



STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

July 23, 2018

The Honorable Alex M. Azar II
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

Today, the State of New Hampshire is submitting its application to amend and extend Demonstration Project #11-W-00298/1. The State seeks authority to implement changes to the current New Hampshire Health Protection Program (NHPPP) demonstration waiver to create the Granite Advantage Health Care Program (Granite Advantage) to provide coverage to the Medicaid expansion population for the next five years, in accordance with the provisions adopted by the New Hampshire State legislature in Senate Bill (SB) 313 and now enacted in law.

New Hampshire is seeking to amend and extend the current Demonstration to improve New Hampshire's Medicaid expansion program while better integrating cost controls and personal responsibility into the State's Medicaid program. The Granite Advantage program will serve beneficiaries through the State's managed care delivery system rather than the current Premium Assistance Program while continuing recently approved work and community engagement requirements. In addition, the State is seeking authority to eliminate retroactive coverage and to make other changes in accordance with SB 313.

These changes will result in substantial savings for federal taxpayers, while also bringing greater stability to the state's federally-facilitated individual marketplace, which has seen substantial upward rate pressure due to the inclusion of those receiving Medicaid services. At the same time, the robust work and community engagement component will work to lift thousands of Granite Staters towards independence and self-sufficiency.

New Hampshire continuously seeks to identify areas to improve its Medicaid program, ensure sustainability, and further the objectives of Title XIX. The enclosed application reflects input from legislators and stakeholders received during the public comment process in New Hampshire. The State also has submitted or will submit any State Plan Amendments necessary to effectuate the changes outlined in SB 313.

We appreciate the ongoing assistance and cooperation of your Department as we strive to meet the implementation timeline set forth in our legislation. We look forward to working with CMS to accomplish these changes and to your continued support as we implement Granite Advantage.

Sincerely,

A black rectangular box redacting the signature of Christopher T. Sununu.

Christopher T. Sununu
Governor

Section I – Historical Narrative Summary of the Demonstration

Include the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

Introduction

To continue New Hampshire's successful track record of extending coverage to low-income populations, New Hampshire seeks to amend and extend Demonstration Project #11-W-00298/1. Specifically, the State seeks authority to implement changes to the current New Hampshire Health Protection Program (NHHP) demonstration waiver. These changes reflect legislation to create the Granite Advantage Health Care Program (Granite Advantage), which was signed into law by Governor Christopher Sununu on June 29, 2019.¹ (Hereinafter, we refer to Project #11-W-00298/1 as Granite Advantage.)

Granite Advantage would extend New Hampshire's Medicaid expansion program with the objective of improving beneficiary health, while better integrating cost control and personal responsibility into the State's Medicaid program. According to State statute, the New Hampshire Department of Health and Human Services (DHHS) must seek a five-year extension and amendment of its expansion demonstration, implementing the new Granite Advantage program effective January 1, 2019. Enacted legislation further requires the State to obtain approval of the waiver(s) no later than December 1, 2018. If waivers necessary for the program are not approved by that date, the State's Health Commissioner shall immediately notify all program participants that the program will be terminated in accordance with the current waiver STCs.

New Hampshire is seeking the current amendment and extension to sustain and improve its Medicaid expansion for low-income adults, retaining health coverage for the expansion population while reducing uncompensated care, better combatting the opioid and substance abuse crisis, and improving the State's workforce while promoting personal responsibility. The primary features of the Granite Advantage follow; some of these features require federal approval, others can be implemented without additional authority and are therefore described in this document to provide a comprehensive overview of Granite Advantage. Program features that do not require federal authority are not reflected in the federal waiver requests included in Section III.

- **Work and Community Engagement Requirements Extension:** In May, CMS authorized New Hampshire to implement work and community engagement requirements

¹ New Hampshire State Legislature. *An act reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds*. Senate Bill 313. 2018 Reg. Sess. (May 23, 2018), https://www.gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&id=1972&txtFormat=pdf&v=current.

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beginning on January 1, 2019.² The Granite Advantage amendment and extension seeks to extend this authority for the five-year waiver extension period, with modest changes to more fully align the CMS-approved waiver STCs with State legislation.

- **Delivery System Changes:** The current NHHPP demonstration will sunset on December 31, 2018 and individuals who currently receive premium assistance—through the NHHPP Premium Assistance Program (PAP) for Marketplace coverage offered through qualified health plans (QHPs)—will transition to the Granite Advantage program, which will be delivered through the State’s Medicaid managed care delivery system. New Hampshire is submitting a State Plan Amendment to effectuate mandatory enrollment of the expansion adult population into Medicaid managed care.³ Starting on January 1, 2019 the State will transition NHHPP PAP enrollees into currently contracted Medicaid managed care organizations (MCOs). In conjunction with the newly enacted legislation, New Hampshire is undertaking a Statewide re-procurement of its Medicaid managed care contracts to ensure that the vision described in this demonstration amendment and extension, as well as the State’s broader delivery system and reform goals, can be fully and successfully realized. These new contracts will begin on July 1, 2019.
- **Healthy Behaviors and Cost Effectiveness:** DHHS will include new healthy behavior and cost effectiveness provisions in its Medicaid managed care program to promote personal responsibility among Medicaid beneficiaries through the use of incentives, loss of incentives, and case management. MCO contracts will include clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program.
- **Benefit Changes:** Because all Medicaid beneficiaries will receive care through the same managed care delivery system, it will be most efficient to provide the same benefit package to all Medicaid beneficiaries. Therefore, the State is updating its Alternative Benefit Plan (ABP, described in more detail below) to align benefits for the adult Medicaid expansion population with State Plan benefits, effective January 1, 2019.
- **Retroactive Coverage:** New Hampshire seeks to amend and extend its current, waiver of the requirement to provide three months retroactive coverage to expansion adults. If granted, New Hampshire will not provide coverage to expansion adults prior to the date of application, without the prior waiver conditions imposed by CMS.

² CMS, Amendment to NHHPP Demonstration, Project Number 11-W-00298/1.

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf>.

³ New Hampshire’s State Plan currently authorizes mandatory managed care enrollment for medically frail expansion adults who are exempt from PAP; the State will update its State Plan to mandatorily enroll all members of expansion adults in managed care. In addition, since its September 1, 2015 CMS approval, New Hampshire also uses a 1915(b) waiver as the vehicle for implementing mandatory managed care for other populations not reflected in the State Plan. The 1915(b) waiver was most recently extended in March 2018.

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- **Presumptive Eligibility Authority for Corrections:** The State will submit a State Plan Amendment to allow State and county correctional facilities to conduct presumptive eligibility determinations for inmates.
- **Citizenship and Residency Documentation:** The State is requesting authority, if allowed by federal law, to make eligibility for Granite Advantage contingent upon applicants verifying United States citizenship with two forms of paper identification, and New Hampshire residency with either a New Hampshire driver's license or a non-driver's picture identification card.
- **Asset Test:** The State is requesting authority, if allowed by federal law, to consider applicant or beneficiary assets in determining eligibility for the Granite Advantage program such that individuals with countable assets in excess of \$25,000 would not be eligible for the program.
- **Other Eligibility Policy Changes:** The State will require beneficiaries to: provide all necessary information regarding financial eligibility, insurance coverage, and assets, residency, citizenship or immigration status (to the extent CMS approves these new eligibility requirements) to DHHS in compliance with DHHS rules; inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and at the time of enrollment, acknowledge that the program is subject to cancellation upon notice.
- **Prohibition of National Instant Criminal Background Check System Submission:** Per State statute, "no person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney."

All of these program features are described in more detail below.

History of New Hampshire's Expansion Demonstration

On March 27, 2014, the bipartisan Senate Bill 413, "an act relative to health insurance coverage," establishing the NHHPP to expand Medicaid coverage in New Hampshire to adults with incomes up to 133% of the federal poverty level was signed into law by then-Governor Maggie Hassan.⁴

The NHHPP instituted:

- (1) A mandatory Health Insurance Premium Payment (HIPP) Program for individuals with

⁴ 2014 New Hampshire Laws, Chapter 3. While the Patient Protection and Affordable Care Act expands coverage to 133% of the federal poverty level, it otherwise establishes a 5% disregard for program eligibility, which extends coverage to those persons up to 138% of the federal poverty level.

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access to cost-effective employer-sponsored insurance;⁵

- (2) A temporary bridge to the premium assistance program to cover the expansion adult group in Medicaid managed care plans through December 31, 2015; and
- (3) A mandatory individual QHP premium assistance program beginning on January 1, 2016.

The PAP was designed to reduce coverage disruption for individuals moving between Medicaid and the Marketplace due to changes in income, offer comparable provider access, enable higher provider payments for covered services to support access, encourage plan participation in both the Medicaid and commercial markets, and achieve cost reductions as a result of greater competition.

On March 4, 2015, CMS approved New Hampshire's application for a one-year Section 1115(a) Medicaid Research and Demonstration Waiver entitled, "New Hampshire Health Protection Program (NHHPP) Premium Assistance" (Project Number 11-W-00298/1), to implement the premium assistance program. The demonstration became effective on January 1, 2016 and its continuation was reauthorized by the New Hampshire Legislature on April 5, 2016. The program is authorized to continue coverage of expansion adults through December 31, 2018.

On June 28, 2017, Governor Sununu signed House Bill 517, the trailer bill to the State's biennial budget for State Fiscal Year 2018-2019, effective July 1, 2017.⁶ House Bill 517 included a provision that required the State to seek a waiver or State Plan amendment from CMS to establish certain work and community engagement requirements as conditions of eligibility in the NHHPP. The legislation, as later amended, directed that any such waiver or State Plan amendment must be in place by June 30, 2018. Pursuant to this statute, on October 24, 2017, after soliciting statewide public comment, New Hampshire submitted an application to CMS to amend the NHHPP demonstration in order to promote work and community engagement opportunities for NHHPP participants. The amendment request sought CMS approval to condition Medicaid eligibility for certain expansion adults on their completion of a minimum number of hours of employment, training, education, or community service activities per month. CMS approved this amendment on May 7, 2018 and Granite Advantage will extend and continue the approved provisions. This extension requests modest revisions to the approved amendment, which are outlined in Section II of this application in the 'Work and Community Engagement' subsection.

As noted, on June 29, 2018 Governor Sununu signed Senate Bill 313, which – in addition to directing that the Medicaid adult group be transitioned from PAP to the new Granite Advantage program – also updates and modifies the previously enacted work and community engagement

⁵ The mandatory nature of applying for HIPP was repealed through a budget bill in September of 2015. Voluntary HIPP participants continue to be excluded from the demonstration.

⁶ 2017 New Hampshire Laws, Chapter 156.

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requirements. The Senate Bill outlines the following program requirements:⁷

“Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

- (1) Unsubsidized employment including by nonprofit organizations.
- (2) Subsidized private sector employment.
- (3) Subsidized public sector employment.
- (4) On-the-job training.
- (5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.
- (6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.
- (7) Vocational educational training not to exceed 12 months with respect to any individual.
- (8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.
- (9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.
- (10) Community service or public service.
- (11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.
- (12) Participation in substance use disorder treatment.

“If an individual in a family receiving benefits under this paragraph fails to comply with the work or community engagement activities required in accordance with this paragraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination... An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

⁷ New Hampshire State Legislature. *An act reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds*. Senate Bill 313. 2018 Reg. Sess. (May 23, 2018), https://www.gencourt.state.nh.us/bill_status/billText.aspx?sy=2018&id=1972&txtFormat=pdf&v=current.

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- (1) The beneficiary experiences the birth or death of a family member living with the beneficiary.
- (2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.
- (3) The beneficiary has a family emergency or other life-changing event such as divorce.
- (4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.
- (5) The beneficiary is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the commissioner on a monthly basis, is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor.”

As described by Senate Bill 313, work and community engagement requirements “shall only apply to those considered able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act” and the following individuals are exempt:⁸

- (1) A person who is unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed alcohol and drug counselor (LADC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.
- (2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.
- (3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.
- (4) A custodial parent or caretaker of a dependent child under 6 years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker in the case of a 2-parent household.
- (5) Pregnant women.
- (6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection

⁸ Ibid.

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and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

- (7) Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.
- (8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

DHHS is currently drafting regulations to implement the program in accordance with the enacted legislation.

Overview of Preliminary Results of New Hampshire's Expansion Demonstration

As of June 1, 2018, the NHHPP provided coverage to approximately 53,000 Granite Staters—approximately 44,000 of whom are part of the NHHPP PAP waiver. Three commercial insurance carriers offering QHP coverage in New Hampshire's federally facilitated Marketplace provide coverage to PAP participants upon plan selection: Ambetter from NH Healthy Families, Anthem BlueCross BlueShield of New Hampshire, and Harvard Pilgrim Health Care.⁹ Approximately 9,000 beneficiaries—those who are medically frail or who can otherwise opt out of PAP—upon plan selection were served by the State's two Medicaid MCOs: NH Healthy Families and WellSense Health Plan. In all, the NHHPP eligibility group is overwhelming young, with 49% of beneficiaries under 35 years of age and 68% under 45 years of age. 52% of NHHPP beneficiaries are female and 48% are male.¹⁰

To evaluate enrollment and quality under the demonstration, New Hampshire conducts PAP waiver monitoring in accordance with the demonstration STCs with CMS and agreements with the QHPs. This monitoring involves regular reviews of beneficiary enrollment data, appeals data, QHP encounter data, and utilization trends for beneficiaries accessing services for substance use disorders. To date, New Hampshire's PAP waiver monitoring has found steady enrollment growth under the demonstration and strong access to a variety of substance use disorder services.

⁹ DHHS, New Hampshire Health Protection Program Demographic Profile, 6/1/18, <https://www.dhhs.nh.gov/ombp/pap/documents/nhhpp-enroll-demo-060118.pdf>.

¹⁰ Ibid.

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New Hampshire also prepared and submitted an Interim Evaluation Report to CMS on March 30, 2018 for the demonstration. The primary conclusive finding from the evaluation was that PAP was found to be more costly than the State's Medicaid Care Management program. Following CMS comments on the report, New Hampshire is finalizing a follow-up analysis to compare the health outcomes of the two programs. The Interim Evaluation Report is included as Appendix D.

Demonstration Features

The following section provides an overview of features of the existing demonstration and notes how the State will approach each of these features under the new Granite Advantage program.

Demonstration Eligibility

a) Eligibility Criteria

Individuals in the expansion adult group are eligible for Medicaid coverage through New Hampshire's State Plan, which adopts coverage of the eligibility group described in Social Security Act §1902(a)(10)(A)(i)(VIII). The current demonstration defines the delivery system for most—but not all—expansion adults, including individuals eligible through the ACA who are:

- 19-64 years old;
- Not entitled to or enrolled in Medicare;
- Not in any other mandatory Medicaid eligibility group;
- Not pregnant at time of eligibility determination; and
- Required to participate in PAP.

Individuals who are medically frail or are enrolled in cost-effective employer-sponsored insurance (ESI) are excluded from PAP participation. American Indian/Alaska Natives may opt out of PAP.

Granite Advantage will not alter State Plan eligibility. The key difference with Granite Advantage, compared to the NHHPP, is that *all* individuals in the expansion adult group—including medically frail individuals—will now receive services through Granite Advantage unless they have access to affordable employer coverage and participate in HIPP. Individuals who are medically frail and currently receive coverage through the State's managed care program will no longer be exempted from the demonstration, but will continue to be exempted from work and community engagement requirements, as noted below. American Indian/Alaska Natives are included in the demonstration population and will be mandatorily enrolled in managed care, in accordance with the State's 1915(b) waiver terms.

Granite Advantage also will include new eligibility and enrollment policies that are unique to the expansion population; some of these features require federal waivers, others do not.

- **Retroactive Coverage:** New Hampshire seeks to amend and extend its current, waiver of the requirement to provide three months retroactive coverage to expansion adults. If

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granted, New Hampshire will not provide coverage to expansion adults prior to the date of application, without the prior waiver conditions imposed by CMS.

- **Presumptive Eligibility Authority for Corrections:** The State will submit a State Plan Amendment to allow State and county correctional facilities to conduct presumptive eligibility determinations for inmates.
- **Citizenship and Residency Documentation:** The State is requesting authority, if allowed by federal law, to make eligibility for Granite Advantage contingent upon applicants verifying United States citizenship with two forms of paper identification, and New Hampshire residency with either a New Hampshire driver's license or a non-driver's picture identification card.
- **Asset Test:** The State is requesting authority, if allowed by federal law, to consider applicant or beneficiary assets in determining eligibility for the Granite Advantage program such that individuals with countable assets in excess of \$25,000 would not be eligible for the program.
- **Other Eligibility Policy Changes:** The State will require beneficiaries to provide all necessary information regarding financial eligibility, insurance coverage, and assets, residency, citizenship or immigration status (to the extent CMS approves these new eligibility requirements) to DHHS in compliance with DHHS rules; inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and at the time of enrollment, acknowledge that the program is subject to cancellation upon notice.
- **Prohibition of National Instant Criminal Background Check System Submission:** Per state statute, "no person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney."

b) Demonstration Enrollment Data

As noted above, the NHHPP demonstration currently provides coverage to 53,000 individuals. The State estimates that enrollment in Granite Advantage will not change materially over the course of the five-year extension period, with enrollment remaining near current levels. Precise enrollment estimates are difficult to predict as features of the waiver change.

The Granite Advantage-eligible population is expected grow over the course of the five-year extension due to population growth, but enrollment in the program could be impacted by several other features. First, the delivery system transformation from the PAP to Medicaid managed care could have an impact on enrollment. Second, enrollment could decline as more beneficiaries seek and find employment and leave the program as their earnings increase. As the State implements newly approved work and community engagement requirements, it will

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undertake active outreach to beneficiaries and partner with community stakeholders to ensure that beneficiaries understand program requirements and do not lose coverage as a result of noncompliance. Another factor influencing enrollment projections is the extent to which the retroactive coverage waiver that New Hampshire is seeking could help reduce churn and encourage beneficiaries to maintain coverage so that they do not face uncompensated care costs during gaps in coverage. The magnitude of these changes is uncertain; New Hampshire will actively monitor enrollment over the course of the demonstration.

Delivery System

The NHHPP demonstration delivery system involves individuals receiving premium assistance from the State to enroll in QHP coverage from the Marketplace, with some services provided through fee-for-service Medicaid. Eligible individuals have a choice between at least two QHPs on the Marketplace and must receive services from providers in their QHP's network. For Medicaid benefits not covered in the QHP, the State provides wrap-around services through its fee-for-service delivery system. (Individuals also receive fee-for-service coverage between their Medicaid eligibility start date and their QHP coverage effectuation date.) In addition, the State offers premium assistance to expansion adults with access to employer-sponsored insurance through the State's HIPP program, which is not part of the NHHPP waiver.

In the future, the Granite Advantage demonstration will provide coverage through Medicaid MCOs and expansion adults will be mandatorily enrolled in MCOs pursuant to authority in the State Plan and, for relevant populations, the State's recently renewed 1915(b) waiver. There will not be any changes to the voluntary employer-sponsored insurance premium assistance program.

New Hampshire will transition beneficiaries to managed care through a two-phased process. In phase one, starting January 1, 2019 (the legislatively mandated start date of the demonstration), the State will auto-assign beneficiaries to its current MCOs and allow beneficiaries to change their MCO without cause within 90 days of auto-assignment. The auto-assignment methodology will take into account existing MCO and provider relationships. This will help address continuity of care and minimize disruptions in coverage for individuals in active treatment for serious conditions and life threatening diseases. Providers will continue to be paid during the transition and the State will communicate to all QHPs and MCOs the importance of ensuring payment to providers is not interrupted as a result of this transition.

In Phase 2, starting July 1, 2019, when the State's new MCO contracts begin, the State will transition beneficiaries to its new MCO contractors—again, using auto-assignment with opportunity for MCO selection within 90 days.

Benefits

Beneficiaries receiving services through the current demonstration receive an Alternative Benefit Plan (ABP) that is provided by a QHP, with fee-for-service Medicaid covering wrap-around benefits not covered by the QHP. These wrap-around benefits include non-emergency

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medical transportation (NEMT), Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), family planning services and supplies, limited adult dental services, and limited adult vision services. While the ABP aligns fairly closely with the State Plan benefits, it does not include long-term care services and supports as the State Plan does. The ABP includes the ten Essential Health Benefits (ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care), some of which are not included in the State Plan.

In conjunction with implementing Granite Advantage, the State will align its ABP for the expansion adult group to the State Plan so that all Medicaid adults will receive the same set of benefits. Expansion adults therefore will be eligible for long-term care services and supports if they meet functional assessment requirements; additional services will be added to the State Plan to the extent that the State Plan does not currently reflect all Essential Health Benefits. Such alignment will reduce administrative burden by streamlining benefit administration for the State's Medicaid MCOs. In addition, because benefits will be aligned between the ABP and the State Plan, New Hampshire will no longer be give medically frail expansion adults the option of selecting between ABP and State Plan benefits; nonetheless, New Hampshire will continue to identify medically frail individuals for purposes of exempting them from work and community engagement requirements.

Premiums and Cost Sharing

NHHPP beneficiaries are not currently subject to premiums but NHHPP enrollees with income greater than 100% of the federal poverty level are subject to cost sharing requirements at the maximum permitted Medicaid cost sharing levels. NHHPP beneficiaries are also subject to limited pharmaceutical cost-sharing that is equivalent to pharmaceutical cost-sharing outside the demonstration.

New Hampshire proposes to discontinue the current cost sharing schedule for expansion adults with incomes over 100% of the federal poverty level. Instead, Granite Advantage will adopt the State Plan co-payment schedule, as amended by the State, which currently applies only to pharmaceuticals, aligning nominal cost sharing requirements across the Medicaid population (except for those exempted from any cost sharing). American Indians/Alaska Natives receiving services from an Indian health care provider will remain exempt from co-payments.

Healthy Behaviors and Cost Effectiveness

As directed by the Granite Advantage legislation, New Hampshire will include new healthy behavior and cost effectiveness provisions in its Medicaid managed care program to promote personal responsibility among Medicaid beneficiaries. Through its new MCO contracts, the State will implement both MCO-level and member-level incentives to promote personal responsibility, reduce inappropriate use of care, and lower managed care health care costs. No waivers are being requested to effectuate these changes.

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Work and Community Engagement Requirements

On May 7, 2018 CMS approved New Hampshire's request to amend its NHHPP waiver to implement work and community engagement requirements for Medicaid expansion adults, with a start date of January 1, 2019. New Hampshire is currently drafting rules to implement the program, consistent with Senate Bill 313. New Hampshire proposes to continue and extend these requirements through Granite Advantage throughout the renewal period.

New Hampshire's work and community engagement requirements will apply to certain expansion adults under §1902(a)(10)(A)(i)(VIII).¹¹ Per the approved STCs, key features of the State's newly approved work and community engagement requirements include:

- **Hours Requirement.** Individuals not excluded or exempt from the requirements must participate for at least 100 hours per calendar month in one or more community engagement activities and attest compliance using any of the options by which individuals may apply for Medicaid (e.g., by internet, telephone, mail, in person, or through other commonly available electronic means). Individuals may also be required to provide appropriate supporting documentation when requested by the State.
- **Exemptions.** Exempt individuals include beneficiaries who are: medically frail; pregnant or 60 days or less post-partum; parents or caretakers where care is considered necessary by a licensed provider; custodial parents or caretaker of a dependent child under six years of age;¹² parents or caretakers of a dependent child of any age with a disability; temporarily unable to participate due to illness or incapacity, documented by a licensed provider; participating in a state-certified drug court program; disabled and unable to meet the requirement for reasons related to that disability or unable to meet the requirement due to the disability of an immediate family member in the home; experiencing hospitalization or serious illness or have an immediate family member in the home who is experiencing hospitalization or serious illness; exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; or enrolled in New Hampshire's voluntary HIPP program.
- **Qualifying Activities.** As described in more detail in the approved STCs, qualifying activities include, but are not limited to: employment (unsubsidized or subsidized); training (on-the-job training, job skills training related to employment, job search and readiness assistance, or vocational educational training); education (enrollment at an accredited community college, college or university, or—for beneficiaries who have not received a high school diploma or certificate of high school equivalency—education

¹¹ CMS, Amendment to NHHPP Demonstration, Project Number 11-W-00298/1. Accessed 7 May 2018. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf>.

¹² This parent/caretaker exemption shall only apply to one parent or caretaker in the case of a two-parent household.

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directly related to employment or attendance at a secondary school or in a course of study leading to a certificate of general equivalence); community service and public service; participation in substance use disorder treatment; caregiving services for a non-dependent relative or other person with a disabling health, mental health, or developmental condition; and participation in SNAP and/or TANF employment initiatives.

- **Penalties for Non-Compliance and Opportunities to Cure.** Non-exempt beneficiaries who fail to complete at least 100 hours of these activities per month will have their eligibility suspended, unless the beneficiary obtains a “good cause exemption” within an allotted time period or appeals the suspension prior to its effective date.¹³ Beneficiaries who are identified as non-compliant will be given 30 days to “cure” their non-compliance (through satisfying the work and community engagement requirement, demonstrating an exemption, or obtaining a good cause exemption). If non-compliance is not “cured” during the 30-day cure period, the State will suspend the beneficiaries’ eligibility.
- **Reactivation of Coverage.** Beneficiaries whose eligibility is suspended as a result of non-compliance with work and community engagement requirements may re-enroll at any time prior to their termination date and will not need to complete another application. The State will reactivate eligibility if beneficiaries demonstrate that they have cured the deficient hours for the one month that caused the suspension.

As is customary, the approved STCs do not include all of the details included in the Granite Advantage authorizing legislation. New Hampshire therefore will promulgate state rules to ensure that the state implements the waiver in a manner consistent with the enacted legislation. The rules will go through standard public notice processes and the State will consider public comments on the regulations before they are finalized. As described in Section II, New Hampshire also is requesting several changes to align the approved STCs with recently enacted State legislation.

The State will work collaboratively with its contracted MCOs to monitor work and community engagement qualifying activities, exemptions, and enrollee status, including through MCO collection of enrollee-reported information, State verification of enrollee- and MCO-reported information, and over time, a State-developed automated verification system.

¹³ According to the STCs, good cause exemptions include, but are not limited to: the birth or death of a family member living with the beneficiary; severe inclement weather (e.g., a natural disaster) causing the beneficiary to be unable to meet the requirement; a family emergency or other life-changing event (e.g., divorce or domestic violence)); disability-related reasons (having a disability as defined by the ADA, Section 504 of the Rehabilitation Act, or Section 1557 of the ACA and being unable to meet the requirement for reasons related to that disability but was not exempted from community engagement requirements), having an immediate family member in the home with a disability and being unable to meet the requirement for reasons related to that disability, or being hospitalized or having a serious illness, or having an immediate family member living in the home who is hospitalized or has a serious illness); and other good cause exemptions defined or approved by the State.

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The State will also establish a pilot program, called Granite Workforce, to provide subsidies to employers in high-need areas, as determined by the State Department of Employment Security based upon workforce shortages, and to create a network of assistance to remove barriers to work for Granite Advantage participants. This initial implementation period for this program will be January 1, 2019 to June 30, 2019—the first six months of implementation of work and community engagement requirements.

As requested by this amendment and extension, New Hampshire's approved work and community engagement STCs, as amended, will continue to apply to the Granite Advantage expansion adults throughout the requested waiver extension period, through 2023.

Section II – Changes Requested to the Demonstration

If changes are requested, include a narrative of the changes being requested along with the objective of the change and the desired outcomes.

New Hampshire plans to implement the following changes to its current demonstration, which standardize services and delivery systems across the State's Medicaid program, reduce administrative costs, ensure good stewardship of public resources, and incentivize beneficiary personal responsibility in improving health outcomes. Most of these changes do not require CMS waiver authority but are described below to provide a comprehensive overview of the new Granite Advantage Health Care Program as authorized by State statute. New Hampshire will pursue state plan changes in some cases.

Change from a Premium Assistance Program to a Managed Care Delivery System

Starting on January 1, 2019, New Hampshire will discontinue its NHHPP premium assistance program; expansion adults who had previously received coverage from QHPs will be transitioned to Medicaid MCOs. As a result, New Hampshire is not requesting the extension of various authorities included in its current waiver that were necessary to operate NHHPP (e.g., expenditure authority for premium assistance and cost-sharing reduction payments, inapplicability of cost effectiveness requirements, and waiver of freedom of choice and provider payment rules needed to provide coverage through QHPs).

New Hampshire currently procures services for its non-expansion Medicaid beneficiaries and for medically frail expansion adults through its managed care program, called New Hampshire Medicaid Care Management (MCM). New Hampshire's State Plan currently authorizes mandatory managed care enrollment for medically frail members of the expansion population who are exempt from the demonstration; the State will update its State Plan to mandatorily enroll all expansion adults in managed care. In addition, since its September 1, 2015 CMS approval, New Hampshire also uses a 1915(b) waiver as the vehicle for implementing mandatory managed care for other populations not reflected in the State Plan. CMS approved

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the latest 1915(b) extension in March, 2018. Granite Advantage will expand and build on this mandatory managed care infrastructure.

The State will use auto-assignment methodologies to enroll current PAP beneficiaries in one of the existing MCOs for coverage effective January 1, 2019. Affected individuals will receive a notice indicating that they have a 90-day period to select a different plan following auto-assignment, if they choose. The State will work to ensure that any person transitioning from PAP to Granite Advantage shall not lose coverage due solely to the transition. MCOs shall honor all pre-existing authorizations for care plans and treatments for all program participants for a period of no less than 90 days after enrollment in the MCO.

The movement of approximately 40,000 beneficiaries from QHP coverage to MCO coverage will streamline the administration of beneficiary services and reduce administrative costs for the State. Given that medically frail individuals and other beneficiaries who can opt out of premium assistance currently receive services through managed care, transitioning all expansion adults to MCOs will allow the State to use one primary delivery system for its Medicaid beneficiaries (managed care, with fee-for-service for a small minority permitted to opt out of managed care). Adding 40,000 covered lives to managed care will also help attract additional plans to serve the State's Medicaid program and help MCO contractors build scale to achieve administrative savings, particularly as they implement State healthy behavior and cost effectiveness initiatives.

Align ABP with State Plan Benefits

To achieve further standardization across Medicaid beneficiaries, the State will align its ABP benefits with its State Plan benefits. The expansion population currently receives benefits under the State's ABP, which are similar, though not identical, to the State Plan benefit package. Going forward, all Medicaid adults will receive the same set of benefits—including Essential Health Benefits as well as medically necessary services required under the Medicaid State Plan. Additional services will be added to the State Plan to the extent that the State Plan does not currently reflect all Essential Health Benefits and, in two cases, the state will substitute existing state plan services that the State's actuary has determined are actuarially equivalent to Essential Health Benefits that would otherwise be required. Eyeglasses will replace chiropractic services and adult medical day care will replace diabetic education and nutrition therapy.

Once the ABP and the State Plan are fully aligned, the State will provide the same benefits for all Medicaid adults, including for LTSS, home health services, drug formularies, optometry services, and SUD services. All benefits will be provided through the State's Medicaid managed care plans unless the benefit is "carved out" of managed care; "carved out" benefits, such as LTSS, will be provided through Medicaid fee-for-service. Aligning the ABP with the State Plan will reduce the administrative complexity of having slightly different sets of benefits for populations served by the same delivery system. In addition, the State is currently re-procuring its managed care program, so the timing for such a change is appropriate.

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Align Cost Sharing Requirements

New Hampshire's current waiver enables the State to vary cost sharing requirements for individuals with incomes above 100% of the federal poverty level who participate in the NHHPP Premium Assistance demonstration and are not determined to be medically frail and exempt from cost sharing to which they would otherwise be subject under the State Plan. New Hampshire is not requesting an extension of this comparability waiver.

Instead, New Hampshire will update its State Plan cost sharing authority to align cost sharing for individuals in the expansion group over 100% of federal poverty level with that of the rest of the Medicaid population (which includes co-payments for pharmaceuticals). Since the expansion and non-expansion populations will be in the same delivery system, standardizing cost sharing requirements across beneficiary groups will increase administrative efficiency in the program. Absent different cost sharing schedules to administer, MCO administrative costs should also decrease.

Incentivize Healthy Behaviors and Cost Effectiveness Policies for MCOs and Individuals

The Granite Advantage program will promote personal responsibility and make coverage available in a cost-effective manner. To promote personal responsibility, MCO contracts will include clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. Initial areas may include but are not limited to:

- Appropriate use of emergency departments relative to low acuity non-emergent visits;
- Reduction in preventable admissions and 30-day hospital readmission for all causes;
- Timeliness of prenatal care and reductions in neonatal abstinence births;
- Timeliness of follow-up after a mental illness or substance use disorders admissions; and
- Reduction of polypharmacy resulting in drug interaction harm.

In addition, MCOs will provide case management to the greatest extent practicable and make wellness visits available to beneficiaries. For eligible beneficiaries, the MCO will support the individual in arranging a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care physicians. The wellness visit will include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

Cost effectiveness will be achieved by MCOs deploying reference-based pricing and cost transparency initiatives, as well as offering incentives (cash or other types of incentives) to beneficiaries choosing high-value, lower cost medical care. To improve performance in cost effectiveness, the State may also implement preferential auto-assignment of expansion adults, shared incentive pools, and/or differential capitation rates. In addition, the State's managed care contracts will require MCOs to implement provider alignment incentives so that the combined efforts of MCOs and their network providers can help increase cost effectiveness.

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MCOs that fail to implement contractually agreed upon incentive programs may be subject to rebate requirements, as directed by the recently enacted State legislation.

Waive Retroactive Coverage Requirement

To better align with commercial health insurance coverage policies, and in light of the broad availability of subsidized coverage options in the State following the implementation of the Affordable Care Act (ACA), New Hampshire seeks to amend and extend its current, limited waiver of the requirement to provide three months retroactive coverage to expansion adults. CMS previously granted New Hampshire permission to conditionally waive retroactive coverage; the State is now seeking to remove the conditionality to support its ongoing efforts to align Medicaid and private market coverage. Expansion adults will become eligible for coverage under Title XIX at the time of application; eligibility will be effective no earlier than the date of application. In addition, the Granite Advantage demonstration will enable the State to test whether eliminating retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy, without increasing the rate of churn in and out of the program. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, with the ultimate objective of improving beneficiary health. Notably, New Hampshire already has a high rate of insurance; since the Medicaid expansion was implemented, the uninsured rate has decreased from 10.7% in 2013 to 5.9% in 2016. The national uninsured rate in 2016 was 8.6%.¹⁴

Recognizing that a retroactive coverage waiver could lead to coverage disruptions and increased costs for the State, New Hampshire also will seek authority to allow State and county correctional facilities to conduct presumptive eligibility determinations for inmates.

Extend Approved Work and Community Engagement Requirements Waivers and Authorities

On May 7, 2018, CMS granted New Hampshire authority to implement a work and community engagement requirement as a condition of Medicaid eligibility for expansion adults who are not otherwise subject to an exemption, per State legislation and federal requirements. This authority allows New Hampshire to suspend or terminate the coverage of non-exempt beneficiaries who do not complete 100 hours of work and community engagement activities per calendar month. Under the new work and community engagement program, the State will test whether requiring participation in work and community engagement activities as a condition of eligibility, as detailed below, will lead to improved health outcomes and greater independence through improved health and wellness.

¹⁴ New Hampshire Health Insurance Department, Final Report of the 2016 Health Care Premium and Claim Cost Drivers (December 1, 2017), available at: <https://www.nh.gov/insurance/reports/documents/nhid-2016-medical-cost-drivers-final-report.pdf>.

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As part of the Granite Advantage amendment and extension, the State is requesting approval to extend the work and community engagement authority through December 31, 2023, so that it can test and evaluate the impact of these requirements, as described in the recently approved amendment. The State is not requesting any changes to the waivers of statutory authority granted as part of the May 7, 2018 amendment, but is requesting the following changes to the STCs to align with Senate Bill 313:

- Limit the exemption for beneficiaries who are a parent or caretaker of a dependent child (of any age) with a disability to apply only to one parent or caretaker in the case of a 2-parent household.
- Revise qualifying activities to clarify that only enrollment at a community college, college or university in New Hampshire counts as a qualifying educational activity.
- Revise the list of enumerated good cause exemptions to include a beneficiary who is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the commissioner on a monthly basis, is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor.

Standardize Prior Authorization Across the Medicaid Program

The State currently has authority to waive §1902(a)(54) of the Social Security Act to permit New Hampshire to respond to prior authorization requests within 72—rather than 24—hours. This request was granted in recognition of standard practices by the QHPs delivering services to the NHPPP population. As the State migrates the expansion adults back to the Medicaid managed care delivery system that serves the majority of the State’s Medicaid population, eliminating this waiver will standardize program delivery and administration.

Require Documentation of Citizenship and Residency to Determine Eligibility

New Hampshire seeks federal authority to require Medicaid expansion adult applicants to verify (1) United States citizenship with two forms of paper identification, and (2) New Hampshire residency with either a New Hampshire driver’s license or a non-driver’s picture identification card. As specified in state legislation, if the State’s request is approved, individuals would not be eligible to enroll or participate in Granite Advantage unless they satisfy this requirement. Adding citizenship documentation requirements will allow New Hampshire to test whether requiring documentation will improve the accuracy of Medicaid eligibility decisions.

The State’s infrastructure and approach to implementation will be monitored so as not to cause excessive burden to applicants or unreasonable delays in eligibility determinations. The State will monitor eligibility determination timeframes to ensure that there is minimal inappropriate impact on participants and will also analyze data to report out any significant delays in eligibility processing or declines in enrollment after the enactment of this requirement.

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Apply an Asset Test to the Expansion Population

Under current federal law, individuals eligible for Medicaid as expansion adults described in §1902(a)(10)(A)(i)(VIII) have their income determined using Modified Adjusted Gross Income (MAGI) income methodologies, which explicitly prohibit resource or asset tests. New Hampshire seeks authority to consider applicant or beneficiary assets in determining eligibility for the Granite Advantage program in accordance with State legislation, though the State understands that this provision currently is not waivable under federal law. If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual resides, furniture, and one vehicle owned by the individual applying for benefits would be excluded. If the total countable resources equal or fall below \$25,000, individuals would be considered asset eligible. Requiring an asset test would help the State preserve Medicaid funding for the lowest income, most vulnerable beneficiaries in the State.

