We expect structural changes to the ACA reinsurance program to increase premiums by 3% from 2015 to 2016.

- We estimated the cost of FFS wraparound services such as non-emergency medical transportation, limited dental services, and EPSDT services for 19 - 20 year olds to be $10 PMPM. We believe this to be a conservatively high estimate.

- We blended our projections for the <100% FPL population (72%) and 100 - 138% FPL population (28%) using the emerging NHHPP Bridge Program enrollment demographics.

The net impact of the "with waiver" projections compared to the "without waiver" projections is shown as a -3.2% adjustment in the "WW" tab of the budget neutrality worksheet. The projection results in a $683.54 PMPM "with waiver" target.

DISPROPORTIONATE SHARE HOSPITAL EXPENDITURE OFFSET

New Hampshire is not proposing to use a reduction in Disproportionate Share Hospital (DSH) claims to offset Demonstration costs in the calculation of budget neutrality.

BUDGET NEUTRALITY WORKSHEET

The budget neutrality projections using the CMS template are included as Attachment A of this letter, which is also provided in Excel format. We customized the CMS template to be consistent with New Hampshire's budget neutrality approach.

Additional support for the projections is shown in Attachment B.

ADDITIONAL INFORMATION TO DEMONSTRATE BUDGET NEUTRALITY

We look forward to working with CMS and New Hampshire to discuss and refine the budget neutrality projections.

CAVEATS AND LIMITATIONS ON USE

This letter is intended for the internal use of the New Hampshire Department of Health and Human Services (DHHS) and it should not be distributed, in whole or in part, to any external party without the prior written permission of Milliman. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party. We understand this letter will be part of New Hampshire's application to CMS.

This letter is designed to provide DHHS with budget neutrality projections for the *New Hampshire Health Protection Program Premium Assistance Program* Section 1115 Demonstration Waiver. This information may not be appropriate, and should not be used, for other purposes.

Actual without-waiver and with-waiver results will vary from estimates due to costs and savings under the demonstration being higher or lower than expected. DHHS should monitor emerging results and take corrective action when necessary.

In preparing this information, we relied on information from DHHS regarding emerging NHHPP Bridge Program experience, projected enrollment, and other information. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

The terms of Milliman's Consulting Services Agreement with DHHS signed on November 16, 2012 apply to this letter and its use.

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Please call Mathieu Doucet or me at (262) 784-2250 if you have any questions.

Sincerely,

[redacted]

John D. Meerschaert
Principal and Consulting Actuary, FSA, MAAA

JDM/vrr

Attachments

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ATTACHMENT A

CMS BUDGET NEUTRALITY WORKSHEET

Attachment A
New Hampshire Health Protection Program
Premium Assistance Program Section 1115 Demonstration Waiver
Budget Neutrality Template

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5	**NHHPP Bridge Program**	**NA**	**NA**	**NA**	**NA**	**CY 2015 (Projected*)**	**Total**
6	**TOTAL EXPENDITURES**	$ -	$ -	$ -	$ -	$ 402,802,986	$ 402,802,986
7	**ELIGIBLE MEMBER MONTHS**	-	-	-	-	540,000	
8	**PMPM COST**	$ -	$ -	$ -	$ -	$ 745.93	
9	**TREND RATES**						**5-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE		NA	NA	NA	NA	NA
12	ELIGIBLE MEMBER MONTHS		NA	NA	NA	NA	NA
13	PMPM COST		NA	NA	NA	NA	NA
47							
48	* Projection based on actual September 2014 - December 2015 NHHPP Bridge Program premium rates and expected enrollment of 45,000 adults.						

Attachment A
New Hampshire Health Protection Program
Premium Assistance Program Section 1115 Demonstration Waiver
Budget Neutrality Template

	A	B	C	D	E	F	G	H	I	J	K
1	DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
2											
3											
4	ELIGIBILITY	TREND	MONTHS	BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
5	GROUP	RATE 1	OF AGING	DY 00	RATE 2	DY 01	DY 02	DY 03	DY 04	DY 05	WOW
6											
7	NHHPP Bridge Program										
8	Pop Type:	Expansion									
9	Eligible Member Months	0.0%	0	540,000	0.0%	540,000	NA	NA	NA	NA	
10	PMPM Cost	0.0%	0	$ 745.93	-5.4%	$ 705.81	NA	NA	NA	NA	
11	Total Expenditure					$ 381,137,400	NA	NA	NA	NA	$ 381,137,400
12											