Section III – Requested Waivers and Expenditure Authorities

A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

Table 1. New Hampshire Waiver and Expenditure Authority Requests

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver Request?
§1902(a)(34) Retroactive eligibility	To permit the State to provide coverage to Granite Advantage applicants beginning on the date of the application; coverage would be effective no earlier than the date of application.	The waiver authority will allow the State to align the beginning of Medicaid coverage with the date of application.	Modified
§1902(a)(8) and §1902(a)(10) Provision of Medical Assistance	To the extent necessary to enable New Hampshire to suspend or terminate eligibility for, and not make medical assistance available to, Granite Advantage beneficiaries who fail to comply with community engagement requirements, as described in STCs approved by CMS, unless the beneficiary is	The waiver authority will allow the State to condition eligibility on work and community engagement activities and to suspend or terminate eligibility for failure to comply with requirements.	Approved

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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver Request?
	exempted or demonstrates good cause, as described in STCs approved by CMS.		
§1902(a)(10) Eligibility	To the extent necessary to enable New Hampshire to require community engagement as a condition of eligibility, as described in STCs approved by CMS.	The waiver authority will allow the State to condition eligibility on work and community engagement activities.	Approved
§1902(a)(46)(B) insofar as it incorporates 42 CFR 435.407 and 435.956 Citizenship Documentation	To permit the State to require paper forms of identification rather than rely on electronic database matching to establish citizenship or residency.	The waiver authority will allow the State to deny eligibility to applicants who are unable to verify their United States citizenship through two forms of identification or unable to prove New Hampshire residency through either a New Hampshire driver's license or a non-driver's picture identification card.	Requested
§1902(e)(14) Asset Test	To permit the State to consider assets when determining Medicaid eligibility.	The waiver authority will enable the state to consider assets when determining eligibility of Granite Advantage members	Requested

Section IV – Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

Summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

1115 Premium Assistance Program Waiver Monitoring

To date, PAP waiver monitoring has aligned with requirements outlined in waiver STCs as well as specific monitoring requirements outlined in the QHP's agreements with New Hampshire DHHS. High-level findings from PAP waiver monitoring follow.

- *Steady enrollment growth:* Enrollment in NHHP grew continuously in calendar year 2016 through February 2017, when enrollment began to stabilize.
- *Strong access to care:* In the first year of PAP, enrollees accessed a wide breadth of substance use disorder services. The most frequently accessed services were Medication Assisted Treatment (MAT) followed by Physician/Clinic Visits, Outpatient Counseling and Opioid Treatment Services. Other substance use disorder services accessed include: screening, assessment and intervention; withdrawal management; residential services; recovery support services; intensive outpatient and partial hospitalization and inpatient acute care hospital services.

CMS 1115 PAP Waiver STCs

New Hampshire has conducted quarterly monitoring of the QHPs through various mechanisms outlined in the waiver STCs. These have included the evaluation of beneficiary enrollment trends and appeals reviews conducted by the New Hampshire Insurance Department. These two performance measures serve as early indicators of potential performance issues associated with each QHP.

In addition to the aforementioned indicators, New Hampshire monitors targeted behavioral health populations associated with the PAP waiver. First, New Hampshire monitors trends in medically frail beneficiaries who transition from PAP to the MCM program as a result of their medical frail designation. New Hampshire also monitors beneficiaries' utilization of services for the treatment of substance use disorder.

QHP Memorandum of Understanding (MOU)

The QHP MOU requires each plan to submit encounter data directly to DHHS. Encounter data can be used in a variety of ad hoc and ongoing applications for evaluation of the PAP program as well as individual QHP performance. Encounter data from the QHPs is used by New

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Hampshire's evaluation contractor to calculate a variety of quality and performance measures such as emergency department visits, cervical cancer screenings, and timeliness of prenatal care.

Section V – Financial Data

Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This section includes a financial analysis of changes to the demonstration requested by the State.

Historically, New Hampshire spent \$394 million in calendar year (CY) 2016 and \$434 million in CY 2017 on the NHHPP population receiving services through the demonstration. CY 2018 spending is projected to be \$535 million. Over time, costs have increased as enrollment in the program has grown and as the cost of providing premium assistance through QHPs increased. See Table 2.

Table 2. Enrollment and Expenditure

Enrollment and Expenditure Data by Demonstration Year (DY)			
	DY01 – Actual (1/1/16-12/31/16)	DY02 – Actual (1/1/17-12/31/17)	DY03 – Projected (1/1/18-12/31/18)
Member Months	548,987	587,426	594,332
Aggregate Expenditures	\$393,919,404	\$433,995,406	\$534,892,729

During negotiation over Senate Bill 313—the legislation that authorizes Granite Advantage—New Hampshire estimated that program spending would be \$171 million over the first six months of the demonstration period. New Hampshire anticipates that spending growth in the future will be consistent with standard growth rates experienced in the past, ranging from the 3.7% trend rate described above to the 4.9% President's budget trend rate. Therefore, New Hampshire estimates that annual program spending will range from \$354.8 million to \$398.1 million over the demonstration period.

These changes reflect savings from enrolling the demonstration population in Medicaid managed care as well as other features of Granite Advantage that will incentivize beneficiary engagement in wellness initiatives and appropriate levels of care and continue to emphasize personal responsibility. Projected spending account for the Medicaid expansion adults currently enrolled in the PAP as well as medically frail expansion adults. Spending estimates also account for other features of Granite Advantage, including new work and community engagement requirements as well as the requested waiver of retroactive coverage, which is predicted to reduce churn in and out of the program. DHHS is continuing to analyze the anticipated budgetary impact of such changes.

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Eligibility for the Granite Advantage population is based on the Medicaid State Plan, which also provides authority to enroll Medicaid beneficiaries in the state's Medicaid managed care program. All expenditures for the program are therefore authorized by the State Plan and State Plan spending is not subject to budget neutrality requirements. New Hampshire will continue to monitor program spending in accordance with Senate Bill 313 to assure alignment with the Granite Advantage budget.

Section VI – Evaluation

An evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

1115 PAP Waiver Evaluation

On March 30, 2018, New Hampshire submitted to CMS its Interim Evaluation Report on the NHHPP demonstration waiver.¹⁵ The report, which is attached to this waiver application as Appendix D, follows the CMS approved PAP Waiver Evaluation Plan that focused on the following goals:

- Continuity of coverage;
- Plan variety,
- Cost-effective coverage,
- Uniform provider access, and
- Cost neutrality.

The report concluded that the New Hampshire PAP has demonstrated that the public marketplace approach can achieve health outcomes at least as good as traditional Medicaid Care Management. The waiver had five goals and 14 hypotheses relating to these goals, which included: continuity of coverage; plan variety; cost effective coverage; uniform provider access; and cost neutrality. While most of the waiver hypotheses were supported, the State's analysis has not validated that the same quality of care can be achieved at an equal or lower cost. DHHS will update and finalize the evaluation in response to CMS comments.

Granite Advantage Monitoring and Evaluation

Per recently enacted State legislation, the Granite Advantage program will be evaluated on an annual basis, using an outcome-based evaluation methodology, with the following goals in mind: providing accountability to beneficiaries and the overall program; determining whether

¹⁵ The State has received feedback from CMS on this Interim Evaluation Report and is currently revising the Report based on this feedback.

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beneficiaries are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care; and analyzing whether the use of incentives and cost transparency efforts is effective at lowering costs while maintaining quality and access. The evaluation results will be included in a report that is submitted to CMS, the president of the State senate, the speaker of the State house, the governor, and the legislative fiscal committee by December 31 each year, beginning in 2019.

1115 Granite Advantage Work and Community Engagement Waiver Monitoring

In accordance with the recently approved work and community engagement waiver amendment, over the course of the extension period the State will monitor and evaluate the implementation of the new requirements to determine if requiring participation in specified community engagement activities as a condition of eligibility improves health outcomes and promotes independence for Granite Advantage beneficiaries. In consultation with CMS, DHHS will operationalize an eligibility and enrollment monitoring plan to address how the State will comply with the assurances described in the STCs. This monitoring plan will continue through the extension period and will inform the waiver evaluation. Where possible, metrics baselines will be informed by State data, and targets will be benchmarked against performance in best practice settings. Performance measures could include but are not limited to:

- Send timely and accurate notices to beneficiaries, including sufficient ability for beneficiaries to respond to notices.
- Assure application assistance is available to beneficiaries (in person and by phone).
- Assure processes are in place to accurately identify including but not limited to the following data points:
 - Number and percentage of individuals required to report work and community engagement compliance each month
 - Number and percentage of beneficiaries who are exempt from the community engagement requirement
 - Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements
 - Number and percentage of beneficiaries granted good cause exemption from reporting requirements
 - Number and percentage of beneficiaries who requested reasonable accommodations
 - Number and percentage and type of reasonable accommodations provided to beneficiaries
 - Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements
 - Number and percentage of beneficiaries disenrolled for failing to report
 - Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements
 - Number and percentage of community engagement appeal requests from beneficiaries

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- Number, percentage and type of community engagement good cause exemptions requested
- Number, percentage and type of community engagement good cause exemptions granted
- Number, percentage and type of reporting good cause exemptions requested
- Number, percentage and type of reporting good cause exemptions granted
- Number and percentage of applications made in-person, via phone, via mail and electronically.
- Maintain an annual renewal process, including systems to complete ex parte renewals and use of notices that contain prepopulated information known to the State, consistent with all applicable Medicaid requirements.
- Maintain ability to report on and process applications in-person, via phone, via mail and electronically.
- Maintain compliance with coordinated agency responsibilities under 42 CFR 435.1200, including the community engagement online portal under 42 CFR 435.1200(f)(2).

Table 3. Evaluation Hypotheses under Consideration

Hypothesis	Evaluation Approach	Data Sources
1. Members enrolled in the demonstration who are subject to community engagement requirements will have positive health outcomes.	Analyze Medicaid disease prevalence and Medicaid and former Medicaid self-reported health status	Encounter data (Medicaid covered), Evaluation survey (both Medicaid covered and former Medicaid)
2. Members enrolled in the demonstration who are subject to community engagement requirements will obtain sustained part-time and full-time employment.	Analyze Medicaid reported employment and Medicaid closure reasons	Medicaid enrollment system data
3. Members enrolled in the demonstration who are subject to community engagement requirements will gain access to employer-sponsored and individual market coverage.	Analyze Medicaid and former Medicaid member self-reported insurance coverage	Evaluation survey (both Medicaid covered and former Medicaid)
4. Eliminating retroactive coverage will encourage beneficiaries to obtain and maintain coverage, even when they are healthy, decreasing churn in and out of the program.	Analyze Medicaid months of gaps in coverage	Medicaid enrollment system data
5. Adding citizenship documentation requirements will allow New Hampshire	Analyze Medicaid enrollment over time;	Medicaid enrollment system data

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Hypothesis	Evaluation Approach	Data Sources
to test whether requiring documentation will improve the accuracy of Medicaid eligibility decisions.	Program integrity review findings	
6. Requiring an asset test would help the State preserve Medicaid funding for the lowest income, most vulnerable beneficiaries in the State.	Analyze enrollment data	Medicaid enrollment system data

Upon approval of this amendment and extension, the State will work with CMS to develop an evaluation design plan consistent with the STCs and CMS policy.

Section VII – Compliance with Public Notice Process

Upon completion of the public comment period, the State will submit documentation of the State's compliance with the public notice process set forth in 42 CFR §431.408, including the post-award public input process described in §431.420(c), with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

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

The State's comment period was from May 8, 2018 to June 29, 2018.

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 (<https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>) beginning on May 8, 2018; the notice was updated on May 30, 2018 to include additional information. The full public notice is included in Section VIII.

New Hampshire also certifies that it provided notice of the proposed demonstration in *The Union Leader*—the newspaper of widest circulation in New Hampshire—on May 8, 2018 and June 1, 2018. In addition, the State provided the demonstration notice in the *Telegraph* newspaper on May 8, 2018. Copies of the notices that appeared in the newspapers are included in Appendix A.

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.

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New Hampshire certifies that it convened three public hearings twenty days prior to submitting the demonstration application to CMS. Specifically, New Hampshire held the following hearings:

- *Concord May 14, 2018 2:00-4:30 PM.* Henry Lipman, New Hampshire's Medicaid Director, provided an overview of the Granite Advantage demonstration waiver amendment and extension application.
- *Nashua May 24, 2018 5:30-8:00 PM.* Henry Lipman provided an overview of the Granite Advantage demonstration waiver amendment and extension application.
- *Concord June 5, 2018 5:00-7:00 PM.* Henry Lipman provided an overview of the Granite Advantage demonstration waiver amendment and extension application. Individuals could also access this public hearing by teleconference.

In addition to the public hearings, comments were also considered at the Monday, May 14, 2018 Medical Care Advisory Committee Meeting, from 10:00-12:00 PM. All Medical Care Advisory Committee Meetings are open to the public.

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 its electronic mailing list to provide notice of the proposed demonstration to the public. The mailing list reaches approximately 400 stakeholders, including payers, providers, and advocates. Emails sent to this mailing list are included in Appendix A.

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

New Hampshire received 68 written comments during the public notice period, including mail and email. In addition, 21 people provided comments during the State's three public hearings and the May Medical Care Advisory Committee Meeting. Written comments are included in Appendix C.

New Hampshire reviewed and considered all public comments received during the public notice period.

6) Summary of the State's responses to submitted comments, and whether or how the State incorporated them into the final application.

The majority of commenters supported New Hampshire's proposal to extend the Medicaid expansion for another five years. Many of these commenters also expressed concern about various elements of the amendment and extension proposal and some sought additional information from the State about cost and coverage impacts of the State's proposals. Commenters expressed concern about the work and community engagement requirement that CMS previously approved and asked a variety of questions about qualifying activities, exemptions, documentation of compliance, and suspension and termination policies. In

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addition, commenters expressed concerns about the administrative burden on the State of implementing the requirements and on beneficiaries of complying with the requirements, particularly noting concern about potential coverage losses.

This application does not seek to revisit the State's prior waiver amendment approval implementing work and community engagements requirements, other than to make modest changes to align the approved STCs with State legislation. Therefore, the State seriously considered these comments and will take them into account in administrative rulemaking. We will consider the concerns raised by commenters as we prepare to implement the requirements on January 1, 2019 and will monitor and evaluate the demonstration in accordance with CMS requirements.

Commenters similarly expressed concern about the State's request to waive retroactive coverage. Some commenters also had questions about how the retroactive coverage policy would work, which we have clarified in this final draft. Some commenters also called into question the legality of the State's waiver requests to require additional documentation of citizenship and residency and to apply an asset test to the expansion population. The State appreciates the concerns that commenters raised about retroactive coverage, citizenship and residency documentation, and asset tests; State legislation directs the Governor to request a waiver that includes these elements and we are therefore unable to withdraw the requests, as requested by commenters.

Commenters supported the State's proposals to align benefits and cost-sharing for the Medicaid expansion population with policies that apply to the rest of the Medicaid population and expressed support for a single delivery system, although some commenters expressed concerns about how the transition from PAP to MCOs would be operationalized. Commenters also supported the State's interest in promoting healthy behaviors, wellness, and cost-effectiveness strategies but had some questions about how these goals would be achieved.

In response to commenters, the State made the following edits to its application:

- Revised introductory language to provide a "roadmap" to explain the various elements of the Granite Advantage program, in response to commenters who noted that the various changes the State is proposing are confusing.
- Supplemented information about the transition from premium assistance to managed care delivery system, in response to commenters who expressed concerns about coverage or reimbursement gaps during the transition period.
- Clarified the State's request to waive retroactive eligibility to be clear that eligibility would begin no earlier than the date of application (not the date all application requirements are met).
- Added hypotheses for the State's waiver requests related to citizenship documentation and application of an asset test.

We attach a document summarizing and responding to the comments received in Appendix B. In addition, we have included written comments received in Appendix C.

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

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.

8) Documentation of the State's compliance with the post-award public input process described in 42 CFR §431.420(c).

Following approval of the NHHPP waiver, DHHS reported to the State's Medical Care Advisory Committee within three months and again within six months, consistent with the requirements outlined in 42 CFR §431.420(c)(3)(i). Over the course of the demonstration, the State has continued to update the Medical Care Advisory Committee regularly; these meetings are open to the public. Given the changes in the expansion group delivery model in waiver extension, the State did not respond to feedback received in its post-award public process in this extension applications. Moving forward, New Hampshire will comply with the post-award public input process described in 42 CFR §431.420(c) to provide the public with an opportunity to comment on Granite Advantage once approved by CMS.

Section VIII – Public Notice

Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver **Public Notice - Updated May 30, 2018**

June 29, 2018

Waiver Application to Be Submitted to CMS Following July 20 Fiscal Committee Meeting

To provide ample opportunity to review and consider all comments received during the comment period, the State will submit the revised Granite Advantage Health Care Section 1115(a) Demonstration Waiver application to CMS in late July. DHHS will review and respond to all public comments, present the revised waiver application the State Legislature's Fiscal Committee at their July 20 meeting, and submit the application to CMS thereafter. The timeline for submission has been adjusted to allow the Department time to incorporate public feedback received during the public comment period.

June 11, 2018

State Plan Amendments Available for Public Review

- [Managed Care Delivery System](#)
- [Presumptive Eligibility](#)
- [Alternative Benefit Plan \(ABP\)](#)

PUBLIC COMMENT PERIOD EXTENDED TO JUNE 29, 2018

The Department of Health and Human Services is extending the Granite Advantage Health Care Section 1115(a) Demonstration Waiver state public comment period to 5 pm on June 29, 2018. The public notice below contains updated information about the proposed amendment and extension and the Department of Health and Human Services to inform public comments during the extended comment period.

[Granite Advantage Abbreviated Public Notice 2](#) 

[Granite Advantage Public Notice 2](#) 

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

To learn more about CMS Section 1115 Demonstration waivers, please visit the CMS web site at: www.medicaid.gov/medicaid/section-1115-demo/

For more information about New Hampshire's current 1115 waiver, which the State is seeking to amend and extend,

see: www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=29927

May 29, 2018

ADDITIONAL PUBLIC HEARING SCHEDULED FOR JUNE 5, 2018

Due to technical difficulties with the call-in telephone capability at the May 24th public hearing, the Department of Health and Human Services is hosting a third public hearing on the Granite Advantage Health Care Program on:

Tuesday, June 5, 2018, 5:00 - 7:00 PM

Department of Health and Human Services

Brown Building Auditorium

129 Pleasant Street

Concord, New Hampshire

If unable to attend, you may call in to the June 5th hearing:


Toll Free Number: 1-866-470-8024

When prompted, dial: 965 412 0884

[Presentation: Granite Advantage Program](#) 

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Leslie Melby at Leslie.Melby@dhhs.nh.gov or 603-271-9074 no later than June 4, 2018 for the June 5th hearing, in order to assure availability. Requests made later than these two dates will attempt to be accommodated but cannot be guaranteed.

PUBLIC NOTICE AND DRAFT WAIVER APPLICATION UPDATED ON MAY 30, 2018 Notice is hereby given that the New Hampshire Department of Health and Human Services (DHHS) is seeking to amend and extend for five years its Medicaid Section 1115(a) Research and Demonstration Waiver, #11-W-00298/W, to continue the State's efforts to integrate cost control and personal responsibility into the State's Medicaid program. As described below, during the Public Comment period New Hampshire is convening three public hearings and providing additional opportunities for public input on a Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver that will enable New Hampshire to extend its Medicaid expansion program, effective January 1, 2019. The updated Public Comment period will close at 5:00 PM on Friday, June 29, 2018.

[Granite Advantage Abbreviated Public Notice 2](#) 

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

[Granite Advantage Public Notice 2](#) 

Read the [Draft Waiver Application](#)  (updated May 30, 2018)

Summary of Current Demonstration

To date, New Hampshire's Health Protection Program (NHPP) Premium Assistance demonstration has used premium assistance to support the purchase of health insurance coverage offered by qualified health plans (QHPs) participating in the Marketplace's individual market, for beneficiaries eligible under the new Medicaid adult group. The demonstration affects individuals in the Medicaid new adult, or expansion group, covered under Title XIX of the Social Security Act who are adults, aged 19 up to and including 64 years, with incomes up to and including 133 percent of the federal poverty level (FPL) who are neither enrolled in nor eligible for Medicare nor enrolled in the State's Health Insurance Premium Payment (HIPP) program. Authority for the current Medicaid expansion expires on December 31, 2018.

On October 24, 2017, New Hampshire submitted an application to the Centers for Medicare & Medicaid Services (CMS) to amend the NHPP demonstration in order to promote work and community engagement opportunities for Premium Assistance Program (PAP) participants. That request was approved by CMS on May 7, 2018. The new Granite Advantage Health Care Program (described below) would extend these work and community engagement requirements, with modifications, throughout the demonstration renewal period.

On May 7, 2018, the Centers for Medicare & Medicaid Services (CMS) approved New Hampshire's request for an amendment to its section 1115 demonstration project, entitled "[New Hampshire Health Protection Program Premium Assistance](#)" (Project Number I I-W-00298/1) in accordance with section 1115(a) of the Social Security Act (the Act).

- [CMS Approval Letter](#)  (05/07/2018)
- [CMS Special Terms and Conditions for NH Health Protection Program Premium Assistance Program Section 1115\(a\)](#)

[Demonstration Waiver](#)  (05/07/2018)

- [October 24, 2017 Application](#) 

Summary of Proposed Amendment and Extension

To continue to provide coverage for the Medicaid expansion population, and in accordance with legislation **passed** by the State Legislature, New Hampshire is seeking to amend and extend its current expansion waiver. Read the [SB 313 legislation](#).

This amendment and extension will create the new Granite Advantage Health Care Program. Granite Advantage Health Care Program will: (1) sunset the NHPP premium assistance program and instead provide Medicaid to expansion individuals through the State's Medicaid managed care network, streamlining Medicaid program administration; (2) continue to apply work and community engagement requirements to the expansion population; (3) provide Medicaid eligibility to expansion individuals on the date all Medicaid eligibility requirements are met (i.e., usually the date of application), rather than three months of retroactive eligibility, without condition; and (4) incentivize beneficiary engagement in wellness activities and appropriate use of care.

In addition, in accordance with legislative direction, the State is seeking to implement the following features as part of Granite Advantage Health Care Program, to the extent permitted by federal law:

- Modify eligibility such that a participant cannot be eligible for coverage unless such person verifies his or her United States citizenship by two forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a non-driver's picture identification card.
- If allowed by federal law, apply an asset test when determining eligibility for members of the Medicaid expansion population.

Historically, New Hampshire spent \$394 million in calendar year (CY) 2016 and \$434 million in CY 2017 on the NHPP population receiving services through the demonstration. CY 2018 spending is projected to be \$535 million. Over time, costs have increased as enrollment in the program has grown and as the cost of providing premium assistance through QHPs increased. During negotiation over Senate Bill 313—the legislation that authorizes Granite Advantage—New Hampshire estimated that program spending would be \$171 million over the first six months of the demonstration period. New Hampshire anticipates that spending growth in the future will

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

be consistent with standard growth rates experienced in the past, ranging from the 3.7% trend rate described above to the 4.9% President's budget trend rate. Therefore, New Hampshire estimates that annual program spending will range from \$354.8 million to \$398.1 million over the extended 5-year demonstration period.

These changes reflect savings from enrolling the demonstration population in Medicaid managed care as well as other features of Granite Advantage that will incentivize beneficiary engagement in wellness initiatives and appropriate levels of care and continue to emphasize personal responsibility. Projected spending accounts for the Medicaid expansion adults currently enrolled in the PAP as well as medically frail expansion adults. Spending estimates also account for other features of Granite Advantage, including new work and community engagement requirements as well as the requested waiver of retroactive coverage, which is predicted to reduce churn in and out of the program. DHHS is continuing to analyze the anticipated budgetary impact of such changes.

Eligibility for the Granite Advantage population is based on the Medicaid State Plan, which also provides authority to enroll Medicaid beneficiaries in the state's Medicaid managed care program. All expenditures for the program are therefore authorized by the State Plan and State Plan spending is not subject to budget neutrality requirements. New Hampshire will continue to monitor program spending in accordance with Senate Bill 313 to assure alignment with the Granite Advantage budget.

Demonstration Objectives, Hypotheses and Evaluation Plan

The extended and amended demonstration will further the objectives of Title XIX of the Social Security Act by making a number of changes to improve beneficiary health. By promoting efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term, by strengthening beneficiary engagement in their health care coverage, care and outcomes, and by aligning Medicaid and commercial plan policies relating to retroactive coverage, the demonstration will promote the health of the Granite Advantage demonstration population. In addition, by transitioning individuals from premium assistance for Marketplace coverage to the State's Medicaid managed care delivery system will enable New Hampshire to realize program administration efficiencies and continue offering expanded coverage to low-income residents, reduce uncompensated care, better combat the opioid and substance use disorder crisis, and improve the State's workforce. Granite Advantage will incentivize beneficiary engagement in wellness initiatives and appropriate levels of care and continue to emphasize personal responsibility through CMS-approved work and community engagement requirements. All of these changes will support the State's ultimate objective of improving beneficiary health.

- [Premium Assistance Program \(PAP\) Evaluation Plan Implementation Interim Evaluation Report March 2018](#) 

Over the course of the Demonstration extension period, New Hampshire will continue to evaluate the Granite Advantage Health Care Program. Per recently enacted State legislation, the Granite Advantage program will be evaluated on an annual basis, using an outcome-based evaluation methodology, with the following goals in mind: providing accountability to beneficiaries and the overall program; determining whether beneficiaries are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care; and analyzing whether the use of incentives and cost transparency efforts is effective at lowering costs while maintaining quality and access. The evaluation results will be included in a report that is submitted to CMS, the president of the State senate, the speaker of the State house, the governor, and the legislative fiscal committee by December 31 each year, beginning in 2019.

Over the course of the demonstration extension period, New Hampshire will test the following hypotheses and evaluate the Granite Advantage Health Care Program accordingly. Details about the hypotheses and evaluation parameters follow:

Hypothesis	Evaluation Approach	Data Sources
1. Members enrolled in the demonstration who are subject to community engagement requirements will have positive health outcomes.	Analyze Medicaid disease prevalence and Medicaid and former Medicaid self-reported health status	Encounter data (Medicaid covered), Evaluation survey (both Medicaid covered and former Medicaid)
2. Members enrolled in the demonstration who are subject to community engagement requirements will obtain sustained part-time and full-time employment.	Analyze Medicaid reported employment and Medicaid closure reasons	Medicaid enrollment system data
3. Members enrolled in the demonstration who are subject to community engagement requirements	Analyze Medicaid and former Medicaid member self-reported insurance coverage	Evaluation survey (both Medicaid covered and former Medicaid)

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

will gain access to employer-sponsored and individual market coverage.

4. Eliminating retroactive coverage will encourage beneficiaries to obtain and maintain coverage, even when they are healthy, without negatively impacting churn in and out of the program.

Analyze Medicaid months of gaps in coverage

Medicaid enrollment system data

Upon approval of this amendment and extension, the State will work with CMS to develop an evaluation design plan consistent with the approved demonstration and CMS policy.


Waiver Authorities

As part of this amendment and extension, New Hampshire is requesting the following federal waivers:

- That CMS waive Section 1902(a)(34) of the Social Security Act to permit the State to provide coverage to Granite Advantage applicants beginning on the date of the application; coverage would be effective no earlier than the day all eligibility requirements are met, if all eligibility requirements are met on that date.
- That CMS continue, for the upcoming five-year demonstration period, to grant the State authority to condition Medicaid eligibility on completion of work and community engagement activities. The State is therefore seeking to extend waivers of Sections 1902(a)(8) and 1902(a)(10) to the extent necessary to enable New Hampshire to suspend or terminate eligibility for, and not make medical assistance available to, Granite Advantage beneficiaries who fail to comply with work and community engagement requirements, as described in the approved demonstration [Special Terms and Conditions](#) (STCs), unless the beneficiary is exempted or obtains a good cause exemption, as described in the STCs. The State is also seek to extend its waiver of Section 1902(a)(10) to the extent necessary to enable New Hampshire to require community engagement as a condition of eligibility as described in the approved STCs.
- To the extent permissible by federal law, that CMS waive Section 1902(a)(46)(B) insofar as it incorporates 42 CFR 435.407 and 435.956 to permit the State to require paper forms of identification rather than rely on electronic database matching to establish citizenship or residency. The waiver authority will allow the State to deny eligibility to applicants who are unable to verify their United States citizenship through two forms of identification or unable to prove New Hampshire residency through either a New Hampshire driver's license or a non- driver's picture identification card, as required by State legislation.
- To the extent permissible by federal law, that CMS waive Section 1902(e)(14) to permit the State to consider assets when determining Medicaid eligibility. The waiver authority will enable the State to consider assets when determining eligibility of Granite Advantage members.

In addition, New Hampshire will work with CMS to eliminate authorities that were unique to the premium assistance program and are no longer required to operate the Granite Advantage Health Care Program. For example, authority to vary cost-sharing for the premium assistance population will be eliminated.

State Plan Amendment Public Comment

The State will also seek comment on its draft Alternative Benefit Plan (ABP) State Plan Amendment (SPA), pursuant to 42 CFR 440.386, during the waiver public comment period. The Department plans to amend the State Plan to provide the same benefits to the Granite Advantage Medicaid new adult group as is currently being provided to individuals enrolled in other eligibility categories. The cost sharing State Plan will also be amended to align copayments for the expansion population with those for other Medicaid categories. To learn more, view the [ABP-SPA Public Notice](#) .

Public Hearings

DHHS will host three public hearings during the public comment period. The next hearing date is:

Tuesday, June 5, 2018, 5:00 - 7:00 PM

Department of Health and Human Services
Brown Building Auditorium
129 Pleasant Street
Concord, New Hampshire

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

If unable to attend, you may call in to the June 5th hearing:

Toll Free Number: 1-866-470-8024

When prompted, dial: 965 412 0884

[Presentation: Granite Advantage Program](#) 

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Leslie Melby at Leslie.Melby@dhhs.nh.gov or 603-271-9074 no later than June 4, 2018 for the June 5th hearing, in order to assure availability. Requests made later than these two dates will attempt to be accommodated but cannot be guaranteed.

DHHS previously hosted hearings at the following dates and locations:

Monday, May 14, 2018 2:00-4:30 PM

Department of Health and Human Services

29 Hazen Drive, Auditorium

Concord, NH

[Presentation](#) 

Thursday, May 24, 2018 5:30-8:00 PM

Harbor Homes

77 Northeastern Blvd

Nashua, NH

[Presentation](#) 

Comments were also considered at the Monday, May 14, 2018 Medical Care Advisory Committee Meeting, from 10-12 p.m. All Medical Care Advisory Committee Meetings are open to the public.

Medical Care Advisory Committee Meeting location:

NH Hospital Association

125 Airport Rd, Conference Room 1

Concord NH 03301

Public Comment

The public comment period for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver is from May 8, 2018 until June 29, 2018. All comments must be received by 5:00 PM (Eastern Time) on June 29, 2018.

DHHS would like to hear your comments about the changes it is proposing. After hearing the public's ideas and comments about the proposed changes, DHHS will make final decisions about what changes to make to the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver and then submit a revised application to CMS. The summary of comments will be posted for public viewing on this web page along with the waiver renewal application when it is submitted to CMS.

There are several ways to give your comments to DHHS. One way is to attend the public hearings held at the dates/locations noted above, or the Medical Care Advisory Committee Meeting, also noted above. At the public hearings, you can give verbal or written comments to DHHS. Additional information about providing comments is noted below.

Additional Information

Requests for a hard copy of the Granite Advantage Health Care Program 1115(a) Demonstration Waiver application should be submitted by mail to:

Leslie Melby

New Hampshire Department of Health and Human Services

Attn: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

129 Pleasant Street

Concord, NH 03301

A hard copy of the Granite Advantage Health Care Program 1115(a) Demonstration Waiver application can also be picked up at DHHS, which is located at:

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

New Hampshire Department of Health and Human Services
Fred H. Brown Building
129 Pleasant Street
Concord, NH 03301

Another way to provide your comments is by emailing comments to nhmedicaidcaremanagement@dhhs.nh.gov or mailing written comments to the address above. When mailing or emailing please specify the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

All information regarding the Granite Advantage Health Care Program Waiver can be found on this web page. DHHS will update this website throughout the public comment and application process.

APPENDICES

- A. Documentation of Compliance with Granite Advantage Public Notice Process:
 - 1. New Hampshire Department of Health and Human Services (DHHS) Website Screenshots
 - 2. DHHS Communication to Stakeholders
 - 3. Newspaper Excerpts
- B. DHHS Responses to Public Comments on Granite Advantage
- C. Written Public Comments on Granite Advantage
- D. New Hampshire Health Protection Program (NHHPP) Interim Evaluation Report (March 2018)

APPENDIX A

Documentation of Compliance with Granite Advantage Public Notice Process:

- 1. New Hampshire Department of Health and Human Services (DHHS) Website Screenshots**
- 2. DHHS Communication to Stakeholders**
- 3. Newspaper Excerpts**

1. DHHS Website Screenshots

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What's New...

- NH DHHS and Attorney General's Office Response to DRC Report
- NH DHHS Seeks Public Comment on Plan to Transition Medicaid Expansion Population to Medicaid Managed Care**
- DCYF Presentation at 3/7/2018 Governor & Council Breakfast Meeting
- DHHS Behavioral Health Initiatives Presentation at 12/05/2017 G&C Breakfast Meeting
- Medicaid Enrollment Data

DHHS News And Events

- Kellogg's Honey Smacks Cereal Recalled Due To Possible Salmonella Contamination**
June 18, 2018 - DHHS Division of Public Health Services is informing consumers that The Kellogg Company is recalling all boxes of Kellogg's Honey Smacks cereal as part of an investigation into an ongoing, multistate outbreak of Salmonella Mbandaka.
- NH DHHS to Receive Technical Support from Harvard University's Kennedy School Government Performance Lab**
June 14, 2018 - The New Hampshire Department of Health and Human Services (DHHS) is pleased to announce that DHHS will receive technical assistance from the Government Performance Lab (GPL) at Harvard University's Kennedy School, to design and implement strategic initiatives that will support current Departmental efforts to transform the State's child welfare system.
- DHHS Announces Departure of Brady Serafin, Director of Operations for SYSC and Bureau Chief for the DCYF Bureau of Family, Community, and Program Supports**
June 7, 2018 - DHHS announces the resignation of Brady Serafin, Director of Operations of the Sununu Youth Services Center and Chief of the Bureau of Family, Community, and Program Supports in the Division for Children, Youth and Families. Mr. Serafin, who has led SYSC for the past 2 1/2 years, has accepted a new professional opportunity outside of New Hampshire.
- NH Immunization Program Receives National Recognition**
June 4, 2018 - The DHHS Division of Public Health Services (DPHS) is pleased to announce that the Centers for Disease Control and Prevention (CDC) honored the New Hampshire Immunization Program with five awards for excellence in immunization to at the 48th annual National Immunization Conference, held recently in Atlanta, GA.

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New Hampshire MCM MEDICAID CARE MANAGEMENT

New Hampshire Hospital


Press Release

<https://www.dhhs.nh.gov/media/pr/2018/05082018-medicaid-expansion.htm>

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Press Release



NH DHHS Seeks Public Comment On Plan To Transition Medicaid Expansion Population To Medicaid Managed Care

Department Announces 30-Day Public Comment Period for Public Input

Office of Medicaid Services

Contact:
Public Information Office
(603) 271-9290

Publish Date:
May 8, 2018


Concord, NH – To continue to provide health insurance coverage for the Medicaid Expansion population while being consistent with current legislation considered by the NH Legislature, the NH Department of Health and Human Services (DHHS) is seeking to amend and extend its current Medicaid expansion waiver. If the Centers for Medicare and Medicaid Services (CMS) approve the waiver request, Medicaid Expansion will transition from the Premium Assistance Program to Medicaid Managed Care through the Granite Advantage Health Care Program. Work and community engagement requirements will be included to empower people to better their lives.

Prior to submitting the waiver request to CMS to establish the Granite Advantage Health Care Program, DHHS is seeking comment from the public. The **30 day public comment period begins on Tuesday, May 8, 2018 and lasts through Thursday, June 7, 2018**. All comments must be received by 5:00 p.m. Eastern on June 7.

DHHS will also host two public hearings during the public comment period:

- Monday, May 14, 2018**
2:00-4:30 pm
29 Hazen Drive
Concord, NH
- Thursday, May 24, 2018**
5:30-8:00 pm
77 Northeastern Blvd.
Nashua, NH


For more information about the waiver application, submitting a public comment or attending a public hearing, please visit www.dhhs.nh.gov/ombp/medicaid/granite.htm.

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Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

June 29, 2018

Waiver Application to Be Submitted to CMS Following July 20 Fiscal Committee Meeting

To provide ample opportunity to review and consider all comments received during the comment period, the State will submit the revised Granite Advantage Health Care Section 1115(a) Demonstration Waiver application to CMS in late July. DHHS will review and respond to all public comments, present the revised waiver application the State Legislature's Fiscal Committee at their July 20 meeting, and submit the application to CMS thereafter. The timeline for submission has been adjusted to allow the Department time to incorporate public feedback received during the public comment period.

June 11, 2018

State Plan Amendments Available for Public Review

- > [Managed Care Delivery System](#)
- > [Presumptive Eligibility](#)
- > [Alternative Benefit Plan \(ABP\)](#)

May 30, 2018

PUBLIC COMMENT PERIOD EXTENDED TO JUNE 29, 2018

The Department of Health and Human Services is extending the Granite Advantage Health Care Section 1115(a) Demonstration Waiver state public comment period to 5 pm on June 29, 2018. The public notice below contains updated information about the proposed amendment and extension and the Department of Health and Human Services to inform public comments during the extended comment period.

- > [Granite Advantage Abbreviated Public Notice 2](#)
- > [Granite Advantage Public Notice 2](#)

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.

To learn more about CMS Section 1115 Demonstration waivers, please visit the CMS web site at: www.medicaid.gov/medicaid/section-1115-demo/

For more information about New Hampshire's current 1115 waiver, which the State is seeking to amend and extend, see: www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=29927

May 29, 2018

ADDITIONAL PUBLIC HEARING SCHEDULED FOR JUNE 5, 2018

Due to technical difficulties with the call-in telephone capability at the May 24th public

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Program Information

- > Granite Advantage Public Notice
- > Granite Advantage Abbreviated Public Notice 2
- > Granite Advantage Public Notice 2
- > Granite Advantage Abbreviated Public Notice 1
- > Granite Advantage Public Notice 1
- > Draft Application
- > Granite Advantage Special Terms and Conditions
- > October 24, 2017 Application
- > Premium Assistance Program (PAP) Evaluation Plan Implementation Interim Evaluation Report March 2018
- > DHHS Press Release
- > ABP-SPA Public Notice

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

hearing, the Department of Health and Human Services is hosting a third public hearing on the Granite Advantage Health Care Program on:

➤ **Tuesday, June 5, 2018, 5:00 - 7:00 PM**
Department of Health and Human Services
Brown Building Auditorium
129 Pleasant Street
Concord, New Hampshire

If unable to attend, you may call in to the June 5th hearing:

➤ **Toll Free Number: 1-866-470-8024**
➤ **When prompted, dial: 965 412 0884**


[Presentation: Granite Advantage Program](#) 

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Leslie Melby at Leslie.Melby@dhhs.nh.gov or 603-271-9074 no later than June 4, 2018 for the June 5th hearing, in order to assure availability. Requests made later than these two dates will attempt to be accommodated but cannot be guaranteed.

PUBLIC NOTICE AND DRAFT WAIVER APPLICATION UPDATED ON MAY 30, 2018

Notice is hereby given that the New Hampshire Department of Health and Human Services (DHHS) is seeking to amend and extend for five years its Medicaid Section 1115 (a) Research and Demonstration Waiver, #11-W-00298/W, to continue the State's efforts to integrate cost control and personal responsibility into the State's Medicaid program. As described below, during the Public Comment period New Hampshire is convening three public hearings and providing additional opportunities for public input on a Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver that will enable New Hampshire to extend its Medicaid expansion program, effective January 1, 2019. The updated Public Comment period will close at 5:00 PM on Friday, June 29, 2018.

➤ [Granite Advantage Abbreviated Public Notice 2](#) 

➤ [Granite Advantage Public Notice 2](#) 

➤ Read the [Draft Waiver Application](#)  (updated May 30, 2018)

Summary of Current Demonstration

To date, New Hampshire's Health Protection Program (NHHPP) Premium Assistance demonstration has used premium assistance to support the purchase of health insurance coverage offered by qualified health plans (QHPs) participating in the Marketplace's individual market, for beneficiaries eligible under the new Medicaid adult group. The demonstration affects individuals in the Medicaid new adult, or expansion group, covered under Title XIX of the Social Security Act who are adults, aged 19 up to and including 64 years, with incomes up to and including 133 percent of the federal poverty level (FPL) who are neither enrolled in nor eligible for Medicare nor enrolled in the State's Health Insurance Premium Payment (HIPP) program. Authority for the current Medicaid expansion expires on December 31, 2018.

On October 24, 2017, New Hampshire submitted an application to the Centers for Medicare & Medicaid Services (CMS) to amend the NHHPP demonstration in order to promote work and community engagement opportunities for Premium Assistance Program (PAP) participants. That request was approved by CMS on May 7, 2018. The new Granite Advantage Health Care Program (described below) would extend these work and community engagement requirements, with modifications, throughout the demonstration renewal period.

On May 7, 2018, the Centers for Medicare & Medicaid Services (CMS) approved New Hampshire's request for an amendment to its section 1115 demonstration project, entitled "[New Hampshire Health Protection Program Premium Assistance](#)" (Project Number I I-W-00298/1) in accordance with section 1115(a) of the Social Security Act (the Act).

➤ [CMS Approval Letter](#)  (05/07/2018)

➤ [CMS Special Terms and Conditions for NH Health Protection Program Premium Assistance Program Section 1115\(a\) Demonstration Waiver](#)  (05/07/2018)

➤ [October 24, 2017 Application](#) 

Summary of Proposed Amendment and Extension

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

To continue to provide coverage for the Medicaid expansion population, and in accordance with legislation **passed** by the State Legislature, New Hampshire is seeking to amend and extend its current expansion waiver. Read the [SB 313 legislation](#).

This amendment and extension will create the new Granite Advantage Health Care Program. Granite Advantage Health Care Program will: (1) sunset the NHHPP premium assistance program and instead provide Medicaid to expansion individuals through the State's Medicaid managed care network, streamlining Medicaid program administration; (2) continue to apply work and community engagement requirements to the expansion population; (3) provide Medicaid eligibility to expansion individuals on the date all Medicaid eligibility requirements are met (i.e., usually the date of application), rather than three months of retroactive eligibility, without condition; and (4) incentivize beneficiary engagement in wellness activities and appropriate use of care.

In addition, in accordance with legislative direction, the State is seeking to implement the following features as part of Granite Advantage Health Care Program, to the extent permitted by federal law:

- Modify eligibility such that a participant cannot be eligible for coverage unless such person verifies his or her United States citizenship by two forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a non-driver's picture identification card.
- If allowed by federal law, apply an asset test when determining eligibility for members of the Medicaid expansion population.

Historically, New Hampshire spent \$394 million in calendar year (CY) 2016 and \$434 million in CY 2017 on the NHHPP population receiving services through the demonstration. CY 2018 spending is projected to be \$535 million. Over time, costs have increased as enrollment in the program has grown and as the cost of providing premium assistance through QHPs increased. During negotiation over Senate Bill 313—the legislation that authorizes Granite Advantage—New Hampshire estimated that program spending would be \$171 million over the first six months of the demonstration period. New Hampshire anticipates that spending growth in the future will be consistent with standard growth rates experienced in the past, ranging from the 3.7% trend rate described above to the 4.9% President's budget trend rate. Therefore, New Hampshire estimates that annual program spending will range from \$354.8 million to \$398.1 million over the extended 5-year demonstration period.

These changes reflect savings from enrolling the demonstration population in Medicaid managed care as well as other features of Granite Advantage that will incentivize beneficiary engagement in wellness initiatives and appropriate levels of care and continue to emphasize personal responsibility. Projected spending accounts for the Medicaid expansion adults currently enrolled in the PAP as well as medically frail expansion adults. Spending estimates also account for other features of Granite Advantage, including new work and community engagement requirements as well as the requested waiver of retroactive coverage, which is predicted to reduce churn in and out of the program. DHHS is continuing to analyze the anticipated budgetary impact of such changes.

Eligibility for the Granite Advantage population is based on the Medicaid State Plan, which also provides authority to enroll Medicaid beneficiaries in the state's Medicaid managed care program. All expenditures for the program are therefore authorized by the State Plan and State Plan spending is not subject to budget neutrality requirements. New Hampshire will continue to monitor program spending in accordance with Senate Bill 313 to assure alignment with the Granite Advantage budget.

Demonstration Objectives, Hypotheses and Evaluation Plan

The extended and amended demonstration will further the objectives of Title XIX of the Social Security Act by making a number of changes to improve beneficiary health. By promoting efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term, by strengthening beneficiary engagement in their health care coverage, care and outcomes, and by aligning Medicaid and commercial plan policies relating to retroactive coverage, the demonstration will promote the health of the Granite Advantage demonstration population. In addition, by transitioning individuals from premium assistance for Marketplace coverage to the State's Medicaid managed care delivery system will enable New Hampshire to realize program administration efficiencies and continue offering expanded coverage to low-income residents, reduce uncompensated care, better combat the opioid and substance use disorder crisis, and improve the State's workforce. Granite Advantage will incentivize beneficiary engagement in wellness initiatives and appropriate levels of care and continue to emphasize personal responsibility through CMS-approved work and community engagement requirements. All of these changes will support the State's ultimate objective of improving beneficiary health.

- [Premium Assistance Program \(PAP\) Evaluation Plan Implementation Interim Evaluation Report March 2018](#) 

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

Over the course of the Demonstration extension period, New Hampshire will continue to evaluate the Granite Advantage Health Care Program. Per recently enacted State legislation, the Granite Advantage program will be evaluated on an annual basis, using an outcome-based evaluation methodology, with the following goals in mind: providing accountability to beneficiaries and the overall program; determining whether beneficiaries are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care; and analyzing whether the use of incentives and cost transparency efforts is effective at lowering costs while maintaining quality and access. The evaluation results will be included in a report that is submitted to CMS, the president of the State senate, the speaker of the State house, the governor, and the legislative fiscal committee by December 31 each year, beginning in 2019.

Over the course of the demonstration extension period, New Hampshire will test the following hypotheses and evaluate the Granite Advantage Health Care Program accordingly. Details about the hypotheses and evaluation parameters follow:

Hypothesis	Evaluation Approach	Data Sources
1. Members enrolled in the demonstration who are subject to community engagement requirements will have positive health outcomes.	Analyze Medicaid disease prevalence and Medicaid and former Medicaid self-reported health status	Encounter data (Medicaid covered), Evaluation survey (both Medicaid covered and former Medicaid)
2. Members enrolled in the demonstration who are subject to community engagement requirements will obtain sustained part-time and full-time employment.	Analyze Medicaid reported employment and Medicaid closure reasons	Medicaid enrollment system data
3. Members enrolled in the demonstration who are subject to community engagement requirements will gain access to employer-sponsored and individual market coverage.	Analyze Medicaid and former Medicaid member self-reported insurance coverage	Evaluation survey (both Medicaid covered and former Medicaid)
4. Eliminating retroactive coverage will encourage beneficiaries to obtain and maintain coverage, even when they are healthy, without negatively impacting churn in and out of the program.	Analyze Medicaid months of gaps in coverage	Medicaid enrollment system data

Upon approval of this amendment and extension, the State will work with CMS to develop an evaluation design plan consistent with the approved demonstration and CMS policy.

Waiver Authorities

As part of this amendment and extension, New Hampshire is requesting the following federal waivers:

- ▶ That CMS waive Section 1902(a)(34) of the Social Security Act to permit the State to provide coverage to Granite Advantage applicants beginning on the date of the application; coverage would be effective no earlier than the day all eligibility requirements are met, if all eligibility requirements are met on that date.
- ▶ That CMS continue, for the upcoming five-year demonstration period, to grant the State authority to condition Medicaid eligibility on completion of work and community engagement activities. The State is therefore seeking to extend waivers of Sections 1902(a)(8) and 1902(a)(10) to the extent necessary to enable New Hampshire to suspend or terminate eligibility for, and not make medical assistance available to, Granite Advantage beneficiaries who fail to comply with work and community engagement requirements, as described in the approved demonstration [Special Terms and Conditions](#) (STCs), unless the beneficiary is exempted or obtains a good cause exemption, as described in the STCs. The State is also seeking to extend its waiver of Section 1902(a)(10) to the extent necessary to enable New Hampshire to require community engagement as a condition of eligibility as described in the approved STCs.
- ▶ To the extent permissible by federal law, that CMS waive Section 1902(a)(46)(B)

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

inssofar as it incorporates 42 CFR 435.407 and 435.95b to permit the State to require paper forms of identification rather than rely on electronic database matching to establish citizenship or residency. The waiver authority will allow the State to deny eligibility to applicants who are unable to verify their United States citizenship through two forms of identification or unable to prove New Hampshire residency through either a New Hampshire driver's license or a non-driver's picture identification card, as required by State legislation.

- To the extent permissible by federal law, that CMS waive Section 1902(e)(14) to permit the State to consider assets when determining Medicaid eligibility. The waiver authority will enable the State to consider assets when determining eligibility of Granite Advantage members.

In addition, New Hampshire will work with CMS to eliminate authorities that were unique to the premium assistance program and are no longer required to operate the Granite Advantage Health Care Program. For example, authority to vary cost-sharing for the premium assistance population will be eliminated.

State Plan Amendments Available for Public Review

Managed Care Delivery System

The State is making available for public review its **Managed Care Delivery System State Plan Amendment (SPA)**, which will be submitted to CMS prior to June 29, 2018. Please contact Diane Peterson at (603) 271-4367, or via email at diane.peterson@dhhs.nh.gov if you would like a copy of the SPA and have any questions or comments on the SPA. The SPA pages may undergo further revisions before and after submittal to CMS based on public input or CMS feedback.

Presumptive Eligibility

The State is also making available for public review its draft **Presumptive Eligibility State Plan Amendment (SPA)**, which will be submitted to CMS prior to June 29, 2018. Please contact Dawn Landry at (603) 271-9315, or via email at dawn.landry@dhhs.nh.gov if you would like a copy of the SPA and have any questions or comments on the SPA. The SPA pages may undergo further revisions before and after submittal to CMS based on public input or CMS feedback.

Alternative Benefit Plan (ABP)

The State will also seek comment on its draft **Alternative Benefit Plan (ABP) State Plan Amendment (SPA)**, pursuant to 42 CFR 440.386, during the waiver public comment period. The Department plans to amend the State Plan to provide the same benefits to the Granite Advantage Medicaid new adult group as is currently being provided to individuals enrolled in other eligibility categories. The cost sharing State Plan will also be amended to align copayments for the expansion population with those for other Medicaid categories. To learn more, view the [ABP-SPA Public Notice](#).

Public Hearings

DHHS will host three public hearings during the public comment period. The next hearing date is:

➤ Tuesday, June 5, 2018, 5:00 - 7:00 PM

Department of Health and Human Services
Brown Building Auditorium
129 Pleasant Street
Concord, New Hampshire

If unable to attend, you may call in to the June 5th hearing:

Toll Free Number: 1-866-470-8024

When prompted, dial: 965 412 0884

[Presentation: Granite Advantage Program](#)

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Leslie Melby at Leslie.Melby@dhhs.nh.gov or 603-271-9074 no later than June 4, 2018 for the June 5th hearing, in order to assure availability. Requests made later than these two dates will attempt to be accommodated but cannot be guaranteed.

DHHS previously hosted hearings at the following dates and locations:

➤ Monday, May 14, 2018 2:00-4:30 PM

Department of Health and Human Services
29 Hazen Drive, Auditorium
Concord, NH
[Presentation](#)

➤ Thursday, May 24, 2018 5:30-8:00 PM

Harbor Homes
77 Northeastern Blvd

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

Nashua, NH
[Presentation](#) 

Comments were also considered at the Monday, May 14, 2018 Medical Care Advisory Committee Meeting, from 10-12 p.m. All Medical Care Advisory Committee Meetings are open to the public.

Medical Care Advisory Committee Meeting location:
NH Hospital Association
125 Airport Rd, Conference Room 1
Concord NH 03301

Public Comment

The public comment period for the Granite Advantage Health Care Program Section 1115 (a) Demonstration Waiver is from May 8, 2018 until June 29, 2018. All comments must be received by 5:00 PM (Eastern Time) on June 29, 2018.

DHHS would like to hear your comments about the changes it is proposing. After hearing the public's ideas and comments about the proposed changes, DHHS will make final decisions about what changes to make to the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver and then submit a revised application to CMS. The summary of comments will be posted for public viewing on this web page along with the waiver renewal application when it is submitted to CMS.

There are several ways to give your comments to DHHS. One way is to attend the public hearings held at the dates/locations noted above, or the Medical Care Advisory Committee Meeting, also noted above. At the public hearings, you can give verbal or written comments to DHHS. Additional information about providing comments is noted below.

Additional Information

Requests for a hard copy of the Granite Advantage Health Care Program 1115(a) Demonstration Waiver application should be submitted by mail to:

Leslie Melby
New Hampshire Department of Health and Human Services
Attn: Granite Advantage Health Care Program Section 1115(a)
Demonstration Waiver
129 Pleasant Street
Concord, NH 03301

A hard copy of the Granite Advantage Health Care Program 1115(a) Demonstration Waiver application can also be picked up at DHHS, which is located at:

New Hampshire Department of Health and Human Services
Fred H. Brown Building
129 Pleasant Street
Concord, NH 03301

Another way to provide your comments is by emailing comments to nhmedicalcaremanagement@dhhs.nh.gov or mailing written comments to the address above. When mailing or emailing please specify the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

All information regarding the Granite Advantage Health Care Program Waiver can be found on this web page. DHHS will update this website throughout the public comment and application process.

 Adobe Acrobat Reader format. You can download a free reader from [Adobe](#).

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New Hampshire Department of Health and Human Services
129 Pleasant Street | Concord, NH | 03301-3852



2. DHHS Communication to Stakeholders

Email to Stakeholders About Public Comment Period

From: Melby, Leslie

Sent: Tuesday, May 08, 2018 3:20 PM

Subject: Request for Public Comment: Granite Advantage Health Care Program

New Hampshire has issued its draft proposal to amend and extend our current Medicaid expansion Section 1115 demonstration (Project #11-W-00298/1) for five years, through December 2023. This demonstration extension will enable New Hampshire to continue its successful track record of extending coverage to the Medicaid adult expansion group, consistent with changes being considered by the New Hampshire State legislature.

In conjunction with this request, New Hampshire plans to amend its Medicaid State Plan to update the Medicaid Alternative Benefit Package (ABP) that will be provided to the Medicaid new adult group.

Our 30-day State public comment period on the Granite Advantage Health Care Program begins today, on May 8th, and we will be holding two public hearings – one on May 14th and another on May 24th. We also will consider comments at our May 14th Medical Care Advisory Committee meeting, which is open to the public.

New Hampshire will carefully review and respond to comments received during the public comment period. As required by State legislation and by our current demonstration special terms and conditions, we plan to submit our amendment and extension request to the Centers for Medicare & Medicaid Services no later than June 30, 2018.

All information regarding the Granite Advantage Health Care Program waiver and the Alternative Benefit Package State Plan Amendment can be found on the Department of Health and Human Services' website, <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>. This website will be updated throughout the public comment and application process.

Information regarding times and location and telephonic access to the public hearings and the MCAC meeting is available on this website.

Leslie K. Melby, MHA

Special Projects Administrator

Office of Medicaid Services

Department of Health and Human Services

Brown Building

129 Pleasant Street

Concord NH 03301

603-271-9074 (office)

Leslie.Melby@dhhs.nh.gov

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

Email to Stakeholders About Public Hearing on May 14, 2018

From: Melby, Leslie

Sent: Friday, May 11, 2018 2:27 PM

Subject: Granite Advantage Health Care Program: Public Hearing May 14, 2-4pm

Reminder: Granite Advantage Health Care Program Public Hearing

Monday, May 14, 2018 2:00-4:30 PM

Department of Health and Human Services

29 Hazen Drive, Auditorium

Concord, NH

Presentation materials are available at <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

New Hampshire has issued its draft proposal to amend and extend our current Medicaid expansion Section 1115 demonstration (Project #11-W-00298/1) for five years, through December 2023. This demonstration extension will enable New Hampshire to continue its successful track record of extending coverage to the Medicaid adult expansion group, consistent with changes being considered by the New Hampshire State legislature.

In conjunction with this request, New Hampshire plans to amend its Medicaid State Plan to update the Medicaid Alternative Benefit Package (ABP) that will be provided to the Medicaid new adult group.

The 30-day State public comment period on the Granite Advantage Health Care Program began May 8th, and we will be holding two public hearings – one on May 14th and another on May 24th. We also will consider comments at our May 14th Medical Care Advisory Committee meeting, which is open to the public.

New Hampshire will carefully review and respond to comments received during the public comment period. As required by State legislation and by our current demonstration special terms and conditions, we plan to submit our amendment and extension request to the Centers for Medicare & Medicaid Services no later than June 30, 2018.

All information regarding the Granite Advantage Health Care Program waiver and the Alternative Benefit Package State Plan Amendment can be found on the Department of Health and Human Services' website, <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>. This website will be updated throughout the public comment and application process.

Information regarding times and location and telephonic access to the public hearings and the MCAC meeting is available on this website.

Leslie K. Melby, MHA

Special Projects Administrator

Office of Medicaid Services

Department of Health and Human Services

Brown Building

129 Pleasant Street

Concord NH 03301

603-271-9074 (office)

Leslie.Melby@dhhs.nh.gov

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

Email to Stakeholders About Public Hearing on May 24, 2018

From: Melby, Leslie

Sent: Wednesday, May 23, 2018 2:10 PM

Subject: Granite Advantage Health Care Program: Public Hearing May 24, 5:30-8:00 pm

Reminder: Granite Advantage Health Care Program Public Hearing

Thursday, May 24, 2018 5:30 – 8:00 PM

Harbor Homes

77 Northeastern Blvd

Nashua, NH

Presentation materials are available at <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

New Hampshire has issued its draft proposal to amend and extend our current Medicaid expansion Section 1115 demonstration (Project #11-W-00298/1) for five years, through December 2023. This demonstration extension will enable New Hampshire to continue its successful track record of extending coverage to the Medicaid adult expansion group, consistent with changes being considered by the New Hampshire State legislature.

In conjunction with this request, New Hampshire plans to amend its Medicaid State Plan to update the Medicaid Alternative Benefit Package (ABP) that will be provided to the Medicaid new adult group.

The 30-day State public comment period on the Granite Advantage Health Care Program began May 8th. Comments will be taken at the public hearing on May 24th. Comments may also be submitted by email to nhmedicaidcaremanagement@dhhs.nh.gov.

New Hampshire will carefully review and respond to comments received during the public comment period. As required by State legislation and by our current demonstration special terms and conditions, we plan to submit our amendment and extension request to the Centers for Medicare & Medicaid Services no later than June 30, 2018.

All information regarding the Granite Advantage Health Care Program waiver and the Alternative Benefit Package State Plan Amendment can be found on the Department of Health and Human Services' website, <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>. This website will be updated throughout the public comment and application process.

Information regarding times and location and telephonic access to the public hearings and the MCAC meeting is available on this website.

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Special Projects Administrator

Office of Medicaid Services

Department of Health and Human Services

Brown Building

129 Pleasant Street

Concord NH 03301

603-271-9074 (office)

Leslie.Melby@dhhs.nh.gov

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

Email to Stakeholders About Public Hearing on June 5, 2018

From: Melby, Leslie

Sent: Tuesday, May 29, 2018 4:39 PM

Subject: Granite Advantage Health Care Program Public Hearing - Tuesday, June 5, 2018

Please know that, due to technical difficulties with the call-in telephone capability at the May 24th Granite Advantage public hearing, the Department of Health and Human Services is hosting a third public hearing on the Granite Advantage Health Care Program on:

Tuesday, June 5, 2018, 5:00 - 7:00 PM

Department of Health and Human Services

Brown Building Auditorium

129 Pleasant Street

Concord, New Hampshire

If unable to attend, you may call in to the June 5th hearing:

❖ Toll Free Number: 1-866-470-8024

When prompted, dial: 965 412 0884

Presentation materials are available at <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

Summary:

New Hampshire has issued its draft proposal to amend and extend our current Medicaid expansion Section 1115 demonstration (Project #11-W-00298/1) for five years, through December 2023. This demonstration extension will enable New Hampshire to continue its successful track record of extending coverage to the Medicaid adult expansion group, consistent with changes being considered by the New Hampshire State legislature.

In conjunction with this request, New Hampshire plans to amend its Medicaid State Plan to update the Medicaid Alternative Benefit Package (ABP) that will be provided to the Medicaid new adult group.

The 30-day State public comment period on the Granite Advantage Health Care Program began May 8th. Comments will be taken at the public hearing on June 5th. Comments may also be submitted by email to nhmedicaidcaremanagement@dhhs.nh.gov.

New Hampshire will carefully review and respond to comments received during the public comment period. As required by State legislation and by our current demonstration special terms and conditions, we plan to submit our amendment and extension request to the Centers for Medicare & Medicaid Services no later than June 30, 2018.

All information regarding the Granite Advantage Health Care Program waiver and the Alternative Benefit Package State Plan Amendment can be found on the Department of Health and Human Services' website, <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>. This website will be updated throughout the public comment and application process.

Information regarding times and location and telephonic access to the public hearings and the MCAC meeting is available on this website.

Leslie K. Melby, MHA

Special Projects Administrator

Office of Medicaid Services

Department of Health and Human Services

Brown Building

129 Pleasant Street

Concord NH 03301

603-271-9074 (office)

Leslie.Melby@dhhs.nh.gov

GRANITE ADVANTAGE 1115 WAIVER AMENDMENT AND EXTENSION APPLICATION

Email to Stakeholders About The Public Comment Period Extension

From: Melby, Leslie

Sent: Thursday, May 31, 2018 1:51 PM

Subject: Granite Advantage Health Care Program Update - Public Comment Period Extended; Public Hearing June 5, 2018

Public Comment Period Extended to June 29, 2018

The Department of Health and Human Services is extending the state public comment period to **5 PM on June 29, 2018** for the Granite Advantage Health Care Section 1115(a) Demonstration Waiver. The DHHS [Granite Advantage website](#) includes a detailed public notice with more information about the waiver amendment and extension request.

Additional Public Hearing Scheduled for June 5, 2018

DHHS will host an additional public hearing on **Tuesday, June 5, 2018 from 5:00 to 7:00 PM** at:

Department of Health and Human Services
Brown Building Auditorium
129 Pleasant Street
Concord, NH

Telephone Access to the June 5th public hearing will be available using the following dial-in numbers:

Toll Free Number: 1-866-470-8024

Access Code: 965 412 0884

The public hearing presentation is available at:

<https://www.dhhs.nh.gov/ombp/medicaid/documents/ga-presentation.pdf>

Comments will be taken at the June 5th public hearing. Comments may be submitted by email, to nhmedicaidcaremanagement@dhhs.nh.gov; by regular mail, to NH Department of Health and Human Services, Attn: Granite Advantage Section 1115(a) Demonstration Waiver, 129 Pleasant Street, Concord, NH 03301; or in person at NH Department of Health and Human Services, Fred H. Brown Building, 129 Pleasant Street, Concord, NH 03301.

Summary

New Hampshire has issued its draft proposal to amend and extend our current Medicaid expansion Section 1115 demonstration (Project #11-W-00298/1) for five years, through December 2023. This demonstration extension will enable New Hampshire to continue its successful track record of extending coverage to the Medicaid adult expansion group, consistent with changes being considered by the New Hampshire State legislature.

In conjunction with this request, New Hampshire plans to amend its Medicaid State Plan to update the Medicaid Alternative Benefit Package (ABP) that will be provided to the Medicaid new adult group.

New Hampshire will carefully review and respond to comments received during the public comment period. As required by State legislation and by our current demonstration special terms and conditions, we plan to submit our amendment and extension request to the Centers for Medicare & Medicaid Services no later than June 30, 2018.

All information regarding the Granite Advantage Health Care Program waiver and the Alternative Benefit Package State Plan Amendment can be found on the Department of Health and Human Services' [Granite Advantage web page](#). DHHS will update this website throughout the public comment and application process.

Leslie K. Melby, MHA

Special Projects Administrator

Office of Medicaid Services
Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord NH 03301
603-271-9074 (office)
Leslie.Melby@dhhs.nh.gov

APPENDIX B

Department of Health and Human Services (DHHS) Responses to Public Comments on Granite Advantage

APPENDIX B

Responses to Public Comments on Granite Advantage Waiver Amendment and Extension

General Comments

Comment: Numerous commenters wrote in general support of the Medicaid expansion and many of these applauded the Department of Health and Human Services' (DHHS) efforts to preserve Medicaid expansion in New Hampshire through implementation of Granite Advantage. Most commenters who supported continuation of the Medicaid expansion also raised concerns about elements of the State's proposal.

Response: The State appreciates the commenters' support of the State's efforts to ensure that low-income adults have access to needed health care coverage and services. The Medicaid expansion provides coverage to approximately 53,000 adults who would not otherwise be eligible for Medicaid. The specific concerns that some of these commenters raised are described and discussed below.

Comment: One commenter noted that the State's waiver requests related to implementing a work requirement, eliminating retroactive eligibility, requiring additional verification of citizenship, and instituting an asset test are impermissible under federal law because they do not promote the objectives of the Medicaid program, one of which is to promote health care services. In light of a June 29th ruling about Kentucky's similar waiver, the commenter urged New Hampshire to refrain from submitting its waiver. The commenter stated that to be approved pursuant to Section 1115, the State's application must propose an "experiment, pilot, or demonstration" likely to promote the objectives of the Medicaid Act, which is to enable states to furnish medical assistance to individuals who are too poor to meet the costs of necessary medical care and to furnish assistance and services to help these individuals attain or retain the capacity for independence and self-care.

Response: The State appreciates the commenter's input and is aware of the recent ruling about Kentucky's Medicaid waiver. Centers for Medicare and Medicaid Services (CMS) previously approved work requirements in New Hampshire and the State is now pursuing this waiver amendment and extension in accordance with enacted State legislation, which directs that the State secure CMS approval of a waiver consistent with that legislation by December 1, 2018, otherwise the current Medicaid expansion will end. To ensure continued authority to extend the Medicaid expansion, the State is proceeding with submission of its waiver amendment and extension. The State will work with CMS to secure approval of a waiver extension and amendment that is consistent with Federal law.

Comment: Several commenters voiced opposition to the waiver overall and asked the State to withdraw its proposal. These commenters noted that the proposed amendments put certain Medicaid beneficiaries at-risk for financial harm, deter beneficiaries from seeking necessary care, and jeopardize beneficiaries' access to quality affordable health coverage.

Response: The State thanks the commenters for their input. To continue providing coverage to Medicaid expansion adults, the State legislature requires DHHS to submit and receive approval for its waiver extension request by December 1, 2018. If the extension is not approved, state legislation requires the Commissioner of DHHS to immediately notify all program participants that the Medicaid expansion will end and be terminated in accordance with the current demonstration's Special Terms and Conditions. The current waiver expires on December 31, 2018. As such, with the goal of continued Medicaid

expansion, DHHS has designed its waiver amendment and extension request to align with both legislative direction and the goals of the Medicaid program.

Comment: Several commenters stated that, as described in the draft waiver application and Alternative Benefit Plan (ABP) State Plan Amendment (SPA), the Granite Advantage program is “difficult to understand” and “confusing.” One commenter inquired about the relationship between the recently approved New Hampshire Health Protection Program (NHHPP) waiver amendment, this Granite Advantage waiver application, and the ABP SPA.

Response: The State acknowledges that the waiver and State Plan Amendment processes and timing can be confusing. To be responsive to these comments, DHHS included revised introductory language in the application to provide a “roadmap” to explain the various elements of the Granite Advantage program. More detail is provided in the revised application but, in summary:

- The current NHHPP demonstration will sunset on December 31st, and individuals enrolled in NHHPP will transition to the Granite Advantage program, which will be delivered through the State’s existing Medicaid managed care plans.
- Because all Medicaid beneficiaries will receive care through the same managed care delivery system, it will be most efficient to provide the same benefit package to all Medicaid beneficiaries. Therefore, the State is updating its ABP to align benefits for the adult Medicaid expansion population with State Plan benefits, effective January 1, 2019.
- The recently approved amendment to authorize New Hampshire to implement work and community engagement requirements beginning on January 1, 2019. Therefore, the Granite Advantage amendment and extension is seeking to extend this authority for the 5-year waiver extension period.
- In addition to seeking authority to continue work and community engagement requirements, the Granite Advantage application requests CMS authority for other programmatic features described in the State’s authorizing legislation, including waiving retroactive coverage, imposing an asset test, and adding to citizenship documentation requirements.

To help explain proposed program changes, the State also held three public hearings and an extended public comment period (more than 50 days in length) to ensure stakeholders had opportunities to raise questions and better understand the changes being requested as part of this amendment and extension. DHHS also looks forward to reviewing additional comments during the upcoming federal comment period.

Comment: Several commenters cited concern about potential confusion among beneficiaries as New Hampshire is making various program changes and called for notices to beneficiaries to be as clear as possible. One stakeholder organization (New Hampshire Legal Assistance) requested to receive notices for review before they are sent to beneficiaries; this organization also asked to have their contact information included in the notices for the purpose of assisting beneficiaries.

Response: The State seeks to ensure that all communication to beneficiaries regarding Granite Advantage is both clear and timely. DHHS will work with its communication staff and stakeholders to ensure that notices are written in an easy-to-understand manner, in line with State and federal requirements.

Comment: One commenter inquired whether the waiver is applicable to the traditional Medicaid program.

Response: The authority that the State is requesting from the federal government in the waiver amendment and extension is *not* applicable to the traditional Medicaid program. The waiver amendment and extension request applies to the individuals in the Medicaid expansion adult group. However, some of the Medicaid managed care changes that are described in the application will impact the entire Medicaid population. The State will be seeking comment on these changes as part of its re-procurement of Medicaid managed care contracts.

***Comment:* Two commenters expressed an interest in better understanding program costs, including how the costs of administering Granite Advantage will impact taxpayers and overall Medicaid costs. One of these commenters was also interested the financial savings associated with transitioning the program from premium assistance to managed care.**

Response: DHHS is required to report on the success and progress of the demonstration regularly and this information is publicly available on the DHHS website, providing transparency about program spending over time.

As described in this waiver application, historically, New Hampshire spent \$394 million in calendar year (CY) 2016 and \$434 million in CY 2017 on the NHHPP population receiving services through the premium assistance demonstration. CY 2018 spending is projected to be \$535 million. Over time, costs have increased as enrollment in the program has grown and as the cost of providing premium assistance through Qualified Health Plans (QHPs) have increased. The State estimates that transitioning Medicaid beneficiaries to the Medicaid managed care network will result in annual program spending ranging from \$354.8 million to \$398.1 million over the demonstration period. These changes reflect savings from enrolling the demonstration population in Medicaid managed care as well as other features of Granite Advantage that will incentivize beneficiary engagement in wellness initiatives and appropriate levels of care and continue to emphasize personal responsibility.

***Comment:* Several commenters expressed concern that the public comment period ends on June 29th and that the State intends to submit the waiver application to CMS on June 30th. Commenters noted that the timeline suggests that New Hampshire does not intent to incorporate public feedback into the final proposal and encouraged New Hampshire to delay submission to CMS to allow for time to review all comments received during the public comment period.**

Response: The State agrees with the commenters. To provide ample opportunity to review and consider all comments received during the comment period, the State will submit the revised application to CMS in late July. DHHS will review and respond to all public comments, present the revised waiver application the State Legislature's Fiscal Committee at their July 20 meeting, and submit the application to CMS thereafter.

***Comment:* Several commenters noted that the Granite Advantage application posted for public comment lacks information about the impact of the waiver on enrollment and that federal waiver transparency regulations require the State to include these projections and their impact on budget neutrality in the application posted for public comment. The commenters therefore requested that the State include this information and reopen the public comment period for an additional 30 days. Other commenters noted that because the draft does not provide an estimate about the number of enrollees or applicants the waiver could impact, it is impossible to offer complete comments.**

Response: The State takes seriously the federal transparency and public comment requirements and in fact extended our Granite Advantage state public comment period to ensure that the public had appropriate notice and opportunity to comment on the provisions of the proposed amendment and extension. We disagree with the commenter, however, that the application is insufficient. The application includes current enrollment numbers and notes that the Granite Advantage-eligible population is expected grow over the course of the five-year extension due to population growth, but that enrollment in the program also could be impacted by other features. The magnitude of these changes is uncertain and the State will actively monitor enrollment over the course of the demonstration.

With respect to the impact of enrollment and policy changes on waiver spending, in Section V. Financial Data, the application states that New Hampshire estimated that program spending would be \$171 million over the first six months of the demonstration period. New Hampshire anticipates that spending growth in the future will be consistent with standard growth rates experienced in the past, ranging from the 3.7% trend rate described above to the 4.9% President's budget trend rate. Therefore, New Hampshire estimates that annual program spending will range from \$354.8 million to \$398.1 million over the demonstration period. After consulting with CMS, however, we determined that because eligibility for the Granite Advantage population is based on the Medicaid State Plan, which also provides authority to enroll Medicaid beneficiaries in the state's Medicaid managed care program, all expenditures for the program are therefore authorized by the State Plan. Because State Plan spending is not subject to budget neutrality requirements, the application does not include standard budget neutrality calculations. As noted in the application, New Hampshire will continue to monitor program spending in accordance with Senate Bill (SB) 313 to assure alignment with the Granite Advantage budget.

***Comment:* One commenter expressed a desire to work toward alignment of the proposed monitoring and evaluation measures with existing programs and requirements to increase the likelihood of success with the required evaluation.**

Response: The state thanks the commenter for their feedback and interest in measuring success of the demonstration. Upon approval of this amendment and extension, the State will work with CMS to develop an outcome-based evaluation design plan consistent with the Special Terms and Conditions (STCs) and CMS policy. The draft hypotheses included in the waiver application include measures that can leverage the State's existing data sources.

***Comment:* One commenter noted that the waiver application does not include any information regarding health care provider access to real-time data on beneficiary eligibility for Granite Advantage. The commenter stressed the importance of clinicians having accurate information before seeing a patient and when submitting claims to ensure proper reimbursement for services provided to Medicaid enrollees in good faith.**

Response: The State appreciates the commenter's commitment to serving Medicaid beneficiaries in a timely and accessible manner. While the State is changing its delivery system for Medicaid expansion adults from the Premium Assistance Program (PAP) to managed care organizations (MCOs), the State is not changing its system data interfaces with providers. Similarly, the state is not updating systems that MCOs use to communicate with DHHS. Providers will be able to check patient eligibility as they do today.

Rulemaking

Comment: One commenter requested more details on the rulemaking schedule for the Granite Advantage program.

Response: DHHS plans to follow its standard process for drafting proposed and final administrative rules to implement Granite Advantage. The State expects to publish the draft rule for public comment in October 2018. The State's public comment process on the draft rules, which will include public hearings, is expected to take place in November 2018. After considering public comments, the State will present the final rules to the Joint Legislative Committee on Administrative Rules (JLCAR) in December, in order for them to be approved prior to January implementation.

Comment: One commenter inquired whether CMS has oversight on the rules that are promulgated by DHHS.