Attachment A
New Hampshire Health Protection Program
Premium Assistance Program Section 1115 Demonstration Waiver
Budget Neutrality Template

	A	B	C	D	E	F	G	H	I
1	DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS								
2									
3									
4				DEMONSTRATION YEARS (DY)					TOTAL WW
5	ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DY 01	DY 02	DY 03	DY 04	DY 05	
6									
7	NHHPP Premium Assistance Program								
8	Pop Type:	Expansion							
9	Eligible Member Months	540,000	0.0%	540,000	NA	NA	NA	NA	
10									
11	PMPM Cost	$ 745.93	-5.4%	$ 705.81	NA	NA	NA	NA	
12	Adjustment to Reflect Projected 2016 Marketplace Premiums and Other Related Payments			-3.2%	NA	NA	NA	NA	
13	PMPM Cost Under Premium Assistance Program			$ 683.54	NA	NA	NA	NA	
14	Total Expenditure under Premium Assistance Program			$ 369,111,600	NA	NA	NA	NA	$ 369,111,600
15									
16									$ -
17									$ -
18									
19	Total Expenditure			$ 369,111,600	NA	NA	NA	NA	$ 369,111,600
70									
71									
72									
73									
74	NOTES								
75	For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.								

134

Attachment A
New Hampshire Health Protection Program
Premium Assistance Program Section 1115 Demonstration Waiver
Budget Neutrality Template

	A	B	C	D	E	F	G
1	**Panel 1: Historic DSH Claims for the Last Five Fiscal Years:**						
2	RECENT PAST FEDERAL FISCAL YEARS						
3		20__	20__	20__	20__	20__	
4	State DSH Allotment (Federal share)						
5	State DSH Claim Amount (Federal share)						
6	DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -	
7							
8	**Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**						
9	FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS						
10		FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
11	State DSH Allotment (Federal share)						
12	State DSH Claim Amount (Federal share)						
13	DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
14							
15	**Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**						
16	FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS						
17		FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
18	State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
19	State DSH Claim Amount (Federal share)						
20	Maximum DSH Allotment Available for Diversion (Federal share)						
21	Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
22	DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
23	DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
24							
25	**Panel 4: Projected DSH Diversion Allocated to DYs**						
26	DEMONSTRATION YEARS						
27			DY 01	DY 02	DY 03	DY 04	DY 05
28	DSH Diversion to Leading FFY (total computable)						
29	FMAP for Leading FFY						
30							
31	DSH Diversion to Trailing FFY (total computable)						
32	FMAP for Trailing FFY						
33							
34	Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Attachment A
New Hampshire Health Protection Program
Premium Assistance Program Section 1115 Demonstration Waiver
Budget Neutrality Template

	A	B	C	D	E	F	G
1	**Budget Neutrality Summary**						
2							
3	**Without-Waiver Total Expenditures**						
4		DEMONSTRATION YEARS (DY)					TOTAL
5		DY 01	DY 02	DY 03	DY 04	DY 05	
6	**Medicaid Populations**						
7	NHHPP Bridge Program	$ 381,137,400	NA	NA	NA	NA	$ 381,137,400
17							
18	TOTAL	$ 381,137,400	$ -	$ -	$ -	$ -	$ 381,137,400
19							
20	**With-Waiver Total Expenditures**						
21		DEMONSTRATION YEARS (DY)					TOTAL
22		DY 01	DY 02	DY 03	DY 04	DY 05	
23	**Medicaid Populations**						
24	NHHPP Premium Assistance Program	$ 369,111,600	NA	NA	NA	NA	$ 369,111,600
37							
38	TOTAL	$ 369,111,600	$ -	$ -	$ -	$ -	$ 369,111,600
39							
40	VARIANCE	$ 12,025,800	$ -	$ -	$ -	$ -	$ 12,025,800

136

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ATTACHMENT B

DETAILED BUDGET NEUTRALITY PROJECTIONS FOR PREMIUM ASSISTANCE PROGRAM

Attachment B
1115 Waiver Budget Neutrality Projections for Premium Assistance Program

Bridge Program Cost Projection (Without Waiver)	0-138% FPL	Comments
Sept 2014 - Dec 2015 Bridge Program capitation rate	$793.54	Average rate based on emerging Bridge program demographics and July 7, 2014 NHHPP rate report
Impact of expected pharmacy rebates	0.940	Reflects estimated Medicaid drug rebate of 35% collected by DHHS on MCO drug expenditures
Average Bridge Program rate net of pharmacy rebates	$745.93	
Annual trend rate	4%	Reimbursement trend is 0% (fixed at 2014 Medicare fees), therefore utilization and Rx trend only
Trend factor to CY 2016	1.047	Trend period is 14 months (midpoint of Sept 2014 - Dec 2015 rate period to midpoint of CY 2016)
Trended Premium	$780.86	
Wear-off of adverse selection	0.909	Remove 10% adverse selection adjustment from Bridge Program rate calculation
Wear-off of pent-up demand	0.952	Remove 5% pent-up demand adjustment from Bridge Program rate calculation
Adjustment for actual medically frail population	1.044	Actual medically frail identification rate in Bridge Program is 8% compared to rate setting assumption of 10% (still assumes medically frail population acuity is 2.5 x average 0-138% FPL population acuity)
Total "Without Waiver" CY 2016 cost projection (assumes Bridge Program continues)	**$705.81**	

Premium Assistance Program Cost Projection (With Waiver)	<100% FPL	100-138% FPL	Comments
CY 2015 Average Non-Smoker Premium on New Hampshire's Individual Marketplace	368.15	$368.15	Average non-smoker premium rate across all carriers' age-specific rates and Bridge Program population age demographics
Average Tobacco use surcharge	1.20	1.20	Average tobacco use load for all carriers in 2015 New Hampshire individual marketplace
Percent of Premium Assistance Program enrollees identifying as using tobacco	27%	27%	Assume 27% of population identifies as a tobacco user. Assume 18% of the New Hampshire adult population uses tobacco (16-20% depending on the source), and the low income population is about 50% more likely to use tobacco than an average adult (based on National Health Interview Survey, United States, 2005 and 2012).
CY 2015 Average Premium on New Hampshire's Individual Marketplace	388.03	388.03	
Annual pricing trend rate	10%	10%	Conservative commercial market trend factor assumption
Trend factor to CY 2016	1.100	1.100	Trend period is 12 months (midpoint of CY 2015 to midpoint of CY 2016)
Trended premium	$426.84	$426.84	
Actuarial Value	70%	70%	Silver plans reflect an average member cost sharing percentage of 30% (i.e., an actuarial value of 70%)
Actuarial Value of subsidized plan	100%	95%	For 100-138% population benefit, 2015 AV calculator is 95% (in allowable +/- 1% range for 94% AV plan)
Value of cost sharing subsidy	$182.93	$152.44	
Total plan value	$609.77	$579.28	
AV of covering deductible for 100-138% FPL plan	0.0%	2.0%	Estimated value of the 94% AV plan deductible
PMPM to cover deductible for 100-138% FPL plan	$0.00	$12.20	
Total Medicaid payments to carriers	$609.77	$591.47	
Impact of induced utilization by removing cost sharing (impact on total risk pool)	1.030	1.030	Impact of reduced cost sharing on utilization levels
Adjusted plan value	$628.06	$609.22	
Premium assistance population impact on individual marketplace risk pool average acuity	1.050	1.050	Assumes the premium assistance population is 10% "sicker" than the 2015 individual marketplace risk pool (after adjusting for A/G differences), and adding the premium assistance population doubles the size of the risk pool.
Adjusted Premium	$659.46	$639.68	
General commercial pricing changes due to changes in the ACA reinsurance program	1.030	1.030	Based on Milliman's general commercial pricing work
Adjusted Premium	$679.25	$658.87	
Estimate of FFS Medicaid wraparound service cost	$10.00	$10.00	Conservatively high placeholder
"With Waiver" CY 2016 projected cost by FPL group	$689.25	$668.87	
Bridge Program population split by FPL	72%	28%	October 2014 Bridge Program enrollment data
Total "With Waiver" CY 2016 projected cost for Premium Assistance Program		**$683.54**	
Projected Waiver Savings ($ PMPM)		**$22.27**	
Projected Waiver Savings (as a % of "Without Waiver" projection		**3.2%**	