Response: CMS will approve revised STCs to govern the waiver over the extension period. DHHS is obligated to operate its waiver in accordance with the STCs and with all Medicaid statutory and regulatory requirements not otherwise waived, including provisions in New Hampshire's approved Medicaid State Plan. DHHS will also draft its own administrative rules consistent with these requirements. CMS does not have oversight authority with respect to State rulemaking.

Comment: One commenter expressed concern about the timing of the rulemaking process—i.e., that having final rules in December 2018 may be too close to waiver approval—and questioned how discrepancies between the final approved waiver and rules would be resolved, if they arise.

Response: Once CMS approves the extension of New Hampshire's waiver, the updated STCs will be the key governing authorities for the waiver and DHHS will be obligated to operate the waiver in accordance with the STCs. The State uses the rulemaking process to elaborate on operational details that are not described in the STCs; the administrative rules therefore should be consistent with the STCs. DHHS is currently drafting rules—for completion by December 2018—to implement the May 7, 2018 CMS approval of the State's new work and community engagement requirements. The May 7th approval is generally consistent with the work requirement provisions of SB 313, which are reflected in this waiver application. Therefore, the State does not anticipate any conflict between the forthcoming rules and the final approved waiver.

Eligibility and Retroactive Coverage

Comment: Two commenters inquired about resources available to assist beneficiaries with eligibility determination, application and enrollment in Granite Advantage coverage.

Response: The State appreciates the commenters' question. DHHS has resources in place to ensure that people can get help to obtain and keep coverage. After the initial transition period—in which DHHS will ensure that individuals currently receiving Medicaid premium assistance to purchase coverage from QHPs on New Hampshire's Marketplace are reassigned to Medicaid MCOs—the eligibility and enrollment process for Medicaid expansion adults will be identical to the process for all other Medicaid beneficiaries.

Beneficiaries who have questions about the Medicaid application process and eligibility can access online resources on the DHHS website, <https://www.dhhs.nh.gov/dfa/apply.htm>. In addition, members

can contact Medicaid Client Services through phone and email: <https://www.dhhs.nh.gov/ombp/medicaid/contact.htm>.

Comment: One commenter noted that the application proposes that applicants, at the time of enrollment, acknowledge that the program is subject to cancellation upon notice. The commenter stated that this will cause confusion for Medicaid applicants. The commenter requested clarification about how the program can be subject to cancellation upon notice.

Response: The State appreciates the commenter's question. The enacted Granite Advantage legislation requires that – to the extent allowed by federal law – to receive benefits through the Granite Advantage adult Medicaid expansion, individuals must acknowledge upon enrollment that the program is subject to cancellation upon notice, consistent with longstanding policy. Unlike other Medicaid categories that the state must cover, the Medicaid expansion is optional for states and New Hampshire has opted to cover the adult Medicaid expansion as authorized by the State legislation. Therefore, if the legislative authorization ends, the expansion would end, after appropriate notice is provided to beneficiaries in accordance with CMS-required program termination procedures. The legislative provision, and the corresponding language in the waiver amendment and extension application, is designed to advise beneficiaries of that possibility. In all other cases, standard appeal rights will apply to the adult Medicaid expansion population; eligibility could not be terminated prior to appropriate notice and opportunity for hearing, if requested.

Comment: Several commenters discussed presumptive eligibility policies, including whether certain providers, e.g., Community Mental Health Centers, can determine beneficiaries presumptively eligible and whether beneficiaries deemed presumptively eligible, e.g., at a hospital or a Federally Qualified Health Center (FQHC), would receive full benefits under Granite Advantage. In addition, one commenter asked about whether the State would be expanding training on presumptive eligibility. Another commenter wrote to affirm that current presumptive eligibility procedures allowed under Medicaid will continue.

Response: The State thanks commenters for their comments about presumptive eligibility, which allows qualified entities, such as health care providers, to help individuals get access to Medicaid services while their application for coverage is processed. The State is not changing current presumptive eligibility practices.

Once an individual is determined to be presumptively eligible, they receive full Medicaid benefits. Overall, the Granite Advantage program will align with the existing managed care presumptive eligibility policies and continue its existing outreach efforts to providers. The State does not currently plan to expand training relating to presumptive eligibility; as is the case today, if a provider requests training, the State will provide it.

Entities seeking to learn more about presumptive eligibility can access additional information on presumptive eligibility at <https://www.dhhs.nh.gov/dfa/presumptive/index.htm>.

Comment: Referencing the State's intent to allow State and county correctional facilities to conduct presumptive eligibility determinations for inmates, one commenter asked for clarification about how the presumptive eligibility process will work for inmates and inquired about when this policy would go into effect. Another commenter asked for clarification about whether inmates would be eligible for Granite Advantage.

Response: As required by SB 313, the authorizing legislation for Granite Advantage, DHHS is submitting a Medicaid SPA to authorize State facilities under the direction of the New Hampshire Department of Corrections (NH DOC) and County Correctional facilities under the direction of New Hampshire's ten counties to conduct presumptive eligibility determinations for inmates. Federal law prohibits the payment of federal Medicaid matching funds for inmates, but an exception exists for the costs of inpatient hospitalization; therefore, although New Hampshire cannot claim Medicaid reimbursement for inmates while they are incarcerated, inmates who meet Granite Advantage eligibility criteria can be enrolled in Granite Advantage so that the costs of any hospitalizations while they are incarcerated are reimbursed by Medicaid. Because New Hampshire is seeking authority to eliminate retroactive coverage for the Granite Advantage population—which previously would have ensured that inmates needing hospitalization could be found retroactively eligible for Medicaid even if they were not enrolled when they entered the hospital—updating the Presumptive Eligibility SPA will enable correctional facilities to assure that eligible inmates' hospitalization costs can be covered by Medicaid. DHHS is seeking a January 1, 2019 effective date for the Presumptive Eligibility SPA. Further details will be released after the State receives approval from CMS, if approval is granted.

Comment: Another commenter noted that it may be in the State's interest to cover individuals who are recently discharged from New Hampshire Hospital (NHH) and returning to the community, to lessen the likelihood of relapse.

Response: The State appreciates the comment's suggestion. The State has an existing policy that establishes a procedure for NHH staff to assist individuals with their Medicaid application upon discharge. In addition, DHHS is currently implementing a policy and system change that will allow individuals with Medicaid coverage prior to entering NHH to have their Medicaid coverage suspended while in NHH. This process would allow Medicaid coverage to be reactivated without requiring a new application.

Comment: Many commenters expressed concern that the requested waiver of retroactive coverage will cause significant financial strain for providers and members, in addition to barriers and delays in obtaining coverage. They raised concern that waiver retroactive eligibility would increase uncompensated care for hospitals and providers, particularly safety net hospitals and clinics that rely on retroactive eligibility for reimbursement of provided services (including emergency services provided pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA)). Commenters also expressed concern about medical debt for individuals who need medical care and may not even be aware of gaps in coverage that sometimes arise from failure to renew their coverage due to administrative barriers and/or not understanding notices of Medicaid renewal. One commenter indicated that such situations could mean that individuals would face substantial costs at their doctor's office or pharmacy. In addition to concerns about medical debt, one of these commenters also expressed concern that the retroactive coverage waiver would result in delays in diagnosis and/or treatment. Noting that the proposed waiver does not detail how the state would ensure that eligibility determinations are made in a timely manner, the commenter expressed concern that eliminating retroactive coverage will force eligible individuals go to without coverage, which could jeopardize health. Another noted that the waiver could exacerbate the mental health/substance use crisis in the state.

Response: The State appreciates the commenters' concerns. The state is requesting the waiver consistent with enacted state legislation and to test whether eliminating retroactive coverage will encourage beneficiaries to obtain and maintain coverage, even when they are healthy. If approved, a

critical component of the evaluation will be to consider whether this goal is met without increasing the rate of churn in and out of the program.

Comment: Commenters questioned how the State's request to waive retroactive coverage supports an acceptable experimental purpose or how the likely outcomes if the waiver is granted (i.e., increased uncompensated care and medical debt) would promote the objectives of the Medicaid act.

Response: The State appreciates the commenter's input. As noted in the application, the purpose of the retroactive coverage waiver is to test whether eliminating retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. This request is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, with the ultimate objective of improving beneficiary health. The State is requesting the waiver consistent with State legislation.

Comment: Two commenters objected to the request to waive retroactive coverage by questioning whether the waiver would actually reduce churn or encourage individuals to seek and maintain coverage. One mentioned that low income individuals might not be aware that they are Medicaid eligible and may not seek care until the condition becomes unmanageable. The other commenter noted that waiving retroactive coverage would not address enrollment barriers such as documentation requirements that can cause coverage gaps and instead stressed the importance of application assistance services and enrollee education to help maintain coverage.

Response: The State appreciates the commenters' concern about whether eliminating retroactive coverage will reduce churn and promote beneficiary enrollment in coverage, as is intended. We acknowledge that various factors can contribute to churn and will continue to seek ways to educate the adult expansion population about the importance of maintaining coverage. If CMS approves the waiver of retroactive coverage, DHHS plans to make the policy change clear and will undertake other forms of education to inform beneficiaries about the importance of maintaining coverage. The Department's goal is to encourage individuals to sign up for coverage and retain their coverage.

Comment: In light of the requested waiver of retroactive coverage, three commenters sought clarification about the effective date of eligibility and whether eligibility begins on the date of the application.

Response: The State is requesting a waiver of retroactive coverage whereby expansion adults would become eligible for Medicaid coverage no earlier than the date of application. DHHS has clarified the language in the waiver application in response to these comments.

Comment: One commenter asked for data about retroactive coverage, specifically relating to churn and gaps in coverage, in response to the waiver application's hypothesis that eliminating retroactive coverage will encourage beneficiaries to obtain and maintain coverage, without negatively impacting churn in and out of the program. This commenter and another commenter noted that the State's current retroactive coverage waiver is conditionally approved and commented that sufficient data have not been made available to support its being extended for five years. The commenters expressed concern that, if approved, this provision would lead to increased uncompensated care, greater medical debt for consumers, and barriers to access for medically necessary services. An additional commenter noted that because the State's draft application does not provide an estimate about the

number of enrollees or applicants the elimination of retroactive coverage couple impact, it is impossible to offer complete comments.

Response: The State appreciates the request for more information on retroactive coverage. As the commenter and the draft waiver application note, the State's retroactive coverage waiver was conditionally approved by CMS. DHHS has previously reported to CMS on the number of NHHPP adults seeking retroactive coverage (see: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf>). With the Granite Advantage waiver amendment, New Hampshire is seeking to remove the conditions on this approval so that the State has full authority to determine expansion adults eligible for coverage with an effective date no earlier than the date of application. This is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, with the ultimate objective of improving beneficiary health. As part of ongoing monitoring and evaluation during the waiver extension period, the State will test the hypothesis that eliminating retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy.

***Comment:* Three commenters wrote with questions about the State's proposal to eliminate retroactive coverage; two of the commenters provided hypothetical situations (e.g., a middle class family that experiences a catastrophic event and goes bankrupt, an individual in withdrawal who is receiving temporary detox services).**

Response: The State thanks the commenters for their input. The goal of eliminating retroactive coverage is to encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. If the waiver of retroactive coverage is granted by CMS, DHHS will no longer provide retroactive coverage as it does today. Rather, expansion adults will become eligible for coverage beginning no earlier than the date of application. While this provision does raise a risk that medical costs incurred before that date would not be reimbursed by Medicaid, the waiver of retroactive coverage is consistent with the State's interest in using this demonstration to test personal responsibility approaches. The State will monitor whether, over time, the requirement is successful in encouraging beneficiaries to maintain coverage and reducing churn in and out of the program.

With respect to the commenters' particular questions, we note that the waiver of retroactive coverage applies only to the Granite Advantage expansion population. Individuals with certain health care needs, such as those in need of expensive long term care services, may be eligible for standard Medicaid eligibility categories and would still be able to receive retroactive coverage.

***Comment:* Nine commenters asked the State to adopt rules to protect beneficiaries experiencing eviction or homelessness from termination of benefits due to a failure to renew eligibility or to report a change in circumstances.**

Response: The State acknowledges the unique challenges that people who are homeless or have unstable housing confront with regard to work readiness, documentation of eligibility factors, and timely engagement with DHHS on renewal or change reporting. Given these challenges, during its rulemaking process, DHHS will consider instituting a good cause exemption for people who are homeless or who have unstable housing.

Delivery System

Comment: One commenter requested that the State provide the dates of the waiver and re-procurement processes. Another commenter asked specifically about the timing of the comment period for the transition.

Response: DHHS is targeting July 2018 for submission of the Granite Advantage waiver amendment and extension application to CMS. The State legislation requires that DHHS receive CMS approval of the waiver by December 1, 2018 and that implementation begin on January 1, 2019.

The State is also in the process of re-procuring its Medicaid managed care contracts. DHHS is targeting July 2018 for release of its Request for Proposals (RFP) from potential MCO bidders, at which point the State will provide detailed timelines about the MCO re-procurement process on its website.

Comment: Several commenters wrote to express concerns about the transition from the PAP program to Medicaid managed care. One expressed support for this transition, while several inquired about how the State will ensure that beneficiaries do not lose coverage and providers do not lose reimbursement during the transition. In particular, several commenters raised concerns about ensuring continuity of care during the transition for beneficiaries undergoing treatment for serious or chronic medical conditions. One recommended special dispensation for these vulnerable populations from the MCO auto-assignment methodology so that they may have a continuous treatment plan with their preferred providers during and after the State's managed care transition. Another commenter requested that the Department set aside funding to ensure timely reimbursement for services provided to Medicaid expansion enrollees during the transition period. A commenter also recommended that the State undertake a strong public education campaign to educate beneficiaries about upcoming changes.

Response: The State is committed to ensuring individuals do not lose coverage as a result of the change in delivery system from premium assistance to managed care. In the coming months, DHHS will send several rounds of notices to affected beneficiaries to educate and inform them of the upcoming changes. To avoid gaps in coverage, DHHS will automatically assign ("auto-assign") NHHPP beneficiaries who are enrolled in a QHP into one of the State's two current Medicaid MCOs, for coverage beginning on January 1, 2019.

The State appreciates the importance of continuity of care for beneficiaries with serious medical conditions and has built processes to try to minimize disruptions to care. While each beneficiary will have a 90-day plan selection period in which they can switch MCOs if they wish, the use of auto-assignment helps ensure that beneficiaries do not need to take action in order to maintain coverage and also seeks to minimize disruption of provider relationships. The State will use the following criteria for auto-assignment: (1) Preference to an MCO with which there is already a family affiliation; (2) Previous MCO enrollment, when applicable; (3) Provider-Member relationship, to the extent obtainable; and (4) Equal assignment among the MCOs. To keep beneficiaries informed, DHHS will be sending notices regarding auto-assignment and enrollment to all affected beneficiaries.

Finally, in response to the commenters seeking assurance that providers will continue to be paid during the transition, the State does not anticipate disruption to provider payment during the transition period and will communicate to all QHPs and MCOs the importance of ensuring payment to providers is not interrupted as a result of this transition.

Comment: Four commenters inquired about the period of time beneficiaries have to select an MCO (i.e., the 90-day plan selection period during which a beneficiary can switch MCOs after being auto-assigned to one). One of these commenters asked about instead implementing a 90-day choice period during which individuals make an active MCO selection and are only auto-assigned if they have not made a selection at the end of the 90-day period. One commenter recommended that beneficiaries be educated about how to select their health plan rather than be auto-enrolled into a plan. Another commenter asked if MCOs will be required to have a continuous open enrollment policy to ensure that enrollees who want to use a particular MCO health plan can enroll, or whether MCOs will be able to cut off enrollment at a certain point.

Response: As noted above, using an auto-assignment process, paired with an opportunity for beneficiaries to choose another plan, ensures that all beneficiaries are assigned to and enrolled in a plan by the effective date of coverage, preventing gaps in coverage during the transition period if individuals do not make a timely selection. The State will not institute a continuous open enrollment policy, but the 90-day plan selection period assures that beneficiaries can choose a different plan if desired. Because of the anticipated timeline for approval of the waiver extension and amendment and subsequent transition to the managed care delivery system, there is not sufficient time to start the 90-day plan selection period ahead of January 1, 2019.

Comment: One commenter requested clarification about how the State will assist beneficiaries with selecting an MCO.

Response: As noted above, beneficiaries will be auto-assigned to an MCO during the transition period but will have a subsequent opportunity to change plans during an initial 90-day plan selection period and annually thereafter at the time of renewal. Individuals newly enrolling in Granite Advantage after January 1, 2019 will be automatically enrolled in a plan if they do not indicate a plan selection at the time of application. To assist with the enrollment and plan selection process, DHHS' Division of Client Services and district offices provide information about the State's Medicaid managed care program to potential enrollees in person, online, and in print. DHHS partners with community-based organizations to target populations entering into managed care, to educate them about the managed care delivery system. DHHS sends beneficiaries, in staggered mailings, materials describing the managed care delivery system and information on enrollment. These materials include important action dates, guidance on MCO selection, information about enrollee rights and responsibilities (such as access to care coordination and to the appeals process), as well as instructions about how to obtain assistance with MCO enrollment.

For individuals who are auto-assigned, the State will also generate a Selection Confirmation Letter that will identify the specific MCO that the beneficiary is assigned to (as well as the fact that they have 90 days to select a different plan). This letter will be sent to beneficiaries no later than fifteen days following their assignment to an MCO. This correspondence will be followed by outreach from the assigned MCO, including but not limited to a welcome call and a member benefit and welcome packet with plan details.

Comment: As the State prepares to transition from PAP to the managed care delivery system, two commenters inquired about the adequacy of the State's MCO network. One commenter expressed concern about whether the two Medicaid MCO plans can handle the anticipated increase in enrollment. Commenters also expressed concern about whether the State can provide adequate coverage in rural areas and encouraged the State to review managed care contracts to ensure that

women have access to enough obstetricians and gynecologists as well as coverage for Food and Drug Administration (FDA)-approved methods of contraception.

Response: The State appreciates the commenters' input and shares their interest in assuring access for Medicaid beneficiaries. As noted above, the State is currently undergoing an RFP process to re-procure its MCO contracts and expects to select three MCOs willing to work responsively with the State, Providers, and Members to provide high-quality, integrated health care on a statewide basis. MCOs are required to meet statewide standards in federally-required areas (e.g., time and distance standards for Primary Care Providers, specialists, obstetrics and gynecology) and additional areas identified by New Hampshire, including for Substance Use Disorder treatment services and for Children with Special Health Care Needs. MCOs are also required to comply with all New Hampshire Health Insurance Department (NHID) statewide network adequacy rules. After the public release of its RFP, the re-procurement process will include a public comment period for stakeholders to provide comments on the proposed network adequacy requirements.

***Comment:* One commenter inquired about the expected number of MCOs to be contracted as part of the State's re-procurement.**

Response: There are two MCOs contracted with the State today, and the State is committed maintaining and, if possible, expanding the number of plans to ensure beneficiary choice.

***Comment:* Two commenters were interested in learning more about the MCO re-procurement process and timelines, with one inquiring about the impact of Granite Advantage on re-procurement.**

Response: DHHS is targeting July 2018 for release of its MCO RFP, at which point the State will provide detailed timelines about the MCO re-procurement process on its website. (The RFP will include a full re-procurement schedule.)

As noted elsewhere in this appendix, the benefits and delivery system for Granite Advantage beneficiaries will align with those of other Medicaid adults starting on January 1, 2019, meaning that all adults must be enrolled in an MCO to receive Medicaid coverage. The State will work collaboratively with its contracted MCOs to implement key features of Granite Advantage including work and community engagement requirements, healthy behavior initiatives, and other activities and incentives to promote personal responsibility among Medicaid beneficiaries.

***Comment:* One commenter inquired about whether long-term services and supports (LTSS) will be provided through fee-for-service Medicaid under Granite Advantage.**

Response: LTSS will be provided to eligible beneficiaries through the Medicaid fee-for-service program. As explained in the "Benefits" section of this appendix, coverage of LTSS will be extended to the Medicaid expansion adult group under Granite Advantage, as part of alignment of Medicaid benefits for the entire adult population. As with the standard Medicaid population, expansion adults who meet functional requirements will be eligible for medically necessary LTSS services.

***Comment:* Several commenters raised questions about the impact of changing delivery systems on provider reimbursement rates. Some expressed concerns that lower Medicaid rates might negatively impact Medicaid patient access and also increase uncompensated care costs; another commenter discussed low reimbursement rates for providers of eye care services; and one asked for increased**

reimbursement rates for primary care, obstetrics and gynecological, mental health and substance use disorder services to avoid more hospitals and physicians withdrawing from participation in the program.

Response: The State appreciates the commenters' concern about how program changes will impact provider reimbursement. As noted above, the State is currently re-procuring its MCO contracts and working with its actuary to determine rate cells for all covered services. In addition, state legislation (SB 313) requires DHHS to establish a commission to evaluate the effectiveness of the Granite Advantage health care program. Among other things, this commission is charged with: reviewing the program's provider reimbursement rates and overall financing structure to ensure that Granite Advantage beneficiaries have access to a stable provider network and there is a sustainable funding mechanism that serves beneficiaries, communities and the State alike; and evaluating reimbursement rates for behavioral health (including substance use disorder) providers specifically, to determine if they are sufficient to ensure access to and provider capacity for all covered behavioral health services.

***Comment:* Expressing the desire to preserve the gains in behavioral health services made through the PAP program, three commenters specifically called out providers of opioid and behavioral health treatment services, questioning how individuals will have the same access to treatment and recovery under Medicaid managed care when QHPs generally pay higher rates to these providers than MCOs do.**

Response: Addressing the opioid epidemic is among the State's highest priorities. In recognition of the need to develop sufficient capacity to address the epidemic, the State legislature directed DHHS to establish behavioral health rates sufficient to ensure access to, and provider capacity for, all behavioral health services including, as appropriate, establishing specific substance abuse disorder service rate cells for inclusion into capitated rates paid to MCOs. DHHS is working with its actuaries to implement these legislative requirements.

***Comment:* One commenter inquired whether the updates to behavioral health rates will be reviewed at the Fiscal Committee.**

Response: To combat the opioid and heroin crisis facing New Hampshire, SB 313 directs DHHS to establish behavioral health rates sufficient to ensure access to, and provider capacity for, all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care. The Governor and Executive Council approve rates as part of the annual MCO contract amendment to establish rates for the fiscal year; rates are not reviewed at the Fiscal Committee.

***Comment:* One commenter inquired whether case management funding will be available for FQHCs to assist patients with applying for Granite Advantage.**

Response: The State thanks the commenter for acknowledging that FQHCs can play a vital role in helping eligible individuals apply for coverage and assure access to care for many Medicaid beneficiaries. During the waiver extension period, DHHS will continue to reimburse FQHCs for allowable Medicaid expenditures.

Benefits

Comment: Responding to the State’s efforts to align the benefits and delivery system for Granite Advantage beneficiaries with those of other Medicaid adults, two commenters called for a simpler and more uniform approach to the coverage of eye care, citing varying policies between MCOs and QHPs currently serving expansion adults. One of these commenters noted their support for the State’s alignment efforts and expressed interest in being involved in any benefit design discussions being had as DHHS works on the re-procurement of its Medicaid MCO contracts.

Response: The State thanks the commenters for their input. With regard to the re-procurement of the State’s MCO contracts, stakeholders will be able to find information about process (including the dates of the public comment period) on DHHS’ website, <https://www.dhhs.nh.gov/index.htm>, and will be able to provide input accordingly.

Comment: Several commenters requested information about benefits design, including to what extent the traditional Medicaid program and Granite Advantage programs will differ. Some commenters referenced specific benefits (e.g., long-term services and supports, home health services, pharmacy benefits, optometry services, eyeglasses, routine/wellness visits, and substance use disorder (SUD) services in their comments.

Response: The Medicaid expansion population is required to receive an “alternative benefit plan” that includes, at a minimum, ten Essential Health Benefits. Going forward, all Medicaid adults will receive the same set of benefits—including Essential Health Benefits as well as medically necessary services required under the Medicaid State Plan. Additional services will be added to the State Plan to the extent that the State Plan does not currently reflect all Essential Health Benefits and, in two cases, the State will substitute existing State Plan services that the State’s actuary has determined are actuarially equivalent to Essential Health Benefits that would otherwise be required. Namely, eyeglasses will replace chiropractic services and adult medical day care will replace diabetic education and nutrition therapy.

Once the ABP and the State Plan are fully aligned, Medicaid expansion adults therefore will be eligible for these services as well as long-term care services and supports (LTSS), currently a State Plan-only benefit, if they meet functional assessment requirements. The State envisions that such alignment will be more straightforward for beneficiaries while also streamlining benefit administration for the State’s Medicaid MCOs.

In response to the specific services mentioned by commenters, the ABP and the State Plan will be fully aligned and will provide the same coverage for all Medicaid adults for LTSS, home health services, drug formularies, optometry services, routine/wellness visits, and SUD services. All benefits will be provided through the State’s Medicaid managed care program (i.e., by an MCO) unless the benefit is “carved out” of managed care; “carved out” benefits, such as LTSS, will be provided through Medicaid fee-for-service.

Comment: Three commenters discussed early intervention services for newborns. Two of these commenters requested that Neonatal Abstinence Syndrome (NAS) and intrauterine opiate exposure be added as qualifying diagnosis for Early Intervention Services.

Response: Children are not part of the population covered by the Granite Advantage waiver, but the State appreciates the commenter’s concern about ensuring early intervention services for children impacted by the opioid epidemic. Early Intervention is known as Early Supports and Services (ESS) and

participation is voluntary. Neonatal abstinence syndrome is an established condition and child is automatically deemed eligible for ESS if the family agrees to receive these services. Intrauterine opiate exposure is considered to be a risk factor and the family would be offered an evaluation if the family agrees, to determine the extent of any developmental delay or disability. If not found eligible, the family would be referred to other early intervention resources such as the home visiting programs offered by DHHS' Maternal and Child Health Bureau.

Premiums and Cost Sharing

Comment: One commenter supported the State's decision to align cost sharing requirements for enrollees above and below 100% of poverty. The commenter expressed concern, however, that even the nominal copayments could negatively impact Granite Advantage enrollees. Finally, the commenter expressed concern about the impact of penalties for non-payment of cost sharing on Medicaid expansion group beneficiaries.

Response: The State appreciates the commenter's input but notes that the Granite Advantage demonstration does not impact co-pays for the Medicaid population. Furthermore, the State wishes to clarify that the State is not applying any penalties for nonpayment of co-payments; the same policies that apply to the standard Medicaid population will apply to the Granite Advantage expansion population. There are no copayments for individuals under 100% of the Federal Poverty Level (FPL) and only pharmacy copayments will apply to individuals above 100% FPL. Co-payments cannot exceed 5% of annual family income and pharmacies cannot deny services for failure to pay pharmaceutical copays.

Prior Authorization

Comment: One commenter requested clarification about the prior authorization waiver; specifically, the commenter asked the State to confirm how many hours plans will have to respond to prior authorization requests.

Response: To standardize program delivery and administration across the Medicaid population, the State is not seeking to renew its current prior authorization waiver, which allowed QHPs to respond to prior authorization requests within 72 hours, rather than 24 hours, as is otherwise required by the Medicaid statute. This means that, starting on January 1, 2019, prior authorization requests for Granite Advantage beneficiaries enrolled in Medicaid managed care would need to be responded to within 24 hours.

Healthy Behaviors and Cost Effectiveness

Comment: One commenter requested additional information about the types of incentives that New Hampshire will offer to promote health behaviors and cost effectiveness, as described in the application. The commenter expressed concern that the waiver application does not include sufficient detail about how incentives will be incorporated into provider contracts and implemented by the State. In particular, the commenter expressed concern about how the proposal will address the "appropriate use of emergency departments relative to low acuity non-emergent visits", particularly in light of recently passed State legislation (House Bill (HB) 1809) that incorporates prudent layperson language into the State's insurance statute. The commenter noted that the legislative change could require insurers to cover emergency care based on a patient's presenting symptoms and not the final diagnosis. An additional commenter also noted that any incentive programs should be consistent with the new state legislation.

Response: The State appreciates the commenters' views about and interest in the healthy behaviors initiatives described in the Granite Advantage legislation. The draft waiver application describes these provisions to give a comprehensive overview of the Granite Advantage program but the State does not envision making any changes that will require waiver of federal authority. Therefore, details about healthy behavior incentives and cost effectiveness will be made as part of the State's upcoming Medicaid managed care reprocurement process, which also will be open to public comment. The State looks forward to engaging with interested stakeholders through that process and is committed to implementing an approach that is consistent with HB 1809.

Comment: Several commenters wrote in general support of the Department's goal of promoting and incentivizing healthier lifestyles through wellness programs and to share their views about how best to craft such efforts. One of these commenters urged DHHS to ensure that any wellness programs are evidence-based incentive or participatory wellness programs rather than outcomes-based incentive programs that penalize beneficiaries for noncompliance or failing to meet outcomes. The commenter urged the Department to consider the impact of a wellness program on low-income residents. Finally, the commenter asked for clarification about the criteria that the State intends to use in determining thresholds for wellness behaviors in order to better assess possible impact of this program on Granite Advantage enrollees. Another commenter expressed doubt about prior authorization and utilization management strategies and instead encouraged the Department to align new incentives with existing efforts, including strategies associated with the State's Delivery System Reform Incentive Payment (DSRIP) waiver, and to focus on alignment of proposed measures with existing programs and requirements to increase the likelihood of success.

Response: We appreciate the commenters' support of wellness programs and the insights they shared in their comment letters about effective strategies. As noted in response to the previous comment, the Department is still designing the wellness program and more details will be available as part of the state's managed care reprocurement process. We look forward to receiving additional input and to partnering with interested stakeholders.

Comment: One commenter asked about whether MCOs will receive incentives to keep people healthy and out of the hospital.

Response: The State appreciates the commenter's attention to improving individuals' health, which is one of the primary goals of Granite Advantage. Through its new MCO contracts, beginning in July 2019, the State will implement both MCO-level and member-level incentives to promote personal responsibility, reduce inappropriate use of care, and reduce unnecessary health care costs. This program will incentivize MCOs to keep people healthy and, to the extent appropriate, out of the hospital. More information about these programs will be available on the DHHS website, <https://www.dhhs.nh.gov/index.htm>.

Comment: One commenter wrote to support the inclusion of incentive programs and cost effectiveness provisions but also expressed concern that language in the enacted Granite Advantage legislation suggests that cost-effectiveness shall be achieved by offering incentives to beneficiaries who seek care at lower cost medical providers, as opposed to lower cost medical procedures. The commenter is concerned that this provision could deter people from seeking care at FQHCs, which are required to receive their encounter rate pursuant to federal and state law.

Response: We appreciate the commenter's concern and agree that FQHCs play a vital role in serving the Medicaid population. The State is committed to implementing cost effectiveness measures in a manner that acknowledges the key role of FQHCs in caring for Medicaid and uninsured populations.

Comment: One commenter noted that Medicaid should do more to address social determinants of health to improve the quality of life for Medicaid beneficiaries. The commenter expressed concern that the State's work requirement would deter the State from focusing on more effective strategies to help people.

Response: The state appreciates the commenter's response and agrees that addressing social determinants of health is an important strategy to improve health and well-being of Medicaid beneficiaries. Although addressing social determinants is not the focus of the current Medicaid waiver, addressing Medicaid beneficiaries' non-medical needs is an area that the state will continue to explore in the future.

Work and Community Engagement Requirements

Comment: Many commenters expressed opposition to work and community engagement requirements. Among commenter concerns are that these requirements are inconsistent with objectives of the Medicaid program, violate federal law, and create barriers to accessing coverage, including by introducing administrative barriers associated with either demonstrating compliance or establishing exemptions. One of these commenters cited research from other human services programs finding that most recipients subject to work requirements stayed poor and that employment increases were modest and in some cases even increased poverty; the commenter argued that this evidence demonstrates that imposing work requirements would lead to a large number of individuals losing coverage, which is at odds with the objectives of the Medicaid Act.

Response: The State appreciates the commenters' input. On May 7, 2018, CMS approved the State's waiver amendment to implement work and community engagement requirements for its Medicaid expansion adults. The State is designing its work and community engagement program in accordance with the STCs of this waiver amendment as well as CMS' guidance on work and community engagement requirements (see <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>). The State recognizes that a broad range of social, economic, and behavioral factors can impact an individual's health and wellbeing, and a growing body of evidence suggests that targeting certain health determinants, including access to work and community engagement opportunities, may improve health outcomes. The demonstration will assess whether beneficiaries subject to work and community engagement requirements will have positive health outcomes.

The State also recognizes the importance of assuring appropriate beneficiary protections, consistent with the approved STCs and CMS guidance. To this end, DHHS will provide protections for beneficiaries through clearly defined exemptions, including good cause exemptions, permissible under State legislation, a comprehensive list of qualifying activities, and supports for individuals subject to or interested in participating work and community engagement activities.

Comment: One commenter noted that work requirements in Medicaid cannot be imposed through the federal Department of Health and Human Services' Secretary's waiver authority because such requirements are contrary to the objectives of the Medicaid program. The commenter also noted that a work requirement in New Hampshire is unnecessary because New Hampshire has one of the lowest unemployment rates in the country and the majority of nondisabled, nonelderly Medicaid

beneficiaries already are working. Other commenters also noted that most Medicaid beneficiaries who can work, do work.

Response: We understand the commenter's concerns and note that CMS already has approved New Hampshire's waiver amendment to permit the State to implement work requirements, consistent with State legislation. New Hampshire will work with CMS to ensure that the continuation of the work and community engagement requirement within the Granite Advantage Health Care Program is consistent with the coverage goals of the Medicaid program.

***Comment:* The State received a number of comments from individuals who shared personal information and raised concerns that work and community engagement requirements would jeopardize their access to Medicaid.**

Response: The State appreciates the commenters' questions and the opportunity to clarify the various exemptions that apply. With respect to Medicaid beneficiaries in the adult expansion group who have health issues that could make participation in work activities difficult, several categories of exemptions are available. First, individuals who are medically frail or have a disability under the Americans with Disabilities Act (ADA) are exempt from work requirements, as are beneficiaries who are temporarily unable to participate due to illness or incapacity as documented by a licensed provider and beneficiaries who experience a hospitalization or serious illness. The State will be providing more information to beneficiaries about how to secure an exemption in these cases. In addition, individuals can qualify for good cause exemptions if they experienced a hospitalization or serious illness and were not already exempted from work and community engagement requirements, or if they have a disability and were unable to meet the requirement for reasons related to that disability and were not already exempted from work and community engagement requirements. Here, too, the State will provide information to beneficiaries about the process to establish a good cause exemption.

***Comment:* Several commenters expressed concern that work requirements could have a detrimental impact on individuals who are in the middle of a course of treatment and for whom a gap in coverage could have serious health consequences. Examples of health conditions mentioned by commenters include cancer, cystic fibrosis, rare diseases, and chronic conditions.**

Response: The State appreciates the commenters' concern about potential disruption of coverage for individuals in the midst of treatment for complex, serious, or chronic medical conditions. We note that many individuals with such conditions will be exempt from the work and community engagement requirements, either because they satisfy the "medically frail" definition or because a provider documents that they are unable to participate due to an illness or incapacity, or because they are hospitalized. The State will provide information to beneficiaries to clearly explain how to secure an exemption, including a good cause exemption, in such circumstances.

***Comment:* One commenter expressed concern about the impact of work and community engagement requirements on children, indicating that their parents losing coverage puts children at greater risk of becoming uninsured. The commenter also noted that unstable childcare arrangements, which many families rely on when they have low-wage work with uncertain schedules, also can harm a child's health development.**

Response: The State thanks the commenter for this input. In accordance with State legislation and the recently approved waiver Special Terms and Conditions, and its recognition of the importance of

caregiving responsibilities for young children, beneficiaries who are a custodial parent or caretaker of a dependent child under 6 years of age are exempt from the work and community engagement requirement. This exemption only applies to one parent in a two-parent household. Consistent with enacted state legislation, the State also is seeking to revise the list of enumerated good cause exemptions in the Standard Terms and Conditions to include a beneficiary who is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the commissioner on a monthly basis, is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor.

***Comment:* Many commenters expressed concern about beneficiaries' ability to find and attain suitable employment. Most of these commenters noted specific hardships—such as age (e.g., over 50), amount of time since prior employment, lack of affordable child care, lack of access to transportation, fewer employment opportunities in rural areas, the seasonal nature of many work opportunities, and employers that limit number of hours an individual can work—which may make meeting work and community engagement requirements especially difficult. Several commenters inquired about the State's plans to recognize and provide support for these hardships.**

Response: The State thanks the commenters for their input. The State seeks to ensure all beneficiaries subject to work and community engagement requirements have access to needed supports and information about how to meet the requirements—either through participation in qualifying activities or if appropriate, exemption from the requirements, including good cause exemption. In accordance with the CMS-approved STCs governing New Hampshire's work and community engagement program, the State will be providing information about community supports and resources available to connect beneficiaries to opportunities to participate in qualifying activities.

In response to comments about lacking access to affordable child care, DHHS notes that State legislation has defined both an exemption and a good cause exemption relating to child care:

- The exemption applies to a custodial parent or caretaker of a dependent child under 6 years of age or a child of any age with a developmental disability who is residing with the parent or caretaker, provided that the exemption only applies to one parent or caretaker in the case of a two-parent household. (The STCs approved by CMS on May 7, 2018 do not limit the exemption for beneficiaries who are a parent or caretaker of a dependent child with a disability to apply only to just one parent or caretaker in two-parent households; State legislation does, however. As a result, the State is requesting that the STCs be revised to align with State legislation.)
- The good cause exemption applies to a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the commissioner on a monthly basis, is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor. (The State is also requesting that the STCs be updated to include this good cause exemption, which does not appear in the CMS-approved STCs but is required by State legislation.)

DHHS also notes that there are a number of ways beyond employment that beneficiaries can satisfy work and community engagement requirements. For example, job skills training, job search and job readiness assistance (including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment

counselors, offered by the department of employment security), and vocational educational training all count as qualifying activities in which beneficiaries may participate to comply with the requirements.

In addition, State legislation established a pilot program, Granite Workforce, to provide subsidies to employers in high-need areas, as determined by the State Department of Employment Security based upon workforce shortages, and create a network of assistance to remove barriers to work for low-income families. Such assistance may include case management services, vocational assessment, referrals to training and apprenticeship opportunities, direct job placement, and other assistance in meeting work and community engagement requirements. Further, DHHS will assess areas within the State that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas lacking public transportation to determine whether there should be additional strategies deployed so that the requirements will not be unreasonably burdensome for beneficiaries to meet.

***Comment:* Several commenters expressed concern that the requirement of 100 hours per month of work or community engagement activities is too high, noting that lower wage jobs tend to be more volatile in terms of regular work hours due to seasonal or shift changes. One commenter indicated that data shows that most low-income workers have jobs with variable and unpredictable schedules, for instance in construction, retail, or food service, which not only can contribute to worsening health outcomes, but can make it difficult to comply with the State’s weekly-hours requirements. Another commenter noted that the proposed cure period for noncompliance will likely not be enough for New Hampshire’s seasonal workers, who may struggle to complete the monthly hours requirement due to the nature of their employment.**

Response: The State appreciates the commenters’ concern. The recently enacted Granite Advantage legislation specifies 100 hours per month and the waiver amendment approved by CMS in May authorizes the State to require 100 hours of employment or community engagement activities per month, beginning in January. The Special Terms and Conditions governing the waiver outline a number of other qualifying activities that can satisfy the requirement. The broad range of qualifying activities is expected to provide the opportunity for seasonal workers to come into compliance during periods when they are not able to complete 100 hours per month of their regular employment activity.

***Comment:* Four commenters expressed concern about individuals with disabilities, mental illness, and/or substance use disorders needing to meet work and community engagement requirements. Another commenter asked if someone with cognitive or mental health disabilities who is otherwise physically sound is considered “able-bodied.”**

Response: Per State legislation and the CMS-approved work and community engagement STCs, individuals who are medically frail are exempt from work and community engagement requirements. Federal regulations at 42 CFR 440.315(f) specify that individuals with disabling mental disorders, individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, and individuals with a disability determination based on State Plan criteria must be considered to be medically frail. The State will update its administrative rules to describe individuals who are considered to be medically frail, consistent with federal regulations, and thus exempt from work and community engagement requirements.

Comment: A number of commenters had questions or views about how work and community engagement requirements will impact the medically frail population. Several commenters inquired about the process for determining an individual as medically frail, two commenters remarked that requiring documentation and/or certification from certain provider types may serve as a barrier to obtaining a medical frailty exemption, and one commenter asked about how the State will ensure that medically frail members are exempt from work and community engagement requirements. One commenter asked for more information on the process and timeline for provider determinations of medical frailty and another one expressed concern about the increased administrative burden on providers and the impact that the requirements could have on attracting and retaining health care workforce in the State.

Response: The State thanks the commenters for their input. To ensure that medically frail individuals are appropriately exempted from work and community engagement requirements, the State is developing a medical frailty determination process to identify the medically frail population in accordance with State legislation and the CMS-approved work and community engagement STCs. The State will work with providers and other stakeholders to ensure adequate communication about and training on this new medical frailty determination process.

Comment: Two commenters expressed concern about the disproportionately negative impact of work and community requirements on beneficiaries with disabilities noting that many individuals with disabilities are far likelier to be unemployed, working less than full time, or sporadically employed which means many will lose coverage unless they can show they are exempt. They noted that some Medicaid beneficiaries with chronic or disabling conditions that preclude them from working are not eligible for Medicaid based on disability and are instead enrolled in the adult expansion group and therefore at risk of losing coverage due to new work requirements. Commenters expressed concern that such individuals with disabilities may not actually be exempt because it is not yet clear how the State intends to determine which individuals will qualify for an exemption based on disability. The commenters also requested information about what proof will be required in order for an individual to obtain the disability exemption, noting that it can be extremely burdensome for an individual with a disability to prove his/her disability and expressing concern that many individuals with disabilities may not actually be exempted. Finally, the commenters reminded the State that it would be a violation of the ADA for the state to take any action that has a discriminatory impact on people with disabilities. Finally, one of the commenters also noted that it is difficult to comment on the proposed amendment and extension given the lack of details included in the application about work requirements, but cited evidence from other states about how work requirements could impact people, including individuals with disabilities who may have difficulty establishing exemptions.

Response: The State appreciates the commenters concern and reiterates our intent to administer the approved work and community engagement requirement consistent with federal laws such as the ADA and consistent with the approved waiver Special Terms and Conditions. As noted, CMS previously approved the State's request to implement work and community engagement requirements and the State's current proposal is seeking to extend the authority, with only modest changes; therefore, the current application does not elaborate on requests that already have been approved. The Special Terms and Conditions provide that beneficiaries with a disability as defined by the ADA, Section 504, or Section 1557 who are unable to comply with the requirements due to disability-related reasons are exempt from work requirements. The STCs also require the State to provide reasonable modifications related to meeting community engagement requirements for beneficiaries with disabilities, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The State is

developing administrative rules that will address the manner in which beneficiaries may seek an exemption, a good cause exemption, or a reasonable modification; the rules will take into account burden on both beneficiaries and providers as noted by the commenter.

Comment: One commenter indicated that sixty percent of people with disabilities who work and receive supports only work an average of two to nine hours a week, making it impossible for them to meet the qualifying hours requirement. Another commenter inquired about the reasonable modifications that the State will have for disabled individuals.

Response: As described in State legislation and the work and community engagement STCs approved by CMS, individuals with disabilities are exempt from work and community engagement requirements and the State will provide information to beneficiaries about how to demonstrate eligibility for an exemption. Should an individual with disabilities choose to participate in the work and community engagement program, the State will include reasonable modifications such as modification in the number of hours of participation required, where an individual is unable to participate for the otherwise required number of hours, and the provision of support services necessary to participate, where participation is possible with supports. DHHS plans to provide additional information to beneficiaries about reasonable modifications prior to implementation of the work and community engagement requirements.

Comment: One commenter asked whether beneficiaries deemed presumptively eligible, for example, at a hospital, would be deemed ineligible for Medicaid coverage if he/she does not meet work and community engagement requirements.

Response: Beneficiaries who are hospitalized can apply for an exemption or a good cause exemption from work and community engagement requirements.

Further, beneficiaries who are determined to be eligible (either through presumptive eligibility determination or regular eligibility determination) will generally have 75 calendar days beginning with the date of their eligibility determination before they must begin to meet work and community engagement requirements. (Beneficiaries who are reapplying after their eligibility was terminated for failure to meet work and community engagement requirements will have access to this 75-day period only if they have been disenrolled for at least six months.)

Comment: One commenter sought to understand the 75-day period that beneficiaries have to come in compliance with work and community engagement requirements after they are deemed Medicaid eligible.

Response: The 75-day “notice” period is designed to ensure that beneficiaries have adequate time to prepare for and comply with work and community engagement requirements. This and other implementation details not included in State legislation will be further described in the State’s administrative rules.

Comment: One commenter asked whether beneficiaries will retain coverage during periods when they are out of compliance with work requirements and while they are given an opportunity to “cure”. The commenter also asked if the beneficiary does not cure, whether he or she has to repay the cost of coverage provided during that period. Another commenter encouraged DHHS to ensure that providers are compensated for services provided during appeals, probationary, and other transitional processes.

Response: Beneficiaries who are identified as non-compliant with work and community engagement requirements will be given a month to cure their non-compliance either through satisfying the hours requirement through activities or good cause. Beneficiaries will retain coverage during the cure period. Beneficiaries will not have to repay the cost of coverage provided during that cure period and providers will be reimbursed for services rendered during the cure period.

***Comment:* One commenter noted that individuals who fail to satisfy the work requirement may be eligible for “good cause” exemptions but noted that it is not clear how long the appeals process would take and whether the beneficiary will lose coverage during the process. The commenter encourages DHHS to ensure that providers are compensated for services provided during appeals, probationary, and other transitional processes.**

Response: The State appreciates the commenter’s interest in the appeals process. Pursuant to the State’s approved Special Terms and Conditions, eligibility will be suspended for beneficiaries who fail to meet required community engagement hours, unless beneficiaries satisfy a statutory exemption or otherwise demonstrate that they have good cause for failing to meet the requirement, or appeal the suspension, prior to its effective date. Standard state appeals timeframes will apply to good cause appeals. All beneficiaries will have a 30-day period to come into compliance after notification that the requirement was not met in a given month. In accordance with current New Hampshire policy, individuals will have 30 days to request an appeal but, if they wish to have benefits to continue pending an appeal, they have 15 days from the date on the notice to request the appeal.

***Comment:* One commenter requested clarification about the steps needed to resume coverage if an individual does not comply with work and community engagement requirements.**

Response: If non-compliance is not “cured” during the month cure period, the State will suspend the beneficiaries’ eligibility effective the first of the month following the one-month opportunity to cure. The suspension will remain in effect until the beneficiary reactivates eligibility by either satisfying the deficiency in work and community engagement hours, obtaining an exemption, demonstrating good cause, or becoming eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement. Beneficiaries can reactivate eligibility prior to their redetermination date without having to complete a new application, provided that at least one of the above-listed criteria for reactivation is met.

***Comment:* Three commenters wrote with various concerns about a “lockout period,” noting that a “lockout” would interfere with coverage, which could be particularly problematic for individuals who are undergoing treatment for life threatening or otherwise serious diseases, such as cancer. Commenters also noted concern that if individuals are “locked out” serious diseases might not be diagnosed early enough to ensure the best health outcomes. Commenters acknowledged that the “good cause” exemption might provide relief to some individuals who otherwise would be “locked out” and they noted that beneficiaries should maintain coverage while any appeals process is being pursued.**

Response: The State appreciates the commenters’ concern about the risk of terminating coverage mid-treatment but wishes to clarify that New Hampshire is not instituting a “lockout” under which individuals who lose coverage for failure to comply with work requirements are barred from reapplying for Medicaid coverage for a certain period of time. New Hampshire will permit individuals to reapply for

Medicaid at any time after their eligibility is terminated for failure to comply with work requirements. Individuals who do not comply with work requirements will first be suspended from the program, during which time medical assistance will not be available; however, individuals with acute health care conditions may apply for an exemption to avoid suspension. Beneficiaries will retain coverage while the exemption is being sought, as long as they have completed verifying the exemption before the suspension is scheduled to take effect.

***Comment:* One commenter asked about what happens to a person’s outstanding hospital bill if they incurred charges at a hospital and no longer meet work and community engagement requirements.**

Response: If a Medicaid beneficiary was in compliance with work and community engagement requirements during his or her hospitalization, the hospital bill remains the responsibility of Medicaid and the provider would be reimbursed, even if that beneficiary later loses eligibility. Additionally, the State has a defined exemption from work and community engagement requirements for beneficiaries who are ill: beneficiaries can seek an exemption from work and community engagement requirements if they are temporarily unable to participate due to illness or incapacity as documented by a licensed provider. In addition to this established exemption, beneficiaries can also seek a good cause exemption if they experienced a hospitalization or serious illness and were not previously exempted from work and community engagement requirements. The State will provide beneficiaries with information about how to seek such exemptions prior to the January 1, 2019 implementation of the work and community engagement program.

***Comment:* One commenter remarked that new information requests of individuals, such as those relating to obtaining an exemption or confirming compliance with the work and community engagement hours requirements, may cause beneficiaries to lose coverage. Another commenter expressed similar concerns about the administrative burden and risk of coverage losses associated with verifying compliance, noting that in the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) program (which have similar requirements) beneficiaries report not understanding what verification is needed and losing benefits because documents scanned were not timely or properly put into their electronic case file.**

Response: The State thanks the commenters for their input. The State seeks to make information on what is needed in order to obtain an exemption or good cause exemption and report compliance with work and community engagement requirements widely available and known to beneficiaries, their providers, MCOs, and other stakeholders. To mitigate concerns that new information requests will serve as barrier to maintaining coverage, the State also aims to make resources broadly available to ensure that beneficiaries are aware of resources available to assist them with any reporting requirements and to develop user-friendly reporting interfaces to facilitate reporting and verification of work activities.

***Comment:* Two commenters inquired about how the State will verify beneficiary compliance with the work and community engagement requirements.**

Response: The State is currently developing its systems and processes relating to the work and community engagement program, in line with SB 313 and CMS-approved STCs and guidance, and will be describing these processes further in administrative rules.

SB 313 directs DHHS, for the period of January 1, 2019 through June 30, 2020, “to verify beneficiary compliance to the greatest extent practicable” through the verification of beneficiary- and MCO-

reported status and information, including information from the eligibility file. Per SB 313, beneficiaries will be required to report information regarding their qualifying activities, exemptions, compliance, and any changes in their status to DHHS in accordance with the State's administrative rules. DHHS must also develop "a plan for the implementation of a fully automated verification system that utilizes State and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020."

Comment: Five commenters asked about how the State will monitor the work and community engagement program, including tracking work program participation and compliance. Several commenters expressed concern about the high potential costs of administering the program and some expressed the position that state funds could be better invested in other uses, rather than tracking compliance with work requirements.

Response: Per the CMS-approved work and community engagement STCs, the State must develop an eligibility and enrollment monitoring plan. This plan will address how DHHS will comply with the assurances described in the STCs, such as ensuring that there are timely and adequate beneficiary notices provided in writing, that application assistance is available to beneficiaries (in person and by phone), and that the State has processes and procedures in place to obtain data from other sources and systems to enable both beneficiaries to efficiently report compliance or obtain an exemption and DHHS to monitor compliance. The State must also submit regular monitoring reports to CMS related to the overall waiver goals and objectives. DHHS will work with CMS if issues are identified as the State implements the work and community engagement program. The State's administrative rules will reflect these requirements.

Comment: Several commenters noted that work and community engagement reporting requirements will create an administrative burden for both enrollees and the State, and that reporting requirements as well as barriers to securing exemptions could negatively impact enrollment. They noted that even individuals who do comply with hours could have difficulty verifying employment, which could lead to coverage losses.

Response: The State thanks the commenters for their input. The State secured approval to implement work and community engagement requirements consistent with State legislation and, therefore, it is imperative that the State develop mechanisms to track compliance with the new requirements. In implementing the requirement, the State is seeking to minimize reporting burden on beneficiaries. SB 313 recognized the effort required to ensure appropriate and accurate verification of qualifying activity hours and required the Department to submit a report to the Governor and legislature by January 1, 2019 with recommendations as to how the verification can be implemented. Additionally, in the coming months, DHHS will provide information to beneficiaries about reporting mechanisms, which will include telephone, computer, and mobile application reporting so that beneficiaries can report their activities in the manner most convenient and accessible to them. The State is launching a multimedia Digital Inform campaign to educate beneficiaries about the new requirements and compliance reporting. The State also will monitor enrollment in the evaluation to determine how the new requirements impact enrollment over time.

Comment: One commenter questioned whether the State has sufficient funding and resources to adequately administer and measure the effectiveness of the program.

Response: Funding for administration and evaluation of Granite Advantage is included in DHHS' financial projections for the Medicaid program.

Comment: Two commenters requested more information on the role of MCOs in the administration of work and community engagement requirements. One commenter inquired about whether DHHS will pay MCOs to track beneficiary compliance with work and community engagement requirements. The other commenter expressed a concern that MCO involvement could create potential conflicts of interest if MCOs are given responsibility for completing the determination verification.

Response: SB 313 stipulates that MCOs must share with DHHS beneficiary-reported information regarding the work and community engagement requirements obtained through standard contract activities, including enrollment activities, outreach activities, and beneficiary care management. The MCOs must also work collaboratively with DHHS and any outside contractor in encouraging and monitoring work and community engagement activities. The State is currently developing its administrative rules and protocols for work and community engagement implementation, which will outline more details about the role of MCOs in administration.

Comment: One commenter expressed concern that work requirements and financial reporting associated with the new requirement will create new burdens for Community Mental Health Centers as well as more erratic income situations for consumers. The commenter noted in particular concerns that if individuals are working and become ineligible for the Medicaid expansion group, they may become eligible through other eligibility pathways that require a spenddown calculation, which could add to management burden and financial harm for Community Mental Health Centers.

Response: The State appreciates the commenter's concern and recognizes that Community Mental Health Centers (CMHCs) are an essential provider for Medicaid beneficiaries. We note that the work requirements only apply to individuals in the Medicaid adult expansion population but that many people eligible for CMHC services will most likely qualify for an exemption.

Comment: One commenter recommended that DHHS proactively provide a list of exemptions to applicants and beneficiaries. In addition, the commenter asked for clarification on the criteria that will be used in determining exemptions.

Response: The exemptions are described in the work and community engagement STCs approved by CMS on May 7, 2018; the State is currently drafting administrative rules to codify these exemptions. In preparation for implementation of the work and community engagement requirements on January 1, 2019, DHHS will provide notices about exemptions and qualifying criteria to both applicants and existing beneficiaries. The list will also be available on the DHHS website, along with information about how to seek and obtain exemptions. This information will include details about the type of providers who may certify exemptions, consistent with the State legislation, and the information that providers must submit to secure exemptions for their patients. The State will conduct stakeholder education campaigns to educate both beneficiaries and providers about the new procedures.

Comment: Two commenters recommended adding additional exemptions for beneficiaries who could have difficulty meeting the work and community engagement requirement. One recommended exemptions for beneficiaries who are eligible for state-funded community mental health services (as per New Hampshire Administrative Rule He-M 401). The other asked for exemptions for beneficiaries with cystic fibrosis.

Response: The State thanks commenters for their input. Allowable exemptions are defined in state legislation and reflected in the approved waiver Special Terms and Conditions. Individuals with mental health needs and with cystic fibrosis likely qualify for existing exemptions, such as for medical frailty and by certifying illness or incapacity as documented by a licensed provider. In addition, beneficiaries can apply for a good cause exemption if they experienced a hospitalization or serious illness and were not already exempted from work and community engagement requirements.

***Comment:* Two commenters requested that DHHS provide more details about good cause exemptions, including a list of all good cause exemptions.**

Response: State legislation provides direction on good cause exemptions for work and community engagement requirements. These include, but are not limited to: beneficiary experiencing birth or death of a family member living with the beneficiary; severe inclement weather including a natural disaster; a family emergency or other life-changing event; being a victim of domestic violence, dating violence, sexual assault, or stalking; and being a custodial parent or caretaker of a child 6 to 12 years of age who is unable to secure child care in order to participate in qualifying work and other community engagement. The CMS-approved work and community engagement STCs include several other good cause exemptions, consistent with CMS policy, including good cause exemptions for beneficiaries who are not already exempted but who: have a disability as defined by the ADA, section 504, or section 1557, and were unable to meet the requirement for reasons related to that disability; reside with an immediate family member who has a disability as defined by the ADA, section 504, or section 1557, and were unable to meet the requirement for reasons related to the disability of that family member; experienced a hospitalization or serious illness; or resides with an immediate family member who experienced a hospitalization or serious illness.

The State is drafting administrative rules to codify these good cause exemptions and may use its discretion to specify additional exemptions. As the State implements work requirements, DHHS will post information about exemptions online in addition to providing clear notices to beneficiaries.

***Comment:* Two commenters expressed concerns about beneficiaries' ability to comply with work and community engagement requirements due to illness, particularly hourly workers who fall sick.**

Response: Consistent with both State legislation and the CMS-approved work and community engagement STCs, individuals who are unable to participate in the requirements due illness, incapacity, or treatment are exempt from work and community engagement requirements. As noted above, individuals who experience a hospitalization or serious illness may obtain a good cause exemption from work and community engagement requirements, if they are not already exempt.

***Comment:* Two commenters inquired about caregiving exemptions and qualifying activities. Both commenters recommended adding an exemption for caregiving for family member whether or not they live in applicant's household. One commenter asked for clarification about whether the exemption for "beneficiaries who are parents or caretakers where care of a dependent is considered necessary by a licensed provider" includes non-dependents. The commenter asked to add caregiving for non-dependents as an exemption. In addition, the commenter asked whether caregiving can be included as a good cause exemption in the approved work and community engagement STCs under the category "Other good cause reasons as defined or approved by the state."**

Response: Consistent with both State legislation and the CMS-approved work and community engagement STCs, caregiving services for a non-dependent relative or other person with a disabling health, mental health, or developmental condition is a qualifying activity that can be used to satisfy their work and community engagement requirements. Therefore, while the State will not have an exemption for caregiving services, the State recognizes the importance of these activities and would count hours providing caregiving services toward compliance with work and community engagement requirements.

***Comment:* Eleven commenters requested that DHHS add a homeless hardship exemption from work and community engagement requirements.**

Response: The State acknowledges the unique challenges that people who are homeless or have unstable housing confront with regard to work readiness, documentation of eligibility factors, and timely engagement with DHHS on renewal or change reporting. Given these challenges, during its rulemaking process, DHHS will consider instituting a good cause exemption for people who are homeless or who have unstable housing.

***Comment:* One commenter recommended adding completion of coursework, attendance at an out-of-state or online school, and travel time, similar to the TANF program, to the list of qualifying activities.**

Response: The State thanks the commenter for their input. State legislation and the CMS-approved work and community engagement STCs stipulate the activities that may be counted toward work and community engagement hours. The State acknowledges that CMS has encouraged alignment of Medicaid work requirements with TANF/SNAP requirements. The State will consider in its rulemaking process alignment of rules between the two, including rules with regard to counting education, education related activities, and travel time.

***Comment:* Seven commenters noted that the approved waiver STCs do not specifically include self-employment as a qualifying activity and recommended adding self-employment as a qualifying activity. Many commenters expressed concern that the omission would prohibit coverage and health care access for many 1099 independent contractors, such as home health workers, carpenters, plumbers, and other contractors. Another commenter suggested that additional research on the impacts of Granite Advantage on self-employed individuals should be pursued and incorporated into the application.**

Response: The State thanks the commenters for their input. In accordance with SB 313, self-employment will not be permitted as an allowable work activity at this time.

***Comment:* Two commenters requested more information about SUD treatment as it relates to qualifying activities and exemptions from work and community engagement requirements. One of the two commenters asked specifically about whether participation in a SUD day program can count towards qualifying hours for work and community engagement requirements.**

Response: SUD treatment is a qualifying activity for satisfying work and community engagement requirements, meaning that hours spent in treatment can count toward the 100-hour requirement. In forthcoming administrative rules, the State will provide clarification about how “SUD treatment” is defined for the purposes of the work and community engagement program, including whether it is inclusive of SUD day programs. A beneficiary receiving SUD treatment may also be determined to be medically frail and/or temporarily unable to participate in work and community engagement

requirements due to illness or incapacity. Therefore, the beneficiary may be exempted from work and community engagement requirements.

Comment: Several commenters cited low unemployment in New Hampshire and stated that the majority of Medicaid expansion adults are already working and those that are not have a compelling reason. One commenter asked about quantitative evidence regarding work and community requirements and suggested building a “trigger” for CMS review. Another commenter recommended that the State build a transparent process to measure health benefits related to work and community engagement requirements.

Response: The State thanks the commenter for their input. As described in CMS guidance (cited above), demonstrations of work and community engagement requirements in Medicaid are intended to test the hypothesis that employment is beneficial to health outcomes. Per the CMS-approved work and community engagement STCs, the State must develop an eligibility and enrollment monitoring plan and provide data on specific metrics, including, where possible: the number and percentage of beneficiaries who demonstrate exemption, are granted good cause, or requested reasonable accommodations; the number and percentage of beneficiaries whose eligibility was suspended for failing to comply or terminated at eligibility redetermination; the number of community-engagement related appeal requests; the number, percentage and type of good cause exemptions requested and granted; and the number and percentage of applications made in-person, by phone, by mail, and electronically. The State must also submit regular monitoring reports to CMS related to the overall waiver goals and objectives. DHHS will work with CMS if issues are identified as the State implements these new requirements.

Comment: Several commenters asked about the impact of work and community engagement requirements on beneficiary enrollment, calling for data-informed projections and citing concern that the requirement will impact significant portions of Medicaid beneficiaries. One commenter inquired about the number of NHHPP beneficiaries who are not currently meeting work and community engagement requirements.

Response: DHHS estimates that roughly 53,000 beneficiaries will be in the Granite Advantage program, though not all will be subject to work and community engagement requirements. As the State implements the program, it will report regularly on enrollment and participation and will evaluate the impact of work and community engagement accordingly. These reports will be available on the DHHS and CMS websites.

Comment: One commenter noted that the application states the intent to track the number and percentage of beneficiaries who are disenrolled for either failing to report on or comply with the community engagement requirements. The commenter questioned whether seeking to collect information regarding health outcomes for those who are disenrolled may provide insights into the impacts of the community engagement requirements on promoting beneficiary health, particularly for those who re-enroll in Medicaid later following a period of coverage loss.

Response: The State appreciates the commenters’ interest in evaluating the impact of the demonstration. According to CMS guidance, evaluations must be designed to determine whether the demonstration is meeting its objectives, as well as the impact of the demonstration on Medicaid beneficiaries and on individuals who experience a lapse in eligibility or coverage for failure to meet the program requirements or because they have gained employer-sponsored insurance.

Comment: One commenter expressed concern that housing programs for individuals with serious mental illness (SMI) require 90-day certifications and this will provide a disincentive to working.

Response: The State thanks the commenter for the input. As noted above, individuals with SMI will be exempt from the work and community engagement requirement on the basis that they are medically frail.

Comment: One commenter asked whether work and community engagement program features (e.g., qualifying activities, exemptions, and processes) can be commented on during the waiver process, though they will be addressed in rulemaking.

Response: As noted, CMS approved the State's request to implement work and community engagement requirements for the Medicaid adult expansion population on May 7, 2018. The Granite Advantage waiver amendment and extension public comment period provided an important opportunity for the public to continue to comment on the work and community engagement program, which the State is seeking to extend. The State is undertaking rulemaking to codify the CMS-approved work and community engagement requirements in State administrative rules. As part of this process, the State will conduct a public comment period for rulemaking, expected to begin in October.

Citizenship Documentation

Comment: Several commenters expressed concern that the citizenship and residency requirements described in the draft waiver application are inconsistent with federal law.

Response: The State appreciates the commenters' concern and is committed to administering the Granite Advantage program consistent with federal law. In accordance with the recently enacted Granite Advantage legislation, DHHS is seeking a waiver to make eligibility for Granite Advantage contingent upon an individual verifying (1) his or her United States citizenship with two forms of paper identification, and (2) his or her New Hampshire residency with either a New Hampshire driver's license or a non-driver's picture identification card. If this request is granted, the State will implement this authority consistent with the federal approval.

Comment: Several comments noted that the citizenship/residency documentation requirement creates a paperwork burden that could jeopardize access to care and that the requirement does not promote the objectives of the Medicaid program. The commenters also noted that New Hampshire did not include an evaluation hypothesis to test this proposal as part of its waiver evaluation and they indicated that the state should include a hypothesis and outline how it plans to measure the proposal's impact on access to coverage for individuals eligible for Medicaid as part of its application.

Response: The State appreciates the commenter's input and added a hypothesis to the waiver application submitted to CMS. As noted above, DHHS is seeking a waiver to permit citizenship and residency documentation requirements in accordance with the recently enacted Granite Advantage legislation. This authority, if approved will allow New Hampshire to test whether requiring documentation will improve the accuracy of eligibility decisions and enable the State to devote scarce resources to support the Medicaid population. If approved, New Hampshire will update its waiver evaluation design to evaluate whether changing citizenship verification requirements had any negative impact on participants and will also analyze data to report any significant delays in eligibility processing or declines in enrollment after the enactment of this requirement.

Comment: Many commenters expressed concern about the State’s proposed documentation requirements, noting that requesting paper forms of identification is unnecessary, burdensome, and inefficient since DHHS already has access to information through electronic databases. Many of these commenters noted that paper documentation should be required only when verification through electronic databases is not possible, and expressed concern about the administrative burden of requiring paperwork, which could cause beneficiaries to churn in and out of coverage.

Response: The State appreciates the commenters’ concerns about the potential burdens associated with requiring paper documentation to establish citizenship and residency. DHHS is seeking to require paper forms of identification in accordance with the recently enacted Granite Advantage legislation. If this request is granted, DHHS will work to ensure that the requirement does not unduly impact beneficiaries, monitoring the impact of the new policy so that the State can consider changes, if needed. Even then, they argued that a passport should be sufficient proof of citizenship.

Comment: One commenter expressed concern that the proposed citizenship documentation requirements will deter many legal immigrants from pursuing coverage for which they are eligible. The commenter expressed concern that the result of this policy change could be that fewer immigrant women seek prenatal care and that hospitals see more uncompensated care under the Emergency Medical Treatment and Active Labor Act.

Response: The State appreciates the commenter’s concern about unintended consequences of the proposed requirement to require paper documentation of citizenship. As noted in the application, if the request is approved, the State will monitor implementation to identify declines in enrollment after enactment.

Comment: A commenter expressed concern that the proposed citizenship documentation requirement would create unnecessary complexity and confusion for women applying for Medicaid expansion benefits because the documentation requirements will be different for different Medicaid eligibility categories.

Response: The State appreciates the commenters concern and will work to develop clear beneficiary notices so that program requirements are clear.

Comment: One commenter cited the proposed identification requirements and noted that enrolling in Medicaid should not be more difficult than it already is, particularly for vulnerable individuals who cannot advocate well for themselves, afford the cost of securing identification, or access the Department of Motor Vehicles given limited hours and locations. Another commenter asked for clarification about how the State will measure excessive burden and delays of citizenship and related documentation requirements, citing concern that real-time determinations made within 24 hours are done only 25% of the time.

Response: The State thanks the commenters for their concern. New Hampshire continues to update its New Heights eligibility system to maximize efficiencies in the eligibility determination process. Consistent with New Hampshire legislation, DHHS is seeking a waiver to require paper forms of citizenship documentation in order to assure that Medicaid resources are used only to support eligible individuals. If this request is approved, the State will monitor eligibility determination timeframes and

will also analyze data to report out any significant delays in eligibility processing or declines in enrollment after the enactment of this requirement.

Comment: One commenter asked whether it is possible to adopt SSI guidelines for citizenship verification.

Response: The State thanks the commenter for their suggestion. As noted above, the citizenship documentation request included in this waiver application is consistent with State legislation. If the request is approved by CMS, DHHS will implement the changes consistent with CMS guidance and will provide clear information to beneficiaries about the new requirement.

Comment: Nine commenters recommended a homeless hardship exemption from the requirement for the citizenship and residency documentation until stable housing is secured. Additional commenters cited the experience of homeless service providers to note the difficulty that homeless individuals are likely to experience in securing and/or providing two forms of identification, which will present a barrier to enrollment.

Response: The State acknowledges the unique challenges that people who are homeless or have unstable housing confront with regard to work readiness, documentation of eligibility factors, and timely engagement with DHHS on renewal or change reporting. If CMS approves the State's request to require citizenship and residency documentation, New Hampshire will consider creating an exemption from this requirement for people who are homeless or who have unstable housing.

Comment: Two commenters expressed concern that the required documentation specified in the waiver application goes beyond citizenship, creating additional barriers for beneficiaries in accessing Medicaid services. The commenters reference the need to inform DHHS of any changes to financial eligibility within 10 days and requiring photo identification as two such barriers.

Response: The State appreciates the commenters' concerns about reducing barriers to Medicaid eligibility and enrollment. DHHS is seeking federal authority to require photo identification and, if approved, DHHS will work to ensure that the requirement does not unduly impact beneficiaries. With respect to the commenter's concern about reporting changes, beneficiaries are already required to inform the Medicaid agency of changes in circumstances that could impact their eligibility; this is not changing and indeed DHHS is not seeking new CMS authority to implement this requirement, which was included in the State authorizing legislation. Beneficiaries who have questions about the Medicaid application process and eligibility can access online resources on the DHHS website, <https://www.dhhs.nh.gov/dfa/apply.htm>. In addition, members can contact Medicaid Client Services through phone and email (see <https://www.dhhs.nh.gov/ombp/medicaid/contact.htm> for more information).

Asset Test

Comment: Fifteen commenters wrote about the State's request to apply an asset test to the Medicaid expansion population and some urged the State to withdraw the request as it is contrary to the intent of the Medicaid expansion and has no merit as an experiment. Some commenters asserted that the asset test provision is inconsistent with federal law and would impose an inappropriate barrier to coverage. Two commenters specifically urged the state to continue applying modified adjusted gross income (MAGI) rules to income calculations for the adult expansion population and one inquired

whether assets are subject to a clawback. An additional commenter wrote to express concern that assets may not be truly indicative of financial status and that holding assets against a person when they apply for Medicaid will not help people achieve upward economic mobility, health, or promote the goals of the Medicaid program.

Response: The State thanks the commenters for their questions and concerns. The recently enacted State legislation directs New Hampshire to apply an asset test to individuals in the expansion population, if allowed by federal law. Consistent with this legislation, DHHS is therefore seeking a waiver to enable the State to apply an asset test to the adult Medicaid expansion population. If CMS grants the waiver, the State will follow CMS guidance in implementing the authority. Unless and until this authority is granted, DHHS will not determine the parameters of implementation (including whether to implement a clawback). Such issues would be deferred to State rulemaking and the public would have an opportunity to comment at that time.

***Comment:* Commenters noted that Congress expressly limited the Secretary’s ability to grant waivers like the one that the State is requesting to permit application of an asset test and concludes that the State’s request violates federal law and, in addition, does not have any experimental value because decades of research examining asset tests demonstrates that they are cumbersome to administer and complicated for applicants and recipients.**

Response: The State appreciates the commenters’ views. The application requests authority to waive the asset test consistent with enacted State legislation and will be implemented only if CMS authorizes the request.

***Comment:* Several commenters noted that the State did not include an evaluation hypothesis to test the requested waiver to apply an asset test to the adult expansion population.**

Response: The State appreciates the commenter’s input and added a hypothesis to the waiver application submitted to CMS. As noted above, the State is requesting the asset test pursuant to SB 313. If approved, this waiver will enable the state to test the proposition that applying an asset test will help the State preserve Medicaid funding for the lowest income, most vulnerable beneficiaries in the State. If approved, New Hampshire will update its waiver evaluation design to determine how counting assets influences eligibility and enrollment throughout the waiver extension period.

APPENDIX C

Written Public Comments on Granite Advantage

The New Hampshire Department of Health and Human Services (DHHS) received public comments in writing (e.g., emails, letters) and at public meetings (e.g., public hearings on Granite Advantage, Medical Care Advisory Committee meeting). All comments received are summarized in Appendix B.

This Appendix includes copies of the public comments received in writing.

Personally identifiable information has been redacted in comments that contain information about health status or other sensitive information.



Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

May 22, 2018

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. Housing Action NH is a statewide coalition of 80 organizations united around affordable housing policy and ending homelessness in New Hampshire. We work to improve state and federal policy so everyone in New Hampshire has a place to call home. We would like to focus our comments on two issues: 1) the need for a homeless hardship exemption from work or community engagement requirements; and 2) the need for a homeless hardship exemption from the requirement for citizenship/residency documentation.

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.

Similar to the response of the state of Indiana after adopting work or community engagement requirement, we ask that New Hampshire exempt those in our state experiencing homelessness or chronic homelessness.

As noted in a letter from Indiana's Medicaid Director to CMS, "Responding to the comments to expand the list of exemptions for community engagement requirements, the state added beneficiaries **who are homeless...** to the exemption list." We ask that New Hampshire do the same.

In addition, we ask that New Hampshire adopt rules as Kentucky did to protect those experiencing eviction or homelessness from termination of benefits due to a failure to renew eligibility or to report a change in circumstances.

Citizen/Residency Documentation

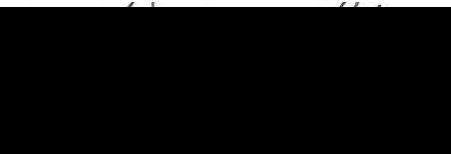
There are many adverse consequences to homelessness, including the inability to store personal effects and documents. According to professionals among the homeless service provider community, the majority of people experiencing homelessness in New Hampshire will be unable to provide two forms of documentation of United States citizenship and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card.

As one provider from NH's Healthcare for the Homeless program noted, "I believe many of our clients or future clients would lose an invaluable resource for medical care, which includes medical, mental health, treatment for chronic disease, vaccinations including the flu shot, preventative care, substance misuse treatment just to name a few. This potentially will create an influx of medical usage in the ED's and Urgent Cares. One of my biggest concerns would be for those that are in a methadone treatment program etc. could potentially spiral into a complete negative situation."

We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Very best regards,



Elissa Margolin
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603 828 5916
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Health Care for the Homeless Program – Manchester

Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

May 22, 2018

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. Healthcare for the Homeless Program - Manchester

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.

Similar to the response of the state of Indiana after adopting work or community engagement requirement, we ask that New Hampshire exempt those in our state experiencing homelessness or chronic homelessness. As noted in a letter from Indiana's Medicaid Director to CMS, "Responding to the comments to expand the list of exemptions for community engagement requirements, the state added beneficiaries **who are homeless...** to the exemption list." We ask that New Hampshire do the same.

In addition, we ask that New Hampshire adopt rules as Kentucky did to protect those experiencing eviction or homelessness from termination of benefits due to a failure to renew eligibility or to report a change in circumstances.

Citizen/Residency Documentation

There are many adverse consequences to homelessness, including the inability to store personal effects and documents. According to professionals among the homeless service provider community, the majority of people experiencing homelessness in New Hampshire will be unable to provide two forms of documentation of United States citizenship and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card.

As one provider from NH's Healthcare for the Homeless program noted, "I believe many of our clients or future clients would lose an invaluable resource for medical care, which includes medical, mental health, treatment for chronic disease, vaccinations including the flu shot, preventative care, substance misuse treatment just to name a few. This potentially will create an influx of medical usage in the ED's and Urgent Cares. One of my biggest concerns would be for those that are in a methadone treatment program etc. could potentially spiral into a complete negative situation."

We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Very best regards,



Danielle Provencal
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Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

May 23, 2018

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. [Insert agency info here]

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.

Similar to the response of the state of Indiana after adopting work or community engagement requirement, we ask that New Hampshire exempt those in our state experiencing homelessness or chronic homelessness. As noted in a letter from Indiana's Medicaid Director to CMS, "Responding to the comments to expand the list of exemptions for community engagement requirements, the state added beneficiaries **who are homeless...** to the exemption list." We ask that New Hampshire do the same.

In addition, we ask that New Hampshire adopt rules as Kentucky did to protect those experiencing eviction or homelessness from termination of benefits due to a failure to renew eligibility or to report a change in circumstances.

Citizen/Residency Documentation

There are many adverse consequences to homelessness, including the inability to store personal effects and documents. According to professionals among the homeless service provider community, the majority of people experiencing homelessness in New Hampshire will be unable to provide two forms of documentation of United States citizenship and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card.

As one provider from NH's Healthcare for the Homeless program noted, "I believe many of our clients or future clients would lose an invaluable resource for medical care, which includes medical, mental health, treatment for chronic disease, vaccinations including the flu shot, preventative care, substance misuse treatment just to name a few. This potentially will create an influx of medical usage in the ED's and Urgent Cares. One of my biggest concerns would be for those that are in a methadone treatment program etc. could potentially spiral into a complete negative situation."

We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Very best regards,

A black rectangular box redacting the signature of Lauren Berman.

Lauren Berman
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Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

May 23, 2018

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. Cross Roads House is one of the largest emergency shelter providers in the state, serving over 500 men, women and children each year in the Greater Seacoast region.

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.

Similar to the response of the state of Indiana after adopting work or community engagement requirement, we ask that New Hampshire exempt those in our state experiencing homelessness or chronic homelessness. As noted in a letter from Indiana's Medicaid Director to CMS, "Responding to the comments to expand the list of exemptions for community engagement requirements, the state added beneficiaries **who are homeless...** to the exemption list." We ask that New Hampshire do the same.

In addition, we ask that New Hampshire adopt rules as Kentucky did to protect those experiencing eviction or homelessness from termination of benefits due to a failure to renew eligibility or to report a change in circumstances.

Citizen/Residency Documentation

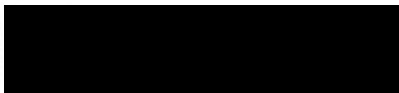
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We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Very best regards,

A solid black rectangular box used to redact the signature of Martha Stone.

Martha Stone
Executive Director
Cross Roads House
600 Lafayette Road
Portsmouth, NH 03801

Phone: [603-436-2218](tel:603-436-2218) ext. 110
martha@crossroadshouse.org
www.crossroadshouse.org



The Mental Health Center
of Greater Manchester

401 Cypress Street
Manchester, NH 03103
www.mhcgmm.org

P: 603.668.4111 F: 603.669.1131

Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

May 23, 2018

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. [Insert agency info here]

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.

Similar to the response of the state of Indiana after adopting work or community engagement requirement, we ask that New Hampshire exempt those in our state experiencing homelessness or chronic homelessness. As noted in a letter from Indiana's Medicaid Director to CMS, "Responding to the comments to expand the list of exemptions for community engagement requirements, the state added beneficiaries **who are homeless**... to the exemption list." We ask that New Hampshire do the same.

In addition, we ask that New Hampshire adopt rules as Kentucky did to protect those experiencing eviction or homelessness from termination of benefits due to a failure to renew eligibility or to report a change in circumstances.

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We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Very best regards,

Patricia Carty
Executive Vice President/Chief Operating Officer



NH Coalition to End Homelessness

Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

May 23, 2018

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. The New Hampshire Coalition to End Homelessness is a statewide organization committed to ending homelessness in New Hampshire. We work to raise the voices of those who have experienced homelessness so that they can play active roles in finding solutions to this solvable problem. We would like to comment on two issues: 1) The need for a homeless hardship exemption from work or community engagement requirements; and 2) The need for a homeless hardship exemption from the requirement for citizenship/residency documentation.

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.

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list of exemptions for community engagement requirements, the state added beneficiaries **who are homeless...** to the exemption list.” We ask that New Hampshire do the same.

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Citizen/Residency Documentation

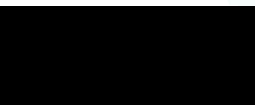
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As one provider from NH's Healthcare for the Homeless program noted, “I believe many of our clients or future clients would lose an invaluable resource for medical care, which includes medical, mental health, treatment for chronic disease, vaccinations including the flu shot, preventative care, substance misuse treatment just to name a few. This potentially will create an influx of medical usage in the ED's and Urgent Cares. One of my biggest concerns would be for those that are in a methadone treatment program etc. could potentially spiral into a complete negative situation.”

We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Sincerely,



Cathy Kuhn, PhD
Director
New Hampshire Coalition to End Homelessness
122 Market Street
Manchester, NH 03101
603-641-9441 x251
ckuhn@nhceh.org



May 24, 2018

Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

Via email to: nhmedicaidcaremanagement@dhhs.nh.gov

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. The Concord Coalition to End Homelessness is a 501(c)(3) non-profit that serves people experiencing homelessness. We operate a daytime Resource Center, a permanent supportive housing program for chronically homeless individuals, and recently “cut the ribbon” on a new Emergency Winter Shelter in Concord.

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.

Similar to the response of the state of Indiana after adopting work or community engagement requirement, we ask that New Hampshire exempt those in our state experiencing homelessness or chronic homelessness. As noted in a letter from Indiana’s Medicaid Director to CMS, “Responding to the comments to expand the list of exemptions for community engagement requirements, the state added beneficiaries **who are homeless**... to the exemption list.” We ask that New Hampshire do the same.

The Concord Coalition to End Homelessness is a 501(c)(3) charitable organization. Donations are tax deductible to the extent allowed by law. No goods or services were provided in exchange for your donation.

In addition, we ask that New Hampshire adopt rules as Kentucky did to protect those experiencing eviction or homelessness from termination of benefits due to a failure to renew eligibility or to report a change in circumstances.

Citizen/Residency Documentation

There are many adverse consequences to homelessness, including the inability to store personal effects and documents. According to professionals among the homeless service provider community, the majority of people experiencing homelessness in New Hampshire will be unable to provide two forms of documentation of United States citizenship and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card.

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We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Very best regards,

A black rectangular redaction box covering the signature of Ellen Groh.

Ellen Groh
Executive Director
Concord Coalition to End Homelessness
P.O. 3933
Concord, NH 03302
(603) 290-3375
ellen@concordhomeless.org
www.concordhomeless.org



Providing a Home. Building Hope.



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Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and Residency Documentation for the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

May 24, 2018

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. Families in Transition-New Horizons operates the largest emergency shelter for single men and women in the state. Every day, we see people who are in facing severe health challenges and are in need of immediate and comprehensive healthcare. We would like to comment on two issues: 1) The need for a homeless hardship exemption from work or community engagement requirements; and 2) The need for a homeless hardship exemption from the requirement for citizenship/residency documentation.

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes of homelessness, they are also the most cost-effective approach to transitioning the homeless to stable housing.



Providing a Home. Building Hope.



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We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Sincerely,



President

GREATER NASHUA CONTINUUM OF CARE

c/o Harbor Homes, Inc
77 Northeastern Blvd, Nashua, NH 03062
603/882-3616

Continuum of Care Membership is comprised of:

May 24, 2018

Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301

RE: Need for **Homeless Hardship Exemptions** from Work Requirements and
Residency Documentation for the Granite Advantage Health Care Program Section
1115(a) Demonstration Waiver

Commissioner Meyers:

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. The Greater Nashua Continuum of Care was founded in 1995. Our mission is threefold: (1) To foster and promote comprehensive, cohesive, and coordinated approaches to housing and community resources for person experiencing homelessness and families; (2) To identify and address service gaps and risk factors in the community; and (3) To prioritize unmet service needs to develop and oversee a system of prevention, intervention, outreach assessment, direct care and aftercare for individuals and families experiencing homelessness.

Through networking and collaborating, we seek to formalize coordinated strategies towards the development of an unduplicated, seamless service provision for the community's homeless population. The ultimate vision for success held by the Greater Nashua COC is one of an idealistic community where homelessness no longer exists. In this vision, there are adequate resources for each individual to access the goods and services he or she requires. An ample supply of safe, affordable, permanent housing and support services would assure that no one will have to sleep on the streets, in automobiles, park benches or places unfit for human habitation. Additionally, The COC is responsible for collaboratively submitting an application for funding each year to HUD grants, approximately \$1.6 million annually for housing and supportive services in our community.

Work or Community Engagement Requirements

The reauthorization of the NH expanded Medicaid program includes new work or community engagement requirements for eligible recipients. However, per RSA 541-A, the Commissioner of Health and Human Services may promulgate and adopt rules to determine good cause and other exceptions to the termination of coverage.

The residents of New Hampshire who are experiencing homelessness are some of the most vulnerable people in our state. Medicaid coverage for health and other related services is one of the most important tools in addressing the crisis of homelessness. Not only are health services essential to addressing root causes

Non-profit agencies

Homeless service
providers

Local, State and Federal
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Representatives

Private Business owners

Town and City Welfare
Administrators

Public Housing
Authorities

Landlords

Faith-based community
members

Homeless and Formerly
Homeless persons

Private
Citizens/Advocates

Hospitals

GREATER NASHUA CONTINUUM OF CARE

c/o Harbor Homes, Inc
77 Northeastern Blvd, Nashua, NH 03062
603/882-3616

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We ask that the Department adopt rules to address this difficulty among the homeless population by providing a full hardship exemption to these documentation requirements until stable housing is secured.

Thank you for your serious consideration of these important issues.

Very best regards,

Mandy Reagan
Co-Chair Greater Nashua COC
Harbor Homes
Partnership for Successful Living
77 Northeastern Blvd Nashua NH 03062
603-882-3616
M.Reagan@nhpartnership.org

Heather Nelson
Co-Chair Greater Nashua COC
Harbor Homes
Partnership for Successful Living
77 Northeastern Blvd Nashua NH 03062
603-882-3616
H.Nelson@nhpartnership.org

Continuum of Care Membership is comprised of:

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members

Homeless and Formerly
Homeless persons

Private
Citizens/Advocates

Hospitals

**Medicaid Expansion
Public Comment
Harbor Homes, Nashua
May 24, 2018**

From: Kathy Staub
374 Laurel Street
Manchester, NH 03103
kstaub@comcast.net
603 624-0249

I am a 60 year-old woman with lots of 60 year-old friends. Someone a little older than me once said that as soon as you turn 50 everything starts falling apart, and was she ever right. Every day I hear from friends and classmates about back injuries, hip replacements, the onset of diabetes, cancer and other serious health problems. People my age need access to health care.

Some of my friends lost their jobs and their health insurance during the recession and have never been able to find full time work. They are surviving on part-time jobs, food stamps, and medicaid expansion. I have one friend in this situation who started working when she was 14. She lost her job and insurance and then injured her back. She has a dropped foot now. She works part-time and picks up extra hours when someone calls in sick or goes on vacation. I'm sure she does work 100 hours some months, but what if no one goes on vacation or calls in sick? Does she lose her insurance? How soon could she get it back?

One of the reasons people in their 60's can't find work is the little check box on the application that asks whether you can lift 50 pounds. Another one of my friends says they put that there just to discourage older people from applying. How will the state find appropriate work for people whose bodies are beginning to break down?

I'm not sure that job training for someone my age is a good use of resources. For younger people it might be a good thing to offer it, but not require it. A lot of people my age are tired or in pain after working 40 years or more and we just hope we live long enough to qualify for Medicare.

Some of us work part time so we can provide childcare for our grandchildren, which is a great benefit to our families. Childcare is expensive and not available in a lot of places. To me that is a community service. Reliable childcare for employees is a great benefit to the business community that grandmothers provide, but it won't count toward their insurance.

Medicaid Expansion is a great program that has helped thousands of people get well or stay well. The federal money has also helped us face the opioid epidemic and keep rural health centers open so people in remote areas have access to health care. Work requirements will not improve these outcomes and it will likely make them worse.

Melby, Leslie

From: [REDACTED]
Sent: Thursday, May 24, 2018 10:18 AM
To: DHHS: nhmedicaidcaremanagement
Subject: Public comments/questions

Questions:

What provisions are made to accommodate for the financial costs of childcare for people required to work who up to now have been able to stay home and care for children?

Who decides who is "able-bodied"? Is someone with cognitive or mental health disabilities but otherwise physically sound "able-bodied"?

How are people supposed to find suitable work with unemployment currently so low?

Exactly how many people are the sponsors claiming are not working who should be; in other words, how big a problem is this really?

What do they claim is the cost/benefit ratio, considering costs of administering the provisions of this law compared to Medicaid costs?

What are the costs to taxpayers of people not having access to health care compared to the costs of Medicaid?

It seems to me the impetus behind this bill is philosophical/political, rather than anything having to do with the public good or fiduciary duty. It's umbrage over the idea that people who are poor choose to be poor and are just bilking those of us who are obviously morally superior, shown by our own relative comfort.

[REDACTED]
[REDACTED]
[REDACTED]

Sent from [Mail](#) for Windows 10

Melby, Leslie

From: [REDACTED]
Sent: Tuesday, May 29, 2018 1:12 PM
To: DHHS: nhmedicaidcaremanagement
Cc: Melby, Leslie; Kristen Bryant; Brian Klinger; Angel Sawyer; Winnie Tseng
Subject: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver/Comments

Comments on Medicaid Expansion/Granite Advantage Health Care Program

To: DHHS, Leslie Melby

[REDACTED]

I am a practicing optometrist in Milford and accept and see patients covered by all the basic and expanded Medicaid products. As the long time NHOA Third Party Chairman I have been involved representing optometrists as stakeholders in many matters involving Medicaid over the last 15 + years, including the transition from DHHS Medicaid to managed care Medicaid.

The NHOA represents about 80% of practicing optometrists in New Hampshire, and I also serve as a liason to this group when issues which concern us arise. I realize GAHCP changes may mostly deal with work and citizenship/residency requirements for members. However, I/we have some concerns with the program in other areas and I feel this is a good opportunity to address some other issues.

Over the years and decades, it has always been a challenge to get optometrists to participate with Medicaid. Without going into all the specifics, I'll write that when DHHS Medicaid transitioned to Managed Care Medicaid our optometric group worked with the MCOs to address many issues of concern to all parties. The processes, programs, and policies which were negotiated were revenue neutral and were a win win win for the MCOs, providers, and members.

However, as Medicaid "expanded" and more MCOs got involved the system got extremely convoluted and problematic for optometry. I see this in my clinical practice every day, and also hear about it from my NHOA colleagues. Some have stopped accepting Medicaid and many others are considering dropping the program.

Optometrists provide "routine" eye care, medical eye care, and most provide hardware (glasses) to Medicaid members. The most significant issues of concern to our profession are:

1. Low reimbursement for medical procedures, and possible differing policies and reimbursements for the same service between optometrists and ophthalmologists.
2. Varying policies for frequency of "routine" eye exams between the various Medicaid and Expanded Medicaid products and carriers.
3. Covered eyeglass frames vary between the various Medicaid and Expanded Medicaid products and carriers.
4. Different Medicaid and Expanded Medicaid carriers require us to send our glasses out to different (ophthalmic fabrication) labs to be made. This specific issue is especially problematic in regards to delivery time for glasses and quality of workmanship, along with many other nuanced problems.
5. Poor eyeglass frame selection.
6. Minimal or no "buy up" provision for patients who wish to have better than basic glasses.

Each of these issues was addressed during the initial DHHS to Managed Care transition, and most of these issues were resolved, with input from our profession, to the satisfaction of the MCOs, DHHS, patients, and practitioners, in a revenue neutral way. However, since the transition took place, more MCOs have become involved and Medicaid has split into basic and expanded Medicaid; there quickly became too many

programs for optometric practitioners to monitor. The involved MCOs generally use programs they've either adapted from another state, or which has been advocated to them by a "vision care carveout (or both). The net effect is that New Hampshire optometrists, who are actually seeing the patients, have to adapt their office policies and procedures to increasingly complicated and convoluted schemes for providing care.

I've copied the following from the request for comments:

The Department plans to amend the State Plan to provide the same benefits to the Granite Advantage Medicaid new adult group as is currently being provided to individuals enrolled in other eligibility categories.

Assuming the DHHS follows through with what was just stated, it stands to reason that a simpler, basic, uniform scheme for providing eye care and hardware should be developed.

I/we realize optometry services are not a high dollar line item, but these services are a valued benefit for members. If the DHHS would like practitioner input to address some of the issues I noted above, both now and when the contracts are re bid next year, I and /or other NHOA members, representing the majority of optometric providers , will be more than willing to meet and talk.

Sincerely,

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Thursday, May 31, 2018 2:43 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Granite Advantage Health Care Section 1115(a) Demonstration Waiver

On behalf of the New Hampshire Health Care Association, which represents 90 long-term care facilities statewide capable of serving over 7,000 residents, we applaud the efforts by the Department of Health and Human Services to keep our state healthy through the preservation of Medicaid expansion. We recognize the hard work, and compromises on all sides, necessary to achieve passage of Senate Bill 313. To those who would, not incorrectly, say the legislation is not perfect, we would note the dire human consequences that would have attached to failure to pass an extension of Medicaid expansion. As part of the community of health care providers, we wish the Granite Advantage Health Care Program success.

Best,

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]



This e-mail and any attachments may contain information which is confidential, proprietary, privileged or otherwise protected by law. The information is solely intended for the named addressee (or a person responsible for delivering it to the addressee). If you are not the intended recipient of this message, you are not authorized to read, print, retain, copy or disseminate this message or any part of it. If you have received this e-mail in error, please notify the sender immediately by return e-mail and delete it from your computer.

Melby, Leslie

From: [REDACTED]
Sent: Thursday, May 31, 2018 5:30 PM
To: DHHS: nhmedicaidcaremanagement
Cc: Young, CJ; CJ Young; trish lee; Sciascia, Nancy; Wyman, Kara; Cunningham, Ross
Subject: Presumptive Eligibility

Hello DHHS,

I am a Medical Assistant from the Medical Division of the Merrimack County Department of Corrections (MCDOC). I've been managing and submitting Medicaid applications for our inmates, who have required in-patient hospitalization, for the last 3 years. The current Medicaid program has helped Merrimack County save thousands of dollars through your current program. I've reviewed your document explaining what is in the new Granite Advantage Program (GAP). I see that the retroactive medical assistance will end with GAP; that inmates will be subject to '**Presumptive Eligibility**' determination. I know that Presumptive Eligibility means:

the Affordable Care Act expands states' ability to use **presumptive eligibility** to streamline enrollment in Medicaid and CHIP (the Children's Health Insurance Program). **Presumptive eligibility** gives uninsured people immediate, temporary Medicaid if they appear to be **eligible** based on income.

1. How does that work for inmates?
2. Do you have a process for that?
3. Will prisons and jails be able to apply for enrollment into GAP based on 'Presumptive Eligibility', and thereby have the inmates' inpatient hospital stays covered by GAP?
4. When does this go into effect?

We here at the MCDOC just learned about the details for of the new Medicaid program today. As you may expect, we have a few questions. Any help and information you can send our way, will be greatly appreciated.

Sincerely,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Sunday, June 3, 2018 6:30 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Work Requirements for Medicaid

I am writing to oppose the **work requirement** on recipients of Medicaid Expansion in NH. I am concerned for single mothers with preschool children and no access to affordable childcare, for mentally ill individuals who cannot always work consistently, and for people living in parts of NH with very little employment opportunities and/or no reliable transportation.

Not everyone is able to work for 25 hours a week and health care should not be denied to those persons who cannot.

[REDACTED]

[REDACTED]

[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Sunday, June 3, 2018 8:46 PM
To: DHHS: nhmedicaidcaremanagement
Subject: reject federal waiver

To Whom It May Concern;

I am strongly opposed to a federal waiver imposing work requirements for health care. Many of the people who need health care the most may be unable to work the 15 hours a week necessary to receive it! It makes health insurance more difficult to access for many - those who have seasonal work, those who may not have the stamina, those with young children (does the waiver cover child care for those people so that they can work the required amount?)

Do not approve this waiver under any circumstances. Reducing services to those in need is the last thing your department should be doing.

Sincerely,

[REDACTED]
[REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
[REDACTED]
Sent: Sunday, June 3, 2018 9:00 AM
To: DHHS: nhmedicaidcaremanagement
Subject: Comments on Medicaid Expansion Work Requirements

I am writing to comment on Medicaid Expansion Work Requirements:

I am concerned that there are some Medicaid recipients who have disabilities and/or conditions that preclude them from holding a job. I volunteer at a Food Pantry and know of clients who would love to be able to work but cannot get to a job or tolerate a work load due to illness. This even includes volunteer work. They have a hard enough time getting to the food pantry to pick up a week's supply of food.

I don't know what the new ID requirements are but enrolling in Medicaid should not be made more difficult than it already is. Some of these people cannot advocate well for themselves and are quite fragile.

Lack of transportation to work is a very important factor to consider, especially in more rural areas.

Thank you for your consideration. I am in favor of helping those who need it most without judgment.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Guide the people of this land, and of all the nations, in the ways of justice and peace; that we may honor one another and serve the common good. - BCP pg 388: Prayers of the People Form IV

Melby, Leslie

From: [REDACTED]
Sent: Sunday, June 3, 2018 6:12 PM
To: DHHS: nhmedicaidcaremanagement
Subject: New Medicare Work Requirements

The proposed monthly work requirements are anti-christian!

Christ said, care for my sheep! Judge not lest ye be judged!

[REDACTED]
[REDACTED]
[REDACTED]

Sent from [BlueMail](#)

Melby, Leslie

From: [REDACTED]
Sent: Sunday, June 3, 2018 8:49 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Work as condition of Medicaid expansion?

Medical insurance should be available to anyone in NH regardless of job status, age, physical condition, or whatever other condition some non-community minded person may think.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Monday, June 4, 2018 9:20 AM
To: DHHS: nhmedicaidcaremanagement
Subject: work requirements should not be a condition of receiving health care

Dear Medicaid Management team,

I am against the proposal that ties work requirements to receiving health care in the form of Medicaid benefits. My grandson was born prematurely at 24 weeks and has received health coverage ever since for which our family is eternally and enormously grateful. We could not have survived financially without Medicaid and to this day [REDACTED] owes his very existence to the numerous and complicated interventions supported by his medical team. His parents too have been an outstanding and ever present support. Now that [REDACTED] has reached his first year mark and has been able to return home he needs around the clock care. For example, he needs suctioning while on his ventilator every fifteen to twenty minutes. Clearly, it would be impossible for my daughter to work the required 25 hours given her current situation. I imagine there to be numerous similar circumstances that for good reason prevent well intentioned people from fulfilling work requirements. Therefore, I ask you not to institute them as a condition for health care. Thank you for your consideration. Sincerely, [REDACTED],
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Monday, June 4, 2018 1:26 PM
To: DHHS: nhmedicaidcaremanagement
Subject: work requirements for health insurance

To the Commissioner:

I am thoroughly opposed to making work a requirement for health insurance.

First of all, most low-income people already work, unless they are children or the disabled or the frail elderly.

Second, it's a punitive approach to the poor. Our state already deals with work requirements through the Division of Employment Security, where people do not get benefits unless they are seeking work. Such requirements should not be a condition of getting health coverage.

Third, in a state like ours with low unemployment, how are those few who do not have a job going to get a job they can get to? Transportation and child care in this rural state can be formidable obstacles for vulnerable people.

Fourth, the idea of community service, "forced labor" as one person recently called it, is unlikely to accomplish what legislators want – a way to qualify for their "largesse." When another state tried that community service, or free work approach, a couple of people were assigned to dust the banisters in a government building. Not exactly building hope, ambition, or self-esteem is it, but who had the time to make a great fit for "prospects" getting free or reduced health care coverage due to limited resources?

Lastly, do you have, or who does have, the wherewithal to set up and monitor a work requirements program? At what cost? Who will handle the paperwork? How about the inevitable clerical errors that will toss someone from Medicaid when they are qualified to be on?

The legislature is determined to see that no one gets something for nothing. If we don't continue our Medicaid expansion, costs will increase for everyone so where is the sense in that. It's time to curb our tendency to blame the poor for the place where they are (temporarily, one hopes) stuck.

[REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Monday, June 4, 2018 1:22 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Comments re Medicaid Expansion

Having been self-employed all my life, I know that gaps can happen quite easily and so any automatic and unfixable loss of coverage just seems mean-spirited. NH can do better. Ditto re lack of transportation and possible loss of insurance because of sprain or illness or mental health episode. NH can do better.

Thank you, [REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Monday, June 4, 2018 2:19 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Medicaid Expansion Work Requirement

I'm writing to express my concern for the Medicaid Expansion Work Requirements. I'm grateful for Medicaid Expansion, but worry that the work requirements are unfair, difficult to enforce, and unrealistic.

The proposal seems very complicated and I'd rather we focus our state's limited resources on something more worthwhile than policing the people who are in need. Who needs more bureaucracy? Who is going to verify if I'm volunteering or taking care of a sick relative? The state is not my boss.

We know that the state has a very low unemployment rate right now. I am I'm concerned about seasonal and self-employed workers, such as farmers. They work all summer, all day long and then take a break in the winter. Will they loose their coverage? I am also concerned about those who are hourly workers get sick and those who don't have access to transportation.

I volunteer at the local food pantry and the folks who come need all the help they can get. Let's not make things harder for the people who have it hard enough.

Thank you,

[REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Monday, June 4, 2018 2:36 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Medicaid Expansion Work Requirements

Sirs:

Thank you for the opportunity to comment on the proposed rulemaking as regards Work Requirements for Medicaid Expansion.

Across the globe, industrialized countries treat health care as a civic entitlement. This is not unlike providing United States children with free public education. Education is a right to enjoy. U.S. medical care, as a right, is slowly coming into being. Medical care via Medicare for those over 65 years of age, is the norm. The elderly can be productive longer and enjoy a better quality of life, paid for by their years of service as citizens. Society benefits from their involvement. Children can receive medical care through their schools.

Unfortunately in New Hampshire, there are many barriers to employment by the very people in medical need. One of the keys to employment is access. Without a personal vehicle, workers are very limited in their employment choices. Here in Manchester, route coverage by the Manchester Transit Authority misses large areas. Even in areas with bus service, it only available 12-hours per day, with no Sunday service. If a person's shift ends after 6:00 pm, a costly taxi ride is necessary to return home. I write from experience. My daughter worked in a Boston hotel restaurant, as a waitress. Her shift ended at 2:00 am, the transit service ending at 12:20 am. She used a taxi to return home, the taxi fare essentially eating up her income for two hours. Thus, she worked eight hours, but only took home income from six hours.

Melby, Leslie

From: [REDACTED]
Sent: Monday, June 4, 2018 8:00 AM
To: DHHS: nhmedicaidcaremanagement
Subject: work requirement

I object to the work requirement for health insurance. I believe it's a way to get people off the health insurance rolls since getting and keeping a job is problematic for most of us these days. We need instead to be sure every person in New Hampshire has health insurance, period.

[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Tuesday, June 5, 2018 12:22 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Comments on Medicaid Expansion/Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

To: DHHS, Leslie Melby

[REDACTED]

I am a practicing optometrist, along with my wife and two associates in Hampton, New Hampshire. Our practice has been in existence since 1983, and we have participated in providing vision care, medical eye care, and eyeglass services to New Hampshire Medicaid recipients since its' inception for the past 35 years.

Despite the many challenges, both administrative and financial, we have continued to participate in the State's Medicaid offerings, mostly as a civic and moral obligation to provide a much needed service to this population. However, with the involvement of Managed Care Organizations and implementation of Medicaid expansion, keeping track of member benefits and plan specific criteria has become much more convoluted and complex for my office and staff. It is not hard to understand why many of my New Hampshire optometric colleagues and ophthalmologists have chosen to discontinue their participation in these plans.

As you begin your review for the Medicaid Expansion/Granite Advantage Health Care, below are some issues that I hope you will take into consideration, as they will influence my ability to continue to provide services for enrollees:

- 1.) Varying policies for frequency of "wellness/routine" exams between the Medicaid and Expanded Medicaid products/carriers.
- 2.) The various product carriers have widely different eyeglasses coverage policies and specified fabrication labs/vendors.
- 3.) Low reimbursement for eye health medical procedures.

It is my hope that you will consider developing a simpler and uniform vision/eye care benefits program during your deliberations and plan design for New Hampshire Medicaid recipients.

Thank you for your consideration.

Sincerely,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Tuesday, June 5, 2018 10:51 AM
To: DHHS: nhmedicaidcaremanagement
Subject: 100 Hours of Work for Medicaid Recipients

Dear Commissioner Meyers:

I am writing in opposition to the notion of requiring Medicaid recipients to work for one hundred hours per month.

By nature, people who qualify to received Medicaid benefits are unable to work regularly, due to a physical, or mental handicap that prevents them from being able to work on a regular basis. Additionally, any recipients who are seasonal workers or self-employed would also be at risk of losing coverage, as they often experience gaps in employment at set times of the year.

Any requirement that would force these folks to work for one hundred hours per month makes no sense whatsoever. You would effectively be denying Medicaid insurance to the people who most qualify for it.

Please reject any plan that would add such cruel requirements for our most needy citizens.

[REDACTED]
[REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Tuesday, June 5, 2018 4:48 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Opiate Exposure and Early Intervention

Hi,

As a general pediatrician caring for children born with opiate exposure and President of the NH Pediatric Society, I am writing with a specific request that would benefit many of our most vulnerable children.

I am strongly requesting Early Intervention for all babies and children 0-3 born with opiate exposure. I would ask that you make NAS (neonatal abstinence syndrome) AND intrauterine opiate exposure an automatically qualifying diagnosis for Early Intervention services.

Currently, many of these NH babies are NOT receiving Early Intervention. Other states, Vermont being one, have found that making opiate exposure one of the automatically qualifying diagnoses improved the rate of delivered services.

Thank you,

[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

603-653-9605



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Melby, Leslie

From: [REDACTED]
Sent: Wednesday, June 6, 2018 7:41 PM
To: DHHS: nhmedicaidcaremanagement
Cc: jim.belanger@leg.state.nh.us; carolyn.gargas@leg.state.nh.us;
Keith.Ammon@leg.state.nh.us; Kevin.Avard@leg.state.nh.us
Subject: Comment for scrapping or modifying proposed medicaid work requirement

6 June 2018

<-----text extends to here ----->

To nhmedicaidcaremanagement@dhhs.nh.gov

cc:jim.belanger@leg.state.nh.us;carolyn.gargas@leg.state.nh.us;Keith.Ammon@leg.state.nh.us;Kevin.Avard@leg.state.nh.us

A letter to the editor in today's newspaper, The Telegraph, stated there was a comment period for the proposed work

requirement for Medicaid eligibility in New Hampshire. As I understand it, the proposed law would mandate recipients to work a minimum of 25 hours a week, or 100 hours per month, either in paid jobs, or in a combination of paid jobs and community service.

I worry that the plan does not contain waivers for those who justifiably could not work the requisite hours, and ignores the many employed in part-time jobs by employers who keep hours under 25 in order to avoid paying health care and other benefits.

This email contains my comments against the proposed plan, and reasons why it should be modified or scrapped.

I am concerned because my 27 year old daughter is currently covered by a Medicaid plan and is in a part-time job that is usually 20 hours per week. In

summary, I think the plan at best creates burdens on those who least afford it, and at worst might be an excuse by the government to throw people off of Medicaid when they get sick. In addition, it would create costs to local communities to create and oversee a community service program for eligible Medicaid recipients.

I argue for scrapping the work requirement, or for reducing the hours to under 20 and making provisions for medical and/or care-giving waivers.

Reasons:

- 1) Many employers choose to hire part time workers to avoid having to furnish health care and other benefits. In my daughter's case, the hours allotted are 20 per week, except in cases the employer has a special project. The work requirement would place an undue extra burden on these workers.
- 2) The work requirement should contain medical waivers for those who cannot work for more than 20-25 hours per week—these are people who still need health coverage. They will get it either with a Medicaid plan with preventative care, or with higher cost emergency care in the emergency room. When my daughter started working, she was not physically capable of lasting more than 20 hours per week.
- 3) In the same vein, I see the possibility the plan would kick people off unjustifiably if someone in the family experienced a medical or family emergency that kept the affected person or care-giver in the family from working the requisite time.
-I was in this situation in California when I was caring for a son who had leukemia relapse after I lost my job. Luckily I had health insurance because an extraordinarily generous person paid for my COBRA coverage after I lost my job.
- 4) The work plan might force people to scrap their coverage and face enrolling in a different plan at higher cost, just when they need to deal with a medical or family emergency.
-Any work plan should allow for those who are tossed off Medicaid coverage to stay in their plans by

paying premiums.

- 5) To be fair, various communities would have to guarantee that community service jobs were available for those who need to pad their regular hours to 25. I question that the money saved would compensate the cost to communities to oversee such a program. Imposing community service requirements would be an unfunded mandate of the state on the local communities in order to satisfy this requirement.

Sincerely,

[REDACTED]

[REDACTED]

[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Wednesday, June 6, 2018 1:10 PM
To: DHHS: nhmedicaidcaremanagement
Subject: prenatal opioid exposure as automatic qualifier for early intervention services

To Whom it May Concern:

I am writing to support prenatal opioid exposure becoming an automatic qualifying diagnosis for early intervention services in New Hampshire.

As director of the Dartmouth-Hitchcock Moms in Recovery Program and of the Center for Addiction Recovery in Pregnancy and Parenting, I provide care for many New Hampshire mothers affected by opioid use disorders and am concerned that their children are not receiving appropriate developmental follow-up during the first three years of their lives, only to be identified as in need of additional services when they enter school.

Although some of these at-risk children are referred for EI services, many initially “screen out” and do not receive important supports. Overwhelmed families often have difficulty navigating systems of care and may not seek help on their own for developmental concerns. Ensuring that all children exposed to opioids prenatally are eligible for EI services would provide access to support for these families during the critical first few years of their children’s lives.

Please do not hesitate to contact me if I can be of further help.

Sincerely,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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Melby, Leslie

From: [REDACTED]
Sent: Wednesday, June 6, 2018 5:00 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Work Requirements

I am totally against the blanket work requirement for people who rely on Medicaid. My son-in-law is self-employed and can not afford health insurance. My daughter and son-in-law also have a child with autism. My husband and I have cared for my grandson two days a week. His mom and dad set their schedules so they covered the other days. My husband and I both have come into heart issues and can no longer do this child care. My daughter 's job (that she had for over 20 years) has changed so she can no longer work. Other relatives have not been reliable for safe care. My daughter is now the main care taker. This child cannot go to regular child care. This requirement will endanger my grandson, and will affect my daughter's and son-in-law's health. This safety net will affect this family in many unexpected ways. I urge you reconsider this requirement.

[REDACTED]

[REDACTED]

[REDACTED]

Sent from my iPhone

Melby, Leslie

From: [REDACTED]
Sent: Thursday, June 7, 2018 3:34 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Proposed work requirement for Expanded Medicaid

I am writing to say that I am strongly against having a work requirement for people on the NH Expanded Medicaid health insurance.

My son is enrolled in the Expanded Medicaid. He is in the "fragile health" category. At 26 years old, he is plagued by several problems that make it virtually impossible for him to live a "normal" life. He has chronic headaches which do not seem to respond to medications, chronic intestinal issues which make it difficult for him to keep weight on and require him to eat small amounts of food every hour (his system can't handle a normal sized meal, that results in intestinal pain), obsessive compulsive disorder which makes it difficult for him to do any tasks in a "normal" amount of time, limited stamina, and a huge requirement for adequate sleep to keep the headache from getting worse. The idea that he would be able to go out of the house and work for 5 hours per day 5 days per week is more or less unimaginable.

He does work from home, I estimate 25 or more hours per week, arranging and composing choral and band music, but makes very little money doing this, so I am guessing that this would not meet the work requirement. I am very concerned that if the work requirement law passes, he will be unable to keep the expanded Medicaid insurance.

Please do what you can to prevent the work requirement from passing.

Thank you.

Sincerely,

[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Wednesday, June 13, 2018 8:37 PM
To: DHHS: nhmedicaidcaremanagement
Subject: No work requirement for Medicaid expansion

I urge you to forego implantation of a work requirement as a condition for Medicaid eligibility. 100 hours is too much, especially for those who most need the health insurance and medical care. Besides, health care should not be tied to employment. Health care is a human right. We need to take care of our people, especially those who are ill and low income.

Thanks,

[REDACTED]
[REDACTED]

--

"Darkness cannot drive out darkness; only light can do that. Hate cannot drive out hate; only love can do that." Martin Luther King, Jr.

Melby, Leslie

From: [REDACTED]
Sent: Wednesday, June 13, 2018 9:39 AM
To: DHHS: nhmedicaidcaremanagement
Subject: Regarding Medicaid Work Requirements

Dear HHS,

I am writing in regards to the work requirements on Medicaid Expansion. I can understand the reasoning and the idea behind the requirement, yet it's an overly simplified solution to a complex problem.

I meet people everyday who suffer from chronic pain or autoimmune conditions that limit their ability to lead full productive lives. In some cases, they might get a 1-2 good hours a day before pain puts them on the sidelines of most activities.

While I am sure that there are people on medicaid who can work, I also am sure that there are many people on medicaid who struggle with their health, like many of my patients. It would be cruel to strip them of benefits because of circumstances that are beyond their control.

I think that volunteering counting as work, again, is a good idea, but not for someone who can barely function due to chronic pain levels.

Thank you for taking my comments.

[REDACTED]

--

"Do the best that you can until you know better. Then when you know better, do better." Maya Angelou

Melby, Leslie

From: [REDACTED]
Sent: Wednesday, June 13, 2018 11:33 AM
To: DHHS: nhmedicaidcaremanagement
Subject: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

I am currently a single head of household member obtaining medical insurance through New Hampshire Health Protection Premium Assistance Program which will be converted to the Granite Advantage Healthcare Program. I served as the public member appointed by the NH speaker of the house on the PAP evaluation committee up and until the time of my debilitating illness that occurred during that tenure in 2017.

The section 1115(A) waivers the state of NH is seeking in sections Sections 1902(a)(8), 1902(a)(10), 1902(e)(14) with regard to work requirement and asset test, will harm me greatly and may prevent me from obtaining health insurance through the program during an ongoing illness, and as a single head of household with dependent child, as a sole proprietor self-employed individual if these waiver sections were granted. They must be withdrawn, or revised to accommodate myself and many other eligible adults who have worked as self-employed individuals as sole proprietors, contractors, loggers, etc. who are not registered themselves as a corporation, or work for another corporation or company, yet have in fact worked in their field of expertise. There must a provision allowing for these people to access the program without complication. Also the asset test must be removed, as many of these same individuals who would normally qualify for the program, would have their life savings put at risk without health insurance especially during an ongoing illness, and not be eligible for the program, yet potentially bankrupting them; these the very people the program was designed to help.

In my own specific case, I have undergone a serious ongoing illness that began August 2017 and has me left unable to work regularly, yet my sole-proprietorship business has many long term lease and vendor obligations that must be met either way. The business has continued to minimally operate with the efforts of my son and fiancée' trying to save it, despite my inability. I continue to file the necessary tax documents annually for the sole-proprietorship under my name that show the income status of the sole proprietorship that meets the current eligibility for the current NHHPP, soon to be Granite Advantage Healthcare which I am desperately dependent on during this ongoing illness as my only means of health insurance in the middle of my medical crisis. The business since it is a sole proprietorship, has moneys saved in accounts necessary for it to operate under my name, as well as what lifelong savings I have amassed at 60 years of age. Both the work requirement which does not provide for the legitimate self-employed and sole proprietorships to work when able at their sole proprietorship or expertise, and the asset test that would have any account under the individuals name disqualify them from the program, must be withdrawn & revised.

Thank You,

[REDACTED]
[REDACTED]
[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Monday, June 18, 2018 9:23 PM
To: DHHS: nhmedicaidcaremanagement
Subject: I'm a physician, and I've seen the work requirement "in action"

Dear Commissioner

,

As a physician who has practiced in Hew Hampshire for 35 years, it has always amazed me that so many lay people believe that the majority of folks on medicaid somehow don't deserve it, or are at fault for being poor or sick or both. I saw a patient last week who was seriously injured in a car accident and is healing a series of fractures (which take 8 weeks to heal) but now needed a note from his doctor that he be excused from working during this period. His xrays are clear cut, but his need for a note that he cannot work the minimum required # of hours is ridiculous. What a waste of my tax money to fund the bureaucracy to account for such nonsense, rather than the health care itself. We already know that about 60% of folks on medicaid will come of of it within 3 years.

It is also already known that the majority of non-elderly adults without disability who are on Medicaid are people already working (at low wage jobs) or married to a person who is working and raising children. (Of course, because of low wages, such spouses typically cannot afford childcare to work out of the home.) In NH, in 2016, 66% of medicaid recipients had a full time worker in the family, but are living in poverty.

So many middle-class Americans cannot afford their basic health care needs - it is the greatest financial worry among Americans. When middle class people are upset that they can barely afford their premiums, it's perhaps human nature that they would assume that folks poorer than themselves on Medicaid are just mooching. But this has not been any primary care doctor's experience, nor is that borne out by the facts.

We live in the only developed nation on earth where health security is scarce among many people who are not well off. Those on medicaid have jobs often in small restaurants and businesses where one illness might have them miss work, miss wages, and then penalize them further to require notes from doctors that they cannot work. I do not want my tax payers dollars going to waste to find the estimated 2-6% of residents who may not qualify for medicaid, and will be off of it in a year or two anyway.

Please consider what necessity there is for this work waiver.

Respectfully,

[REDACTED]

Melby, Leslie

From: [REDACTED]
Sent: Saturday, June 23, 2018 6:35 PM
To: DHHS: nhmedicaidcaremanagement
Subject: "Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver"

New Hampshire Medicaid Management N. H. DHHS

I have heard in the news lately about the possibility of adding restrictions to Medicaid Eligibility. As someone who's needed a helping hand through certain periods of my life, I would encourage you to judge carefully the decisions that are made. There is the danger that people who are in need may be viewed by someone better off as being lowly or incompetent. Lets face it, they may not be able to afford nice clothes. Some may have poor dental health not giving them a great appearance. These people need a leg up. Having been there I can tell you firsthand that you have to give up your pride just to apply for help. The self esteem one has to give up to complete the application process is demeaning. You have to prove what you already know... you don't have much. The coupons you use at the grocery checkout are embarrassing. People in the line behind you roll their eyes. You are wasting their time as well as being judged! Sorting the eligible items adds to the embarrassment. While receiving medical care you are well aware that top notch care is not meant for you. Your pride is gone when what is needed is encouragement and self esteem. You need confidence building, not a reminder of how worthless you are! When my wife was pregnant with our second child we both had jobs with insurance. She was let go for being pregnant! I was let go due to a slow down in work. "Plan J" turned out to be having our birthing experience "on the ward floor". The attitude of the staff was very apparent! It was not pleasant to be judged by your care givers and having to wait for the "paying customers" to be served first. They diagnosed my wife with postpartum depression and as something that was "in your head" knowing that the system would not pay for it. That "in your head" turned out to be an infected ovary! It was months before she could work having that ovary removed with complications.... Who will pay for the child care for working mothers. Again, firsthand it does not pay to have a \$7.50 an hour job and think you will be able to pay for child care! I could go on but I hope you consider your decisions not as an administrator, but as someone who may need the help. You would be surprised at how life can turn on even the most ambitious and employable among us. These people are just that,,, People with Feelings They are not the fodder of political issues.

Respectfully

[REDACTED]
[REDACTED]

June 25, 2018

Jeffrey Meyers
Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord NH 03301

Via Email Only: nhmedicaidcaremanagement@dhhs.nh.gov

Re: Granite Advantage 1115(a) Demonstration Waiver Extension Application

Dear Commissioner Meyers:

New Futures is a nonpartisan, nonprofit organization that advocates, educates, and collaborates to improve the health and wellness of all New Hampshire residents. New Futures envisions State and local communities where public policies support timely access to quality and affordable healthcare for all Granite Staters. With that mission in mind, we offer the following comments on the Granite Advantage 1115 Waiver Extension Application:

Work and Community Engagement Requirement Regarding Self-employed Individuals

The waiver application proposes to continue and extend the work and community engagement requirement as approved by the Centers for Medicare and Medicaid Services (CMS) approved on May 7, 2018. The special terms and conditions (STC) outlined by CMS do not specifically include self-employment, and it is New Futures' understanding that DHHS has interpreted this to **exclude** self-employment as one of the qualifying activities by which a person could satisfy the work and community engagement requirement.

If this understanding of DHHS' interpretation is correct, New Futures questions whether all self-employment activities, including those of 1099 independent contractors, such as home health workers, carpenters, plumbers, contractors, etc., are excluded as one of the qualifying activities that satisfy the work and community engagement requirement. If so, New Futures fears this would prohibit many per diem care providers, substitute teachers and other independent contractors from accessing critical health care coverage.

Waiver of the Requirement to Provide 90-day Retroactive Coverage

New Futures has concerns that obtaining a waiver of the 90-day retroactive coverage requirement could cause significant financial strain for providers and beneficiaries alike. Without retroactive coverage, providers will not be able to bill Medicaid for services rendered to individuals in the process of signing up for Medicaid. Individuals with behavioral health conditions often face unique circumstances and homelessness, which pose challenges for collecting documentation required to complete a Medicaid application. It is not unusual for these providers to encounter a patient three or four times, slowly gathering required information, before a complete an application can be processed. Retroactive coverage allows these providers to bill for services rendered during this period, while preventing beneficiaries from being left with additional medical bills they simply

cannot afford. Threats to reimbursement may pressure some providers to reduce care or assistance provided to individuals in the process of signing up for Medicaid expansion, missing important treatment opportunities. These delays in treatment would only exacerbate the existing mental health and substance use crises.

Behavioral Health Rates Sufficient to Ensure Access to and Capacity for Behavioral Health Services

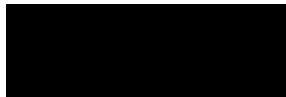
With the Premium Assistance Program (PAP), behavioral health providers experienced enhanced payment rates. These rates encouraged growth in the behavioral health field such that New Hampshire was able to double its treatment capacity. Even with this enhanced capacity, there are still individuals who are not able to access treatment when they need treatment. New Futures is concerned that if the rates under the Granite Advantage Health Care Program are not sufficient, providers will either refuse to serve Medicaid patients, or leave the field, reducing the treatment capacity and further exacerbating New Hampshire's behavioral health and opiate crises.

The Transition from the Premium Assistance Program to the Managed Care Organizations

Finally, when the PAP ends on December 31, 2018 and Granite Advantage begins on January 1, 2019, all the beneficiaries receiving insurance through the individual market will need to be transitioned to the Managed Care Organizations (MCO). If the numbers stay roughly the same as they are currently, more than 41,000 beneficiaries will need to be transitioned from the individual market to the MCOs. New Futures is concerned about this transition and encourages DHHS to ensure there are ample procedures in place to assure that the transition goes as seamless as possible.

Thank you for your consideration of these comments.

Sincerely,



Holly A. Stevens, Esq.
Health Policy Coordinator

Melby, Leslie

From: [REDACTED]
Sent: Tuesday, June 26, 2018 2:18 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Medicaid Expansion

Dear Commissioner,

I would like to make the following comments about this health care issue, as I have a disability and have my health care through Medicaid. It seems to me that this work requirement is quite similar to an unfunded mandate. I have had experiences with the difficulty of finding jobs, and it seems to me that this issue takes no steps toward improving that scenario and works to WORSEN the more urgent matter: how people are able to improve the quality of their health – it remains an unmet need, particularly for this population.

I think it fair to say that Medicaid needs to go further toward satisfying more of the social determinants of health. I think it would be thoughtful to indicate that New Hampshire also thinks that is important. However, I have never heard anyone describe *expansion* in those terms. And I do think that the work issue is likely to deter us from what we *could* do about improving the causes of health.

It is best not to conflate meeting health needs – basically or thoroughly - with the arbitrary idea of work. Perhaps this would not be arbitrary if there is consideration of how to be innovative and conjoin meaningful involvement in the notion of work, to improve Quality of Life – and in addition, address the way to improve the economy. I am suggesting what a non-profit, or some caring institution, could do by initiating meaningful work projects designed to assist others in any given community. The focus, in my mind, is that this project be able to introduce and develop local relationships, which would create a way to contribute meaningfully and healthfully. Any way to reduce social isolation must also be a good remedy. Maybe the idea of 100 hours is also arbitrary, but this should provide a suitable stipend (rather than meeting the suggested “volunteer” concept). I would add that this may help lower the stigma attached to most who receive Medicaid – among other myths, there may be an assumption that “those people” would not know how to help others.

The element of offering a fulfilling kind of work may have escaped some people’s concerns, but I think it is worthwhile to consider, if one is raising the idea of work at all (the original idea is health and well-being). Revisiting the social determinants of health has the potential to help people find many benefits, including some cash but also a better sense of belonging; we might somehow stumble upon a successful form of reform. In any case, please stay with the idea of expanding Medicaid, because nobody here is expanding the opioid response.

Optimistically,

[REDACTED]



June 26, 2018

Leslie Melby
NH Department of Health and Human Services
Fred H. Brown Building
129 Pleasant Street
Concord, NH 03301

Dear Leslie,

NH Family Voices would like to take this opportunity to provide public comment on the proposed amendments to the Granite Advantage Section 1115(a) Demonstration Waiver.

As you know NH Family Voices is an organization supporting families of children and youth with special health care needs. In our experience the NH Medicaid Managed Care system has worked well for the majority of enrollees and we applaud the decision to enroll additional eligible populations into the programs. We would, however, recommend that enrollees be given the opportunity, through a 30 day window of time, to choose their health care plan. The education of individuals regarding health care finance begins with the choice of a plan provider. When NH first enrolled citizens in Managed Care our office was involved in multiple ways to educate citizens who were first time enrollees in a Managed Care plan. Educating enrollees, giving them the power to decide on their own managed care company, is an educational opportunity and can reduce churn. Reducing churn requires approaching the psychology of an individual's decision making. If NH makes a unilateral decision on behalf of its citizens it removes the opportunity for enrollees to become an integral part of the decision making process.

Should NH choose to auto enroll we strongly recommend that enrollees be provided with resources and education regarding NH Medicaid Managed Care plans when they are provided with auto-enrollment notification.

We are also concerned that requesting paper forms of identification when the system already has access to the information through an electronic data base will increase churn.

It is concerning to us that NH is proposing to drop the 90 day retroactive coverage for the expansion population. While we recognize the states desire to have people seek and maintain coverage we also recognize that there has been little to no education provided to youth and young adults about the importance of health care coverage. This particular

129 Pleasant Street - Thayer
Concord, NH 03301
1-800-852-3345 ext 4525 or 271-4525

sector of the population is often unlikely to seek coverage prior to a health care crisis because they do not have the experience or knowledge of its potential impact on their lives. While we would encourage and support a program to educate our citizens we feel the education should occur before you stop providing a retroactive benefit.

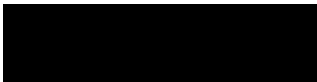
While much of our work in NH is to provide assistance to families seeking coverage for their children we also strongly encourage the adults in the family to seek insurance coverage. Families who reach out to us are sometimes in crisis having lost a job. These families must prioritize their immediate needs during a time of crisis. Housing and food are often the priority over health insurance. In a situation when a family receives a devastating diagnosis for a child it may impact a parent's ability to maintain employment which then impacts their health insurance. As you can imagine in these critical moments the majority of families are most concerned with their *children's* coverage. The coverage of the adults is often a secondary concern. Many families do not even want to discuss their needs until after their children's coverage is in place. Having the 90 day retroactive coverage gives the families the opportunity to focus on what is the most critical at the time and then move to the needs of the parents.

The states argument that removing the 90 day retroactive will encourage beneficiaries to maintain coverage does nothing to address the reason that churn occurs in the first place. Enrollment barriers that require extensive amounts of documentation and a lack of easily accessible application assistance along with education regarding the importance of maintaining coverage are the primary causes of churn.

We STRONGLY urge you not to remove the 90 day retroactive coverage.

Thank you for the opportunity to submit comments on the 1115 waiver extension application.

Sincerely,



Terry Ohlson-Martin
Co-Director



Martha-Jean Madison
Co-Director

Why is NH Proposing to Replace Proven Electronic Citizenship Verification with Burdensome Medicaid Paperwork Requirements?

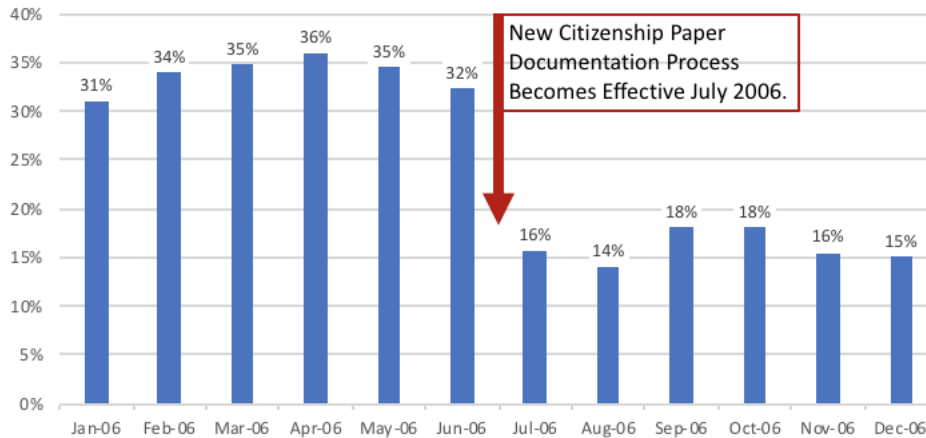
My home state of [New Hampshire is proposing](#) to add burdensome paperwork requirements for U.S. citizens to prove eligibility for Medicaid. That's [one of the requests](#) they are making in the Medicaid waiver proposal that is up for state comment before the end of the week. This is perplexing because the state and federal governments have spent millions of dollars establishing systems that electronically verify citizenship and qualified immigration status efficiently and accurately through the Social Security Administration and the Department of Homeland Security. If, and only if, eligibility cannot be electronically verified, are applicants required to provide paperwork to prove their status.

Now the state wants to return to an inefficient and costly paperwork system that will burden state employees and reintroduce red tape to the application process. We've been there, done that; and experience shows that it had a significant negative impact on U.S. citizen children and low income families who were eligible for Medicaid. In 2006, the Deficit Reduction Act of 2005 enacted new, inflexible requirements on citizens to prove citizenship with paper documentation (also known as "cit-doc"). Unless applicants had a passport, one document – like a birth certificate – wasn't good enough. To be clear, this change did not impact lawfully residing non-citizens as verifying qualified immigration status had been a federal requirement for some time.

At the time this law took effect, I was the CEO of New Hampshire Healthy Kids (NHHK), a legislatively-created nonprofit organization that administered the state's Children's Health Insurance Program (CHIP) from 1997 until 2011. The federal change in 2006 wreaked havoc on uninsured U.S. citizen children in need of health coverage so they could get check-ups, dental care, immunizations, prescription drugs and other health care services they need to thrive in school and in life.

NHHK served as the mail-in application unit for Medicaid and CHIP for children. We worked hard to help families understand what documents were required to act on their applications. Due to the extra hurdles to overcome with a paper-driven process, on average, only about 34 percent of the applications we received each month included all of the documents needed to verify eligibility. That completion rate dramatically dropped by half to an average of only 16% of applications in the six-month period after the "cit-doc" requirement went into place.

Percent of New Hampshire Children's Medicaid and Healthy Kids Applications Received With All Documentation Dropped Dramatically After New Citizenship Paperwork Process Went into Effect in 2006



At NHHK, we took our mission seriously. Our goal was to ensure that every eligible child was enrolled. So we spent a lot of time and effort following up with families to obtain missing documents. I've kept these data all these years to illustrate the impact of administrative changes that complicate rather than streamline the process. It was a great relief when the 2009 reauthorization of CHIP provided a better path to verify citizenship electronically. The process was further improved with the Affordable Care Act, which centralized access to multiple data sources through the federal data services hub.

So why is New Hampshire seeking a waiver of required electronic verification to return to a manual, paper-based system? Waivers are intended to test or demonstrate innovations in Medicaid to advance the purposes of the Medicaid program. What hypothesis is the state planning to test? How does clogging the eligibility pathway for citizens promote the purposes of Medicaid, as required by Section 1115 waivers?

All states use these electronic processes and, as previously noted, states and the federal government have spent millions implementing electronic verification systems. These systems work and there are other safeguards for auditing eligibility determinations, including some [new ones](#) announced by the Center for Medicaid and CHIP services this week. Adding these red-tape barriers will cost taxpayers money as the state will need to update websites and application instructions, retrain state eligibility workers who must process piles of paperwork manually, and inform community organizations who help families apply and enroll. Simply stated, there is no legitimate reason to throw out the current data-driven system and return to outdated manual procedures. As the old adage goes, if it ain't broke, don't fix it.

Tricia Brooks
5 Tower Hill Road
Bow, NH 03304

June 27, 2018

Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

The Arthritis Foundation appreciates the opportunity to submit comments on New Hampshire's Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

The Arthritis Foundation is the Champion of Yes. Leading the fight for the arthritis community, the Foundation helps conquer everyday battles through life-changing information and resources, access to optimal care, advancements in science and community connections. We work on behalf of the over 282,000 people in New Hampshire who live with the chronic pain of arthritis every day.

The Arthritis Foundation believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver as proposed will jeopardize patients' access to quality and affordable health coverage, and the Arthritis Foundation therefore urges New Hampshire to withdraw this proposal.

Waiving Retroactive Eligibility

The 1115 waiver proposes to have coverage become effective on the day the Medicaid enrollee applied for coverage. This would be a departure from the current three-month retroactive eligibility period in Medicaid.

Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.ⁱ

Continuation of Burdensome Administrative Requirements

The Arthritis Foundation is concerned about the continuation of New Hampshire's requirement for enrollees to work 100 hours per month or lose their health coverage. Continuing this policy will increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.ⁱⁱ

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases including arthritis. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Citizenship and Residency Documentation Requirement

The waiver proposes to require enrollees to present paper forms of identification (two forms of identification or a state driver's license or ID card) rather than the electronic database that is currently being used when applying for coverage. The proposal states potential enrollees without the appropriate forms of identification will be denied coverage.ⁱⁱⁱ This proposal puts yet another paperwork requirement on Medicaid enrollees that could jeopardize their access to care. The waiver lacks details on what forms of ID, other than a driver's license or State ID card will be valid for proving citizenship and residency.

Even getting a Driver's License or State ID card can be challenging for the low-income population. Obtaining the underlying documents, like a birth certificate, can be expensive. Conditioning healthcare on the ability to obtain paperwork does not promote the goals of the Medicaid program.

Additionally, the state does not include an evaluation hypothesis to test this proposal as part of its waiver evaluation. The state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to coverage for individuals eligible for Medicaid as part of its application.

Asset Test

The waiver requests the authority to consider an individual's assets when determining Medicaid eligibility. Current Medicaid rules do not allow for asset tests when determining eligibility for the program. Low income households' assets typically include a home – which may be inherited – or a car.^{iv} Owning a home can add to economic security and owning a car provides transportation to work and to medical appointments, and neither may be indicative of enrollees' financial status or eligibility for Medicaid. Holding these resources against a person when they apply for Medicaid will not help people achieve upward economic mobility, health or promote the goals of the Medicaid program.

Similar to the citizenship and residency documentation requirements, there is no evaluation hypothesis to test this proposal in the waiver evaluation. Again, the state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to care in the Medicaid program as part of its application.

Lack of Information on Impact of Waiver

The Arthritis Foundation wishes to highlight that the proposal does not predict the impact of the waiver on enrollment (with or without waiver baseline) or cost savings over 5 years. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. In order to meet these transparency requirements, New Hampshire must include these projections and their impact on budget neutrality. If New Hampshire intends to move ahead with this proposal, the state should at a minimum provide the required information to the public and reopen the comment period for an additional 30 days.

Proposed Timeline

The Arthritis Foundation would also like to comment on the proposed timeline New Hampshire has set forth. Public comment is due on June 29, 2018 and according to the timeline the proposal will be submitted to CMS for review on June 30, 2018. The Arthritis Foundation encourages New Hampshire to push back the date the waiver will be submitted to CMS in order to review all the comments that are received by the deadline (June 29, 2018 at 5pm eastern) and revise the waiver in response to the comments.

The Arthritis Foundation believes healthcare should be affordable, accessible, and adequate. New Hampshire's Section 1115 Demonstration Proposal does not meet that standard, and the Arthritis Foundation urges the state to withdraw this proposal. Thank you for the opportunity to provide comments.

Sincerely,



Ben Chandhok
State Policy Director
Arthritis Foundation

ⁱ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

ⁱⁱ Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009Th.

ⁱⁱⁱ Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver: <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

^{iv} Balance Sheets of Low-Income Households: What We Know about Their Assets and Liabilities: <https://aspe.hhs.gov/execsum/balance-sheets-low-income-households-what-we-know-about-their-assets-and-liabilities>

June 27, 2018

Jeffrey Meyers

Commissioner Department of Health and Human Services

129 Pleasant Street Concord NH 03301

Re: Project #II-W-00298 1

Dear Commissioner Meyers:

The New Hampshire Public Health Association (NHPHA) would like to thank the Department of Health and Human Services for allowing our organization to provide comments on the Granite State Advantage 1115 Demonstration Extension Waiver for NH's Medicaid Expansion program. The New Hampshire Public Health Association is a statewide member driven organization that champions public health policy and practice, enriches the workforce and inspires leaders to improve the public's health in New Hampshire.

NHPHA is pleased that thousands of our vulnerable adults living in New Hampshire will be able to continue to have the medical insurance they need to take care of their health needs. However, we do have some concerns.

The Mandated Work and Community Engagement Requirement

NH's decision to set the work requirement or community engagement at 100 hours per month seems excessive. NHPHA worries that it will be difficult to accomplish those hours, even for those who are currently employed and cause them to lose coverage. While NHPHA objects to any work requirement in exchange for being able to receive health insurance, we feel that the state needs to lower the number of hours it requires. Lower-wage jobs tend to be more volatile, with fewer regular hours. Industries such as food services, retail, and construction, can be subject to seasonal and other shift changes. Those fluctuations may cause many to fall out of compliance with the 100 hour per month requirement at times and thereby put their healthcare coverage in jeopardy.

A [Kaiser Family Foundation analysis](#) found that “most Medicaid enrollees who can work are already working but could face barriers in complying with reporting requirements. The reporting requirements may be difficult and labor intensive for the state to accomplish in a timely manner to keep everyone who is eligible in compliance to keep their coverage. Forcing those who have jobs to prove that they are employed for the required number of hours adds an extra layer of administrative burden. Confirming that unemployed adults meet qualifications for exemptions, are employed, in school, are caregivers or are doing community service among many other exemptions will require DHHS to invest in personnel and procedures that will raise the cost of the program itself. DHHS will further need to follow beneficiaries who are trying to find work, but unable to secure a job or come from regions of NH where job opportunities do not exist. It would be in the best interest of the state to at least make filing less onerous.

The lockout period for failing to meet any of the requirements and community engagement or its exemptions is also problematic for our organization. While there is relief through a “good cause” exemption, our concern is how that will be administered and believe that this group needs to maintain coverage while any appeals process is being implemented.

Finally, NHPHA has examined the list of exemptions to the mandated work requirement and community engagement and believe that homelessness should be added to the list of exemptions.

Citizenship/residency

The requirement of two forms of **paper** identification presents potential barriers to those seeking coverage under Medicaid. Most federal programs allow electronic forms of identification. In addition, this Waiver is also requesting that there be proof of New Hampshire residency by some of government issued “photographic” type of identification. Again, we believe that this is burdensome and would prove a barrier for some.

Asset test

Individuals with countable assets in excess of \$25,000 would not be eligible for the Medicaid program. This presents another reporting burden on individuals seeking medical coverage under the Granite State Advantage Plan. In reviewing Federal requirements for determining Medicaid income eligibility, it states that it does not allow for an asset or resource test. Therefore, it is the opinion of NHPHA that this provision is not legal and should be eliminated.

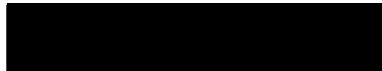
90 Day Waiver

Some NH Medicaid recipients may not become eligible for Medicaid until after they experience a traumatic or acute medical event. Retroactive coverage protects patients and providers by ensuring that medical bills are paid even if Medicaid eligibility is determined and application is not filed until after a medical event. Uncompensated care on the part of hospitals and providers will increase if this is allowed.

Again, we thank the Department of Health and Human Services for allowing us to share our concerns. We also want to say that we support this Waiver but would hope that the Department carefully considers its impact upon those who will be relying on the Granite State Advantage Plan for its health care insurance coverage.

If you have any questions or concerns, I can be reached at 603.228-2983 or jascheim@nhpha.org.

Sincerely,



Joan H. Ascheim, MSN
Interim Executive Director
New Hampshire Public Health Association



June 27, 2018

Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

On behalf of the 1-in-10 New Hampshire residents with one of the approximately 7,000 known rare diseases, the National Organization for Rare Disorders (NORD) appreciates the opportunity to submit comments on New Hampshire's Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

NORD is a unique federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. We are committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

NORD believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver as proposed will jeopardize patients' access to quality and affordable health coverage, and, therefore, we urge New Hampshire to withdraw this proposal.

Waiving Retroactive Eligibility

The Section 1115 waiver proposes to have coverage become effective on the day the Medicaid enrollee applied for coverage. This would be a departure from the current three-month retroactive eligibility period in Medicaid.

Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware that they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a rare disease to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion in uncompensated care as a result of the waiver.ⁱ

Continuation of Burdensome Administrative Requirements

NORD is concerned about the continuation of New Hampshire's requirement for enrollees to work 100 hours per month in order to maintain their health coverage. Continuing this policy will increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.ⁱⁱ

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with rare diseases. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers, or take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Citizenship and Residency Documentation Requirement

The waiver proposes that the state require enrollees to present paper forms of identification (two forms of identification to prove citizenship and a state driver's license or a non-driver's photo identification card to prove state residency), rather than use the electronic database that is currently being used when determining coverage. The proposal states that those who are unable to produce the appropriate forms of identification would be denied coverage.ⁱⁱⁱ This proposal puts yet another paperwork burden on Medicaid enrollees that could jeopardize their access to care. The waiver lacks detail on what forms of identification, other than a driver's license and a non-driver's photo identification card, would be acceptable for proving citizenship and residency.

Getting a driver's license or a non-driver's photo identification card can be challenging for the low-income population. Obtaining the underlying documents, like a birth certificate, can be expensive. Conditioning healthcare on the ability to obtain paperwork does not promote the goals of the Medicaid program.

Additionally, the state does not include an evaluation hypothesis to test this proposal as part of its waiver evaluation. The state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to coverage for individuals eligible for Medicaid as part of its application.

Lack of Information on Impact of Waiver

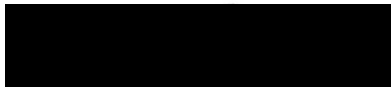
NORD wishes to highlight that the proposal does not predict the impact of the waiver on enrollment (with or without waiver baseline) or cost savings over five years. Federal regulation pertaining to the state public comment process mandates that a state must include an "estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures...if applicable."^{iv} The intent of this regulation is to allow the public to comment on a Section 1115 proposal with enough information to assess its impact. In order to meet these transparency requirements, New Hampshire must include these projections and their impact on budget neutrality. If New Hampshire intends to move ahead with this proposal, the state should, at a minimum, provide the required information to the public and reopen the comment period for an additional 30 days.

Proposed Timeline

NORD would also like to comment on the proposed timeline New Hampshire has set forth. Public comment is due on June 29, 2018, and, according to the timeline, the proposal will be submitted to CMS for review on June 30, 2018. This timeline suggests that New Hampshire does not intend to incorporate public feedback into the waiver proposal. NORD encourages New Hampshire to delay submitting to CMS in order to allow for time to review all the comments received by the deadline (June 29, 2018 at 5:00 p.m. EST) and revise the waiver accordingly.

NORD strongly believes healthcare should be affordable, accessible, and adequate. New Hampshire's Section 1115 Demonstration Proposal does not meet that standard, and we urge the state to withdraw this proposal. Thank you again for the opportunity to provide comments.

Sincerely,



Tim Boyd, MPH
Director of State Policy
tboyd@rarediseases.org



Kim Pang,
NORD Volunteer State Ambassador for New Hampshire
kimberly.pang@rareaction.org
www.RareNH.org

ⁱ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

ⁱⁱ Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

ⁱⁱⁱ Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver:
<https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

^{iv} 42 CFR 431.408 (a)(1)(i)(C)



June 28, 2018

Mr. Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association (ADA) provides the following comments based on the information available on the New Hampshire Department of Health and Human Services' (Department) Section 1115 Demonstration Waiver for the Granite Advantage Health Care Program.

According to the Centers for Disease Control and Prevention, over 6.8% adults in New Hampshire have diagnosed diabetes.ⁱ Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. Adults with diabetes are disproportionately covered by Medicaid.ⁱⁱ For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low-income populations experience great disparities in access to care and health status, which is reflected in geographic, racial and ethnic differences in morbidity and mortality from preventable and treatable conditions.

Lack of Information on Impact of Waiver

During public comment, the federal rules require the state include within the proposal an estimate of increase or decrease in enrollment and expenditures. The proposal presented by the Department does not provide any prediction of potential impact of the waiver on enrollment or cost savings over the next five years. Based on the current proposal, the public does not have adequate information to comment and assess the potential impact. In order to meet these transparency requirements, the Department must include these projections and the impact on budget neutrality. If the Department intends to move ahead with the proposal the state should at minimum provide the required information to the public and reopen the comment period for an additional 30 days.

Work Requirements

The ADA is deeply concerned by the Department's proposal to limit or revoke certain Medicaid beneficiaries' enrollment if they do not meet proposed work or community engagement standards. This type of coverage limit is in direct conflict with the Medicaid program's objective to offer health coverage to those without access to care. Most people with Medicaid who can work, do so. Nearly 8 in



1 in 11

Americans has diabetes today.



Every **21 seconds**, someone in the United States is diagnosed with diabetes.

Nearly **18,000** youth are diagnosed with type 1 diabetes every year.

10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. Of those not working, more than one-third reported that illness or disability was the primary reason, 28% reported they were taking care of home or family, and 18% were in school.ⁱⁱⁱ For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.^{iv} Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured Americans who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.^{v,vi}

Administrative Burden

Under this proposed waiver, individuals will need to either prove they meet certain exemptions or provide evidence of the number of hours they have worked as well as other monthly milestones they have met, all of which significantly increases the administrative burden of health care. Increasing the administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt. Diabetes is a complex, chronic illness that requires continuous medical care and people with diabetes cannot afford a sudden gap in health insurance coverage. This waiver proposal creates administrative barriers impeding access to health services that diabetes patients need.

Summary

We strongly urge the state to withdraw the 1115 Demonstration Waiver for the Granite Advantage Health Care Program as it creates barriers to accessible, affordable, and adequate healthcare. The ADA appreciates the opportunity to comment on the Department's waiver. If you have any questions, please contact me at SHabbe@diabetes.org or (617) 482-4580, ext. 3457.

Sincerely,



Stephen Habbe
Director, State Government Affairs and Advocacy

ⁱ Center for Disease Control and Prevention, Diagnosed Diabetes. Available at:

<https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html>

ⁱⁱ Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf.

ⁱⁱⁱ Garfield R, Rudowitz R and Damico A, Understanding the Intersection of Medicaid and Work, Kaiser Family Foundation, February 2017. Available at: <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>

^{iv} Kaiser Family Foundation, Are Uninsured Adults Who Could Gain Medicaid Coverage Working?, February 2015. Available at: <https://www.kff.org/medicaid/fact-sheet/are-uninsured-adults-who-could-gain-medicaid-coverage-working/>

^v Rector R, Work Requirements in Medicaid Won't Work. Here's a Serious Alternative, Heritage Foundation, March 2017. Available at: <https://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative>

^{vi} Katch H, Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment, Center on Budget and Policy Priorities, July 2016. Available at: <https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly>



June 29, 2018

Jeffrey Meyers, Commissioner
NH Department of Health and Human Services
Fred H. Brown Building
129 Pleasant Street
Concord, NH 03301

Re: Granite Advantage Health Care Program Section 1115 (a) Demonstration Waiver

Dear Commissioner Meyers:

On behalf of our 26 acute care hospitals and our specialty hospitals, the New Hampshire Hospital Association (NHHA) appreciates the opportunity to comment on the State of New Hampshire's Granite Advantage Section 1115 (a) Demonstration Waiver. NHHA and our member hospitals have been supportive of the New Hampshire Health Protection Program (NHHPP) and support the Granite Advantage Health Care Program, which will ensure the continuation of essential health care coverage to over 52,000 New Hampshire residents.

While we are supportive of the Granite Advantage Health Care Program, we do want to share with you the following concerns with the proposed waiver extension:

Retroactive Coverage and Eligibility

The elimination of the three-month retroactive coverage is of concern to our members. This policy change could result in fewer services covered and ultimately increase uncompensated care for hospitals. While we understand the new program prohibits allowing for retroactive coverage, we feel it is counterintuitive to remove this important coverage policy. New Hampshire hospitals will continue to provide care for all patients who seek care, which will likely drive up uncompensated care during the time when the beneficiary is not covered.

It is our understanding that the current presumptive eligibility procedures allowed under Medicaid will continue. Specifically, hospitals and community health centers will be permitted to initiate the presumptive eligibility process for their patients, as is current practice.

Regarding the general eligibility process, our member hospitals request further clarification on the State's eligibility dates intention.

The waiver application states:

“Expansion adults will become eligible for coverage under Title XIX at the time of application; eligibility will be effective no earlier than **the day all eligibility requirements are met** (i.e., usually the date of application).”

Does “the day all eligibility requirements are met” mean the date that the enrollees apply and attest to their eligibility or the date that they produce all necessary documentation to prove eligibility? This is a significant distinction since enrollees will frequently seek coverage when they have an acute care need, so a delay could cause a gap of coverage when it is needed most.

Work and Community Engagement Requirements

While the Granite Advantage Health Care Program community engagement requirements are explicitly written into law, our member hospitals remain concerned that the monthly hours required to be compliant with the requirements are far too robust. 100 hours per month is a higher threshold than any other work requirements in the nation and could pose serious barriers to coverage.

Of particular concern to our members are New Hampshire’s seasonal workers. The proposed “cure” if a patient is non-compliant will likely not be enough for New Hampshire’s seasonal workers, who may struggle to complete the difficult monthly hourly requirement due to the nature of their employment.

Our member hospitals do not believe enough detail has been provided to date on what would be considered a “good cause exemption”. More detail is needed to help ensure a beneficiary remains compliant within the system for extenuating circumstances.

We also believe there needs to be very clear detail on what is counted as a qualifying activity, especially around employment. For example, will self-employed beneficiaries be counted within the work requirement? If not, please provide an explanation as to why self-employment is not considered a qualifying work requirement.

In addition, our members request that more detail be provided regarding who will be responsible for tracking community engagement requirements. As proposed, the statement, “The State will work collaboratively with its contracted MCOs to monitor work and community engagement qualifying activities, exemptions, and enrollee status” is of concern as potential conflicts of interest could result if the MCOs are given the responsibility for completing the determination verification.

Change from a Premium Assistance Program to a Managed Care Delivery System

Under the proposed waiver extension, the State of New Hampshire will be transitioning all expansion beneficiaries from the current marketplace, the Qualified Health Plan structure, to a managed care delivery system. This transition will have a tremendous financial impact on our member hospitals as the current reimbursement under the Medicaid Managed Care Organizations (MCOs) is significantly lower than under the Qualified Health Plan structure. Our members ask that consideration be given to reduce this reimbursement shortfall by working with NHHA to develop programs and strategies that improve reimbursement levels for hospitals over time. Otherwise the shortfalls will result in increased uncompensated care for Medicaid services and could lead to the further reductions in hospital’s operating margins.

Incent Healthy Behaviors and Cost Effectiveness Policies for MCOs and Individuals

Our member hospitals believe further detail is needed on the incentives that are referenced in the waiver extension application regarding health behaviors and cost effectiveness of policies. The applications states; “MCO contracts will include clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program.” While we certainly support efforts to improve the delivery of care to Medicaid beneficiaries, we have concerns with how the proposal to address the “appropriate use of emergency departments relative to low acuity non-emergent visits” will be accomplished, and as such request clarification.

This is of concern to our members as there is not enough detail surrounding this entire section to include how these proposals will be incorporated into provider contracts as well as the implementation and oversight by the State. While New Hampshire hospitals agree that patients should always seek the appropriate level of care, there needs to be proper safeguards to ensure that patients do not avoid seeking care out of a fear of non-coverage. It should be noted that the State legislature passed a bill this session that incorporates Prudent Layperson language into the state insurance statute. This change will require insurers to cover emergency care based on a patient’s presenting symptoms and not the final diagnosis.

Proof of Citizenship and Asset Testing

While our hospital members agree that verifying New Hampshire residency is reasonable, requiring United States citizenship to be proven with two forms of paper identification is far too burdensome on the patient. The reality is that many individuals will have difficulty accessing the necessary documentation, such as a birth certificate, passport, etc. This burden could result in fewer eligible individuals qualifying for coverage. Federal law currently allows for electronic verification of citizenship and there is no reason to believe this form of verification is inaccurate. The requirement to prove citizenship with two forms of paper identification will result in denial of coverage for many US citizens who simply don’t have these documents in hand and find the processes to obtain copies of their vital records challenging.

While current federal law explicitly prohibits beneficiary asset tests in determining eligibility, we understand the State of New Hampshire is seeking authority to seek such testing, consistent with State law. While we understand the reasons for its inclusion in the waiver application, we remain opposed to such asset testing requirements.

On behalf of our hospitals, the New Hampshire Hospital Association thanks NH DHHS for the opportunity to comment on New Hampshire’s Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. If you have any questions, please feel free to contact me or Nick Carano, Director, Financial Policy and Reimbursement at (603) 415-4253 or ncarano@nhha.org.

Sincerely,



Steve Ahnen
President



American Cancer Society
Cancer Action Network
2 Commerce Drive
Suite 110
Bedford, NH 03110
603.471.4115
www.acscan.org/nh

June 26, 2018

Dawn Landry
Department of Health and Human Services
Fred H. Brown Building
129 Pleasant Street
Concord, NH 03301-3857

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Ms. Landry:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on New Hampshire's Granite Advantage Health Care Program Section 1115 Demonstration Waiver extension application. 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 supports New Hampshire's decision to maintain comprehensive health care coverage for thousands of low-income state residents through the Medicaid expansion program (now called "Granite Advantage Health Care Program"). Over 8,000 residents of New Hampshire are expected to be diagnosed with cancer this year¹ – many of whom rely on the expansion of New Hampshire's Medicaid program for their health care coverage. Research has demonstrated that individuals who lack health insurance coverage are more likely to be diagnosed with advanced-stage cancer, which is costly and often leads to worse outcomes.^{2,3} Research has also shown that individuals in expansion states are more frequently diagnosed with cancer at earlier stages than those in non-expansion states.^{4,5} Additionally, individuals enrolled in Medicaid prior to their diagnosis have better survival rates than those who enroll after their diagnosis.⁶

¹ American Cancer Society. *Cancer Facts & Figures: 2018*. Atlanta: American Cancer Society, 2018.

² Ward E, Halpern M, Schrag N, et al. Association of insurance with cancer care utilization and outcomes. *CA Cancer J Clin*. 2008; 58(1):9-31.

³ American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2017.

⁴ Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among non-elderly patients with cancer after the Affordable Care Act. *J Clin Oncol*. 2017; 35:2906-15.

⁵ Soni A, Simon K, Cawley J, Sabik L. Effect of Medicaid Expansion of 2014 on overall and early-stage cancer diagnoses. *Am J Public Health*. 2018; 108:216-18.

⁶ Adams E, Chien LN, Florence CS, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer*. (2009); 115(6):1300-9.

ACS CAN wants to ensure that low-income cancer patients and survivors in New Hampshire have adequate access and coverage under Granite Advantage, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer during their lifetime. We are concerned with many of the proposals included in the Granite Advantage waiver extension, as detailed below. We urge the New Hampshire Department of Health and Human Services ("the Department") to reconsider moving forward with the proposed waiver until these issues can be addressed.

Delivery System – Sunset of New Hampshire's Health Protection Program (NHPP)

We can appreciate why New Hampshire has decided to sunset New Hampshire's Health Protection Program (NHPP) and move those enrollees into currently contracted Medicaid managed care organizations (MCOs) to help streamline program administration. We commend the Department for proposing to align the Alternative Benefit Plan (ABP) for the expansion adult group to the State Plan so they will receive the same Essential Health Benefit (EHB) services and supports without any reduction in coverage. However, we do have some concerns regarding the transition from the Marketplace to a Medicaid MCO and urge the Department to consider these concerns as you prepare the final waiver application.

Continuity of Care

We ask the Department to address in their final waiver application how it will minimize disruptions in coverage and care for individuals in active treatment for life-threatening illnesses, such as cancer. Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care or longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes. Failure to consider the care delivery and/or treatment regimen of patients, especially those individuals managing a complex, chronic condition like cancer, could have devastating effects on patients and their families.

Additionally, we urge the Department to establish a clearly defined process through which Granite Advantage enrollees or their physician can inform the Department that they are in active treatment; allowing them to maintain their cancer care treatment regimen and continue to see their providers through the end of their treatment. This will help ensure the state of New Hampshire's goal of improving beneficiary health.

MCO Network Adequacy

We ask the Department to clarify how they will ensure network adequacy of the Medicaid MCOs, particularly in rural sections of New Hampshire. We are concerned as to whether the current two Medicaid MCO plans in the state will be able to handle the increase in enrollment. Additionally, will the MCOs be required to have a continuous open enrollment policy to ensure enrollees who want to use a particular MCO health plan system are able to enroll? Or will the MCOs be able to cut off enrollment at a certain point?

Premiums and Cost Sharing

We are pleased that the Department will be aligning the cost sharing requirements for enrollees with income greater than 100 percent of the federal poverty level (FPL) with the maximum permitted Medicaid cost sharing levels. However, we remain concerned the cost sharing and related penalties for non-payment for the expansion population, even if they only apply to pharmaceuticals, could create administrative burdens for enrollees, deter enrollment or result in a high number of disenrollment, and potentially cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Imposing copayments on low-income populations has been shown to decrease the likelihood that they will seek health care services.^{7,8,9} Proposals that place greater financial burden on low-income residents create barriers to care and could negatively impact Granite Advantage enrollees – particularly those individuals who are high service utilizers with complex medical conditions. For example, individuals in active cancer treatment may be on multiple supportive drugs to help combat the side effects of their chemotherapy, such as nausea, constipation, high blood pressure, etc. Even a nominal copayment for pharmaceuticals could add up and become unaffordable for someone with complex medical conditions, like cancer, who require multiple supportive drugs.

Demonstration Eligibility

Asset Test

ACS CAN opposes the proposed \$25,000 asset test for expansion adults in the state. The State gives no justification as to how this asset test promotes the objectives of the Medicaid program or the required criteria for an 1115 waiver approval. The proposal is also counterintuitive. It is likely that an enrollee may have an asset – such as a car – that would trigger the asset test but at the same time be cash poor. For example, if a low-income couple living in a rural area of New Hampshire requires a car to get to and from necessary cancer treatments, the asset test could prevent them from receiving this lifesaving care. Likewise, if an individual needs a car to get to the job they are now required to have, that car could cause them to be over the \$25,000 asset threshold and lose their Medicaid coverage. Finally, this provision would add unnecessary administrative costs for both the state and enrollees by increasing the time needed to process eligibility applications, leading to delays in coverage.^{10,11} Any delay in health care coverage could seriously jeopardize a cancer patient's chance of survival. Therefore, we highly recommend the Department to reconsider this provision of the waiver application.

⁷ Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research*. 2000; 34: 1331-50.

⁸ Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care*. 2011; 49: 865-71.

⁹ Trivedi AN, Rakowski W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med*. 2008; 358: 375-83.

¹⁰ The Henry J. Kaiser Family Foundation. Eliminating the Medicaid asset test for families: A review of state experiences. Published April 2001. Accessed May 2017. <https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf>.

¹¹ Cassidy A. Health policy brief: Enrolling more kids in Medicaid and CHIP. *Health Affairs*, January 27, 2011. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_39.pdf.

Work and Community Engagement Requirements

As we have discussed in previous letters to the Department, the requirement that all able-bodied Granite Advantage enrollees be employed, receive job training, or participate in community engagement activities as a condition of eligibility could unintentionally disadvantage patients with complex chronic conditions, including cancer patients, recent survivors, and those women diagnosed with cancer through the state's *Let No Woman Be Overlooked* program. We understand the intent of the proposal is to incentivize employment, but many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.^{12,13,14} ACS CAN opposes tying access to affordable health care for lower income persons to work or participation in community engagement requirements because cancer patients, survivors, and those who will be diagnosed with the disease - as well as those with other complex chronic conditions - could find themselves without Medicaid coverage. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with work absences ranging from 45 days to six months depending on the treatment.¹⁵ If work and community engagement is required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the state's Medicaid program.

We appreciate the Department's acknowledgement that not all people are able to work and the decision to include several exemption categories and good cause exemptions from the community engagement requirement and associated lock-out period. However, the waiver does not go far enough to protect vulnerable individuals, including recent cancer survivors, and other serious chronic diseases linked to cancer treatments.¹⁶ Additionally, the increase in administrative requirements for enrollees to attest to their working status would likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not.

Lock-Out Period

We are deeply concerned about the proposed lock-out period for non-compliance with the work or community engagement requirement. The Department offers individuals who have failed to participate in the requirement "good cause" exemptions, but it is unclear how long the appeals process would take and whether the beneficiary would lose health coverage during the process. If individuals are locked out of coverage during the appeals process they will likely have no access to health care coverage, making it difficult or impossible to continue treatment or pay for their maintenance medication until it is

¹² Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

¹³ de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

¹⁴ Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv.* 2016; 10:480. doi:10.1007/s11764-015-0492-5.

¹⁵ Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy than People Without a Cancer Diagnosis. *Health Affairs*, 32, no. 6, (2013): 1143-1152.

¹⁶ Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation.* 2018; 137(7): CIR.0000000000000556.

determined that they have “good cause.” For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one’s cancer care team could be a matter of life or death for a cancer patient or survivor and the financial toll that the lock-out would have on individuals and their families could be devastating.

Eligibility Reporting Requirements

Low-income populations, particularly those who are hourly workers, are more likely to have an inconsistent income throughout the calendar year. Therefore, the requirement that Granite Advantage applicants must inform the Department of any changes in financial eligibility within 10 days of such change would be administratively burdensome for the applicant, as well as the state. Additionally, the Department proposes that applicants, at the time of enrollment, acknowledge that the program is subject to cancellation upon notice. This is bound to cause confusion for Medicaid applicants, who may believe that the state is implying their health coverage can be cancelled at any time for any reason. Also, we are unclear how the program can be subject to cancellation upon notice. We would appreciate greater clarification on this statement.

Wellness & Healthy Behaviors

We support the Department’s goal of promoting and incentivizing healthier lifestyles. However, we ask the Department to ensure any wellness programs are evidence-based incentive or participatory wellness programs rather than outcomes-based incentive programs. Penalizing enrollees for non-compliance or failing to meet outcomes dictated by their MCO (or the state) will not likely generate cost savings or improve the health of low-income Granite Staters. Instead, a comprehensive, evidence-based participatory wellness program based on incentives that provides adequate and comprehensive coverage of preventive services (including tobacco cessation, weight loss, and cancer screenings) and that emphasizes evidence-based interventions to educate, promote, and encourage patients to participate in prevention, early detection, and wellness programs would better serve state residents. Evidence shows that unhealthy behaviors can be changed or modified by modest incentives, as long as they are combined with adequate medical services and health promotion programs.¹⁷

Outcomes-based programs would not improve the health of low-income residents. Nationally, significant disparities exist in the prevalence of healthy behaviors by income. For example, adults living below the poverty level are more than one and a half times as likely to smoke cigarettes as those with higher incomes¹⁸ and individuals with incomes less than 100 percent of poverty are 30 percent more likely to be obese than people with much higher incomes (above 400 percent of poverty).¹⁹ Low-income individuals and families often face multiple structural barriers to addressing health behaviors, including

¹⁷ Consensus statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action network, American Diabetes Association, and American Heart Association. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *JOEM*. 2012; 54(7): 889-96.

¹⁸ Centers for Disease Control and Prevention. Cigarette smoking and tobacco use among people of low socioeconomic status. Updated February 3, 2017. Accessed May 2017. <https://www.cdc.gov/tobacco/disparities/low-ses/index.htm>.

¹⁹ National Center for Health Statistics. *Health, United States, 2015: with special feature on racial and ethnic health disparities*. Hyattsville, MD. 2016. <https://www.cdc.gov/nchs/data/hsr/hsr15.pdf>.

lack of access to evidence-based tobacco cessation support, few safe places for physical activity in their neighborhoods, lack of access to affordable healthy foods, and lower health literacy.²⁰ Providing enrollees incentives could lead to a change in behavior whereas penalties do little to improve health, and could reduce access to necessary health care services, including preventive care.

We urge the Department, as they consider if and what type of wellness program to implement, to consider the impact of a wellness program on low-income state residents, because it could unfairly penalize individuals managing complex, chronic diseases, like cancer. We ask the Department to clarify the criteria the state intends to use when determining thresholds for wellness behaviors. Greater specification would be helpful in assessing the possible effects this type of threshold-based measurement would have on Granite Advantage enrollees, particularly how it may affect eligibility and enrollment.

Retroactive Eligibility

Medicaid currently allows retroactive coverage if: 1) an individual was unaware of his or her eligibility for coverage at the time a service was delivered; or 2) during the period prospective enrollees were preparing the required documentation and Medicaid enrollment application. Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer.

Further, many uninsured or underinsured individuals who are newly diagnosed with a chronic condition do not receive recommended services and follow-up care because of cost.^{21,22} In 2016, one in five uninsured adults went without care because of cost.²³ Waiving retroactive eligibility could delay necessary care in low-income populations, negatively impact patients with complex medical conditions that require frequent follow-up and maintenance visits to help control their disease process, and result in unnecessary costs.

Safety-net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires emergency departments (ED) to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.²⁴ Retroactive

²⁰ Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services; 2013.

²¹ Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.

²² Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published December 14, 2017. Accessed April 2018. <https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/>.

²³ The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated November 29, 2017. Accessed May 2018. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

²⁴ Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed April 2018. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.²⁵ Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of New Hampshire from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge the Department to consider these providers and their contribution to New Hampshire's safety-net, as well as the patients who rely on Granite Advantage for health care coverage, when deciding whether to waive retroactive eligibility for New Hampshire's adult population.

Conclusion

We appreciate the opportunity to provide comments on the Granite Advantage draft waiver extension. The preservation of eligibility and coverage through New Hampshire's Medicaid expansion program remains critically important for thousands of low-income Granite Staters who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. As the Department considers its final waiver application, we ask that you weigh the impact these proposals could have on Granite Advantage enrollees access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the New Hampshire Department of Health and Human Services to ensure that all Americans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at mike.rollo@cancer.org or 603.471.4115.

Sincerely,



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

²⁵ National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed April 2018. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.



**National
Multiple Sclerosis
Society**
Greater
New England
Chapter

June 28th, 2018

Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301 -6521

Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

The National MS Society appreciates the opportunity to submit comments on New Hampshire's Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

The National MS Society advocates for the 2,500 individuals with multiple sclerosis MS in the Granite State. A smaller unknown number of individuals is currently enrolled in Mass Health. We believe the majority qualify based on disability status but there may also be a smaller percentage that fall in the non-disabled adults ages 21 – 64.

MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. There is no cure but at present the disease modifying treatments are the best frontline approach to slowing the progression of the disease and reducing the likelihood of disability.

The National MS Society believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver as proposed will jeopardize patients' access to quality and affordable health coverage, and the National MS Society therefore urges New Hampshire to withdraw this proposal.

Waiving Retroactive Eligibility

The Society opposes eliminating the current three-month retroactive eligibility period in Medicaid. Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for

Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. For people who begin experiencing MS symptoms and are eventually diagnosed with MS the initial diagnosis period brings high expenses of multiple medical appointments, MRIs and getting put on an MS disease-modifying therapy. People in those circumstances should be able to have medical costs covered retroactively if they, indeed, qualify for Medicaid.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care because of the waiver.

Continuation of Burdensome Administrative Requirements

The National MS Society is concerned about the continuation of New Hampshire's requirement for enrollees to "work" 100 hours per month or lose their health coverage. This is a particularly high standard as other approved proposals in Indiana, Kentucky, and Arkansas require up to 80 hours of work activities per month. Promoting employment is a worthy goal, but there are better avenues to accomplish this, such as providing better workplace supports and more accessible transportation. Ironically, work requirements could keep someone from getting the coverage and services they need to be healthy enough to work. Or people with MS could experience significant MS exacerbations that cause them to temporarily stop working and because of stringent work requirements, lose their health coverage.

Continuing this policy will increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.

Failing to navigate these burdensome administrative requirements could have serious consequences for people with chronic diseases including individuals with MS. People who are in the middle of treatment for serious disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Asset Test

The waiver requests the authority to consider an individual's assets when determining Medicaid eligibility. Current Medicaid rules do not allow for asset tests when determining eligibility for the program. Low income households' assets typically include a home – which may be inherited – or a car. Owning a home can add to economic security and owning a car provides transportation to work and to medical appointments, and neither may be indicative of enrollees'

financial status or eligibility for Medicaid. Holding these resources against a person when they apply for Medicaid will not help people achieve upward economic mobility, health or promote the goals of the Medicaid program.

There is no evaluation hypothesis to test this proposal in the waiver evaluation. Again, the state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to care in the Medicaid program as part of its application.

Lack of Information on Impact of Waiver

The National MS Society wishes to highlight that the proposal does not predict the impact of the waiver on enrollment (with or without waiver baseline) or cost savings over 5 years. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable.

The intent of this section of the regulations is to allow public comment on a Section 1115 proposal with adequate information to assess its impact. In order to meet these transparency requirements, New Hampshire must include these projections and their impact on budget neutrality. If New Hampshire intends to move ahead with this proposal, the state should at a minimum provide the required information to the public and reopen the comment period for an additional 30 days.


Proposed Timeline

Public comment is due June 29, 2018 and according to the timeline the proposal will be submitted to CMS for review on June 30, 2018. This timeline suggests that New Hampshire does not intend to incorporate public feedback into the waiver proposal. We urge New Hampshire to push back the date the waiver will be submitted to CMS in order to review all the comments that are received by the deadline (June 29, 2018 at 5pm eastern) and revise the waiver in response to the comments.

Conclusion

The National MS Society believes access to affordable, high quality healthcare is essential for people with multiple sclerosis (MS) to live their best lives, and health insurance coverage is essential for people to get the care and treatments they need. New Hampshire's Section 1115 Demonstration Proposal does not meet that standard and the National MS Society urges the state to withdraw this proposal.

Sincerely,

A black rectangular redaction box covering the signature of Michelle Dickson.

Michelle Dickson
Senior Manager of Advocacy
National MS Society
Michelle.dickson@nmss.org
1-303-698-6187

Virgil Dickson, “Ohio Medicaid waiver could cost hospitals \$2.5 billion”, Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

Tricia Brooks, “Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP,” Georgetown University Health Policy Institute Center for Children and Families, January 2009Th.

Granite Advantage Health Care Program Section 1115(a) Demonstration

Waiver: <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

Balance Sheets of Low-Income Households: What We Know about Their Assets and Liabilities:
<https://aspe.hhs.gov/execsum/balance-sheets-low-income-households-what-we-know-about-their-assets-and-liabilities>

June 28, 2018

Commissioner Jeffrey Meyers
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Re: Granite Advantage Health Care Program Section 1115(a) Waiver Extension Application

Dear Commissioner Meyers,

Thank you for the opportunity to comment on the Granite Advantage Health Care Program Section 1115(a) Waiver Extension Application seeking to transition from the New Hampshire Health Protection Program to the New Hampshire Granite Advantage Health Care Program.

The New Hampshire Fiscal Policy Institute is an independent, nonpartisan, nonprofit policy research organization based in Concord, New Hampshire, dedicated to exploring, developing, and promoting public policies that foster economic opportunity and prosperity for all New Hampshire residents, with an emphasis on low- and moderate-income families and individuals. The New Hampshire Fiscal Policy Institute provides the following comments regarding the Granite Advantage Health Care Program 1115(a) Waiver Extension Application.

Limited Analysis of Potential Impacts from Work and Community Engagement Requirements

One component of the Application proposes to extend the work and community engagement requirements waivers and authorities approved on May 7, 2018 by the federal Centers for Medicare and Medicaid Services. The Application projects enrollment in the current New Hampshire Health Protection Program will not change materially as a result of the transition to the New Hampshire Granite Advantage Health Care Program, with enrollment remaining near current levels during the five-year period of the extension. National research on work requirements suggests monthly windows for compliance may result in more instances of discontinuous coverage, as work hours vary from month-to-month for many low-income workers, increasing the risk that these individuals would not have access to health care. Estimates suggest significant portions of the Medicaid-enrolled population might be affected by such work requirements.¹

Data-informed projections for potential changes in enrollment due to the implementation of these requirements and other program changes would assist evaluations of whether implementing these changes would improve beneficiary health or negatively impact the health of those served.

The Application includes a stated intent to track the number and percentage of beneficiaries who are disenrolled for either failing to report on or comply with the community engagement requirements. The New Hampshire Fiscal Policy Institute questions whether seeking to collect information regarding health outcomes for those who are disenrolled may provide insights into

the impacts of the community engagement requirements on promoting beneficiary health, particularly for those who re-enroll in Medicaid later following a period of coverage loss.

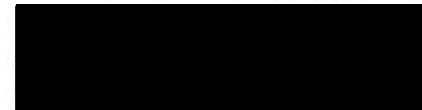
The Application does not address self-employed individuals. The New Hampshire Fiscal Policy Institute questions whether additional research on the impacts of the New Hampshire Granite Advantage Health Care Program's work and community engagement requirements on self-employed individuals should be pursued, and findings incorporated into the Application.

Transition Plan Details Limited

The Application discusses the State's intent to help ensure the transition from the Premium Assistance Program under the New Hampshire Health Protection Program to the Managed Care Delivery System under the New Hampshire Granite Advantage Health Care Program does not result in any person losing coverage solely due to the transition. The New Hampshire Fiscal Policy Institute questions whether additional details regarding this transition plan should be included in the Application to help ensure that all enrollees successfully transition to the new program.

Thank you for your time and your consideration of these comments.

Sincerely,



AnnMarie French
Interim Executive Director

¹ For more information, discussion, and references, see the New Hampshire Fiscal Policy Institute, *Common Cents*, "Expanded Medicaid Proposal Moves Forward with Changes to Work Requirements," April 11, 2018.



NEW HAMPSHIRE LEGAL ASSISTANCE

Working for Equal Justice Since 1971

www.nhla.org

June 29, 2018

NH Department of Health and Human Services
Attn: Granite Advantage Section 1115(a) Demonstration Waiver
129 Pleasant Street
Concord, NH 03301

RE: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

To whom it may concern:

I write on behalf of New Hampshire Legal Assistance (NHLA) clients to convey strong opposition to the Granite Advantage Health Care Program Section 1115(a) Waiver Expansion Application ("waiver"). NHLA is a non-profit law firm. We represent low-income and elderly clients in civil cases impacting their basic needs, including healthcare. In short, the waiver application seeks approval from the Centers for Medicare and Medicaid Services (CMS) to 1) implement a work requirement, 2) eliminate retroactive eligibility, 3) require additional verification of citizenship and 4) institute an assets test.¹ Approval of these provisions is impermissible under federal law. Under 42 U.S.C. § 1315(a), Medicaid § 1115 demonstration projects may only be approved if they promote the objectives of the Medicaid program. The objective of the Medicaid program is to provide healthcare services. Shortly before submitting these comments, an order was issued by United States District Judge James E. Boasberg vacating the Secretary's approval of Kentucky Health.² Given the similar provisions contained in the Kentucky and New

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 proposed changes set forth in the Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver should not be construed as support for those proposed changes nor agreement that they are lawful.

² Section 1901 of the Social Security Act appropriates funds so states can "furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain

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1-800-921-1115
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Manchester Office
1850 Elm Street
Suite 7
Manchester, NH 03104
603-668-2900
1-800-562-3174
Fax: 603-935-7109

Portsmouth Office
154 High Street
Portsmouth, NH 03801
603-431-7411
1-800-334-3135
Fax: 603-431-8025

Berlin Office
1131 Main Street
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
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TTY: 1-800-735-2964

Hampshire waivers, I urge the NH Department of Health and Human Services (NHDHHS) to refrain from submitting this waiver request to CMS.

To be approved pursuant to § 1115, New Hampshire's application must: propose an "experiment, pilot or demonstration," waive compliance only with requirements in 42 U.S.C. § 1396a, be likely to promote the objectives of the Medicaid Act, and be approved only "to the extent and for the period necessary" to carry out the experiment.

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are too poor to meet the costs of necessary medical care and to furnish assistance and services to help these individuals attain or retain the capacity for independence and self-care.³

According to federal regulations, a state must give the public notice of its application, and the notice must contain "a sufficient level of detail to ensure meaningful input from the public, including . . . an estimate of the expected increase or decrease in annual enrollment . . ."⁴ The state's application does not provide estimated enrollment data. Instead it says, "The State estimates that enrollment in Granite Advantage will not change materially over the course of the five-year extension period, with enrollment remaining near current levels. Precise enrollment estimates are difficult to predict as features of the waiver change."⁵

1. Implementation of a Work Requirement

capability for independence or self-care." 42 U.S.C. § 1396-1; *see also generally* Judith Solomon & Jessica Schubel, *Medicaid Waivers Should Further Program Objectives, not Impose Barriers to Coverage and Care*, CTR. ON BUDGET AND POL'Y PRIORITIES, Aug. 29, 2017, <https://www.cbpp.org/research/health/medicaid-waivers-should-further-program-objectives-not-impose-barriers-to-coverage>.

³ 42 U.S.C. § 1396-1.

⁴ 42 CFR 431.408(a)(1)(i)(C)

⁵ Application dated May 8, 2018 states, "Granite Advantage eligible population is expected to grow over the course of the five year extension due to population growth, but enrollment in the program could be impacted by several other features. First the delivery system transformation from the PAP to Medicaid managed care could have an impact on enrollment. Second, enrollment could decline as more beneficiaries seek and find employment and leave the program as their earnings increase."

As you know, in November 2016, CMS rejected an earlier New Hampshire Section 1115 Demonstration Amendment with work requirements in a decision stating:

CMS reviews section 1115 demonstration applications and amendments to determine whether they are likely to further the objectives of the Medicaid program, including strengthening coverage or health outcomes for low-income individuals in the state or increasing access to providers. After reviewing NH's amendment to determine whether it meets these standards, CMS is unable to approve the request which could undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program.

Since this decision, Congress has not amended federal law to allow for work requirements under the Medicaid Act.

Under § 1115 and other relevant law, CMS has no authority to approve a waiver permitting New Hampshire to condition Medicaid eligibility on compliance with work activities (and, thus, prior to this year had never done so). Work requirements are an illegal condition of eligibility above and beyond the Medicaid eligibility criteria clearly enumerated in federal law. Medicaid is a medical assistance program, and although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance to all individuals who qualify under federal law. As courts have held, additional eligibility requirements are illegal.⁶

Work requirements cannot be imposed through the Secretary's waiver authority because those requirements are directly at odds with the objectives of the Medicaid Act.⁷ Conditioning Medicaid eligibility on completion of a work requirement gets it exactly

⁶ See, e.g., *Camacho v. Texas Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children did not get immunizations, check-ups, or were missing school because regulation was inconsistent with Medicaid and TANF statutes).

⁷ By contrast, as far back as the 1970s, states obtained Section 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, <https://aspe.hhs.gov/report/setting-baseline-report-state-welfare-waivers>.

backwards by blocking access to the care and services that help individuals attain and retain independence or self-care and, as a result, enable them to work.

In addition, a work requirement is unnecessary as New Hampshire has one of the lowest unemployment rates in the nation and the majority of Medicaid expansion enrollees who are not disabled or elderly are already working. An issue brief by the Kaiser Foundation on Medicaid enrollees shows that, without a work requirement in place, in New Hampshire 65% of non-elderly adults not on SSI are working and that 77% are in working families.⁸ Moreover, many Medicaid adults who are not eligible for SSI but not working report major impediments to work such as illness/disability, going to school, and taking care of family.⁹

Impact on People with Disabilities

While the application indicates that the work requirements will not apply to individuals who are receiving disability benefits or who are physically or mentally unable to work, evidence from other programs with similar exemptions shows that, in practice, these exemptions are expensive to administer and ineffective.¹⁰ Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical and mental health issues are disproportionately likely to be

⁸ Rachel Garfield, Robin Rudowitz & Anthony Damico, *Understanding the Intersection of Medicaid and Work*, KAISER FAMILY FOUND., Jan. 5, 2018, <http://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

⁹ MaryBeth Musumeci, Rachel Garfield & Robin Rudowitz, *Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues*, KAISER FAMILY FOUND., Jan. 16, 2018, <http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/>.

¹⁰ See, e.g., Hannah Katch, *Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment*, CTR. ON BUDGET AND POL'Y PRIORITIES, Jul. 2016, available at <https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly> (noting that “State experience in implementing the TANF work requirements suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.”).

sanctioned for not completing the work requirement.¹¹ Such individuals may not understand what is required of them, may find it difficult to complete the necessary paperwork or to travel to appointments to be assessed for an exemption. In fact, a study of one state's TANF program revealed that "hardship" extensions were not effective at protecting individuals with a disability. Specifically, this state's data indicates that while nearly 90% of parents receiving TANF for five years or longer have a disability themselves or are caring for a disabled family member, only 17% of families who would have been terminated due to the time limits received a disability-related extension.¹²

In New Hampshire data suggests that 40% of people with disabilities receive SSI and 60% do not.¹³ Some enrollees are also in the program because they are unable to work due to disability but still waiting for a decision in their Social Security disability case. It will now be necessary for these individuals to document that they are unable to work. This will be an added expense and burden to NHDHHS and to enrollees and their health care providers.

Because conditioning Medicaid eligibility on completion of the work requirement will likely disqualify individuals with chronic and disabling conditions, notwithstanding the state's proposed exemptions, the requirement implicates the civil rights protections contained in the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation

¹¹ See, e.g., Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment*, June 2004, (Departmental Paper University of Pennsylvania School of Social Policy and Practice), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.

¹² J.C. McLaughlin & S.S. Butler, *Families in focus: Moving beyond anecdotes: Lessons from a 2010 survey of Maine TANF families*. Augusta, Maine: Maine Equal Justice Partners and Maine Women's Lobby (2011); Sandra S. Butler, *TANF Time Limits, One Year Later: How Families are Faring*, Mar. 2014, www.mejp.org/sites/default/files/TANF-Time-Limits-Study-March2014.pdf.

¹³ MaryBeth Musumeci, *How Might Medicaid Adults with Disabilities Be Affected By Work Requirements in Section 1115 Waiver Programs?* KAISER FAMILY FOUND., Jan. 26, 2018, <https://www.kff.org/report-section/how-might-medicaid-adults-with-disabilities-be-affected-by-work-requirements-in-section-1115-waiver-programs-appendix/>.

Act.¹⁴ These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they cannot be waived or ignored under § 1115 or under any other authority of the Secretary.¹⁵

Impact on Children

To the extent that work requirements cause parents to lose coverage, their children are more likely to be uninsured. In fact, research shows that 21.6% of children whose parents are uninsured are uninsured themselves¹⁶. Whereas, increases in adult Medicaid eligibility are associated with more children in low-income families receiving preventive care.¹⁷

New Hampshire applies the work requirement to parents with school-aged children. The multiple, unstable childcare arrangements that many families rely on when they have low-wage work with uncertain schedules can also harm a child's health development.¹⁸ Numerous studies find a relationship between childcare stability, attachment, and child outcomes including effects on social competence, behavior outcomes, cognitive outcomes, language development, school adjustment, and overall child well-being.¹⁹ The effect of parental low wage jobs and childcare instability may particularly impact children living in poverty.²⁰ To implement work requirements in Medicaid despite evidence that such requirements would likely cause harm to children and their development would be contrary to purpose of the Medicaid Act.

¹⁴ 42 U.S.C. § 12312; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (prohibiting recipients of federal funds from discriminating on the basis of disability).

¹⁵ See *Burns-Vidlak v. Chandler*, 939 F. Supp 765, 772 (D.Haw. 1996).

¹⁶ Karpman, M. and G. Kenney, *Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017*, URBAN INST., Sep.7, 2017.

¹⁷ Venkataramani, M., Pollack, C.E., & Roberts, E.T., *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, (2017) PEDIATRICS. Doi:10.1542/peds.2017-0953.

¹⁸ Gina Adams & Monica Rohacek, *Child Care Instability: Definitions, Context, and Policy Implications*, URBAN INST., Oct. 2010, <https://www.urban.org/sites/default/files/publication/29446/412278-Child-Care-Instability-Definitions-Context-and-Policy-Implications.PDF>.

¹⁹ *Id.* at 7.

²⁰ *Id.* at 8.

Working but Unable to Verify

The work requirements will also pose a barrier to coverage for individuals who are working.²¹ Data shows that most low-income workers have jobs with variable and unpredictable schedules, for instance in construction, retail, or food service, which not only can contribute to worsening health outcomes, but can make it difficult to comply with the State's weekly-hours requirements.²² Moreover, even individuals who do comply with the weekly-hours requirements will have to verify their hours every month to maintain their eligibility. Creating additional verification requirements will inevitably lead to increased disenrollment solely for failure to complete paperwork.²³

Economic Instability

While expanding Medicaid led those with medical debt in one state to fall by nearly half,²⁴ extensive research reveals that work requirements do little or nothing to increase stable, long-term employment and do not decrease poverty.²⁵ In fact, work requirements have had the reverse effect, leading to an increase in extreme poverty in

²¹ See e.g., Julia B. Isaacs, Michael Katz & David Kassabian, *Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance*, URBAN INST., Mar. 2016, <http://www.urban.org/sites/default/files/publication/78846/2000668-Changing-Policies-to-Streamline->

²² Susan J. Lambert, Peter J. Fugiel & Julia R. Henly, *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot*, UNIV. OF CHI., (2014), https://ssascholars.uchicago.edu/sites/default/files/work-scheduling-study/files/lambert.fugiel.henly_precarious_work_schedules.august2014_0.pdf; Stephanie Luce, Sasha Hammad & Darrah Sipe, *Short Shifted*, RETAIL ACTION PROJ., Sep. 2014, http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits*, Sep. 2015, <http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>.

²³ Margot Sanger-Katz, *Hate Paperwork? Medicaid Recipients Will Be Drowning In It*, N.Y. TIMES, Jan. 18, 2018, <https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?nytapp=true&r=0>; Tazra Mitchell & LaDonna Pavetti, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line*, CTR. ON BUDGET AND POL'Y PRIORITIES, Jan. 23, 2018.

²⁴ Ohio Dept. of Medicaid, *Ohio Medicaid Group VIII Assessment: A report to the Ohio General Assembly*, Dec. 20, 2016, <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

²⁵ LaDonna Pavetti, *Work Requirements Don't Cut Poverty, Evidence Shows*, CTR. ON BUDGET & POL'Y PRIORITIES (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. POL'Y ANALYSIS & MANAGEMENT 231, 234 (2016).

some areas of the country, as individuals who do not secure employment also lose their eligibility for cash assistance.²⁶

As this evidence demonstrates, imposing work requirements would inevitably lead to a large number of individuals, including those who are already working or exempt, losing Medicaid coverage and to an increase in medical debt and financial insecurity.²⁷ This outcome is directly at odds with the objectives of the Medicaid Act.

Lessons Learned from Work Requirements in Other Public Programs

Numerous studies of cash assistance programs have already established that a work requirement does little to increase stable, long-term [employment](#). A 2013 study of TANF in another state found only 9.6% of recipients left the TANF program due to finding employment, while almost four times as many individuals (36%) left as a result of sanctions or a failure to comply with the verification and eligibility procedures.²⁸

The proposed work requirements stand Medicaid's purpose on its head by creating barriers to coverage and the pathway to health that the coverage provides. The end result of this policy will be fewer people with coverage and more people seeking uncompensated care in hospitals and FQHCs. NH hospitals report Emergency Department visits among the uninsured decreased 28% in the first year after Medicaid expansion began.²⁹

Making Medicaid eligibility contingent on work fails to address the barriers to work that exist, such as access to and cost of childcare and transportation. The way in

²⁶ *Id.*

²⁷ *Id.*

²⁸ [TAZRA MITCHELL, LADONNA PAVETTI, AND YIXUAN HUANG](#) *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* CTR. ON BUDGET AND POL'Y PRIORITIES (FEBRUARY 20, 2018)

<https://www.cbpp.org/research/family-income-support/life-after-tanf-in-kansas-for-most-unsteady-work-and-earnings-below>

²⁹ *Economic Impact of the NH Health Protection Program*, N.H. HOSP. ASS'N, (Oct. 2015), https://nhha.org/images/NHHPP_economic_impact_document_october_2015_final.pdf.

which hours will be counted fails to address the fluctuation inherent in low-wage jobs, such as seasonal work, varying hours, insufficient hours, and short notice of shifts.

Administrative Burden and Costs

The administrative burden and expense of administering and verifying the work requirement will likely outweigh any financial gain from additional adults finding work or savings from reduced enrollment. Implementation will likely require more involvement of eligibility workers to process cases, which may slow down determinations and create potential for errors.³⁰ Several states contemplating work requirements have estimated administrative costs to make system changes and add necessary staff. These vary significantly, but are substantial.³¹

The waiver, if approved, will undoubtedly require NH Department of Health and Human Services (NHDHHS) to make significant expenditures to administer. As of April 2018, 53,268 individuals received coverage under Medicaid expansion. The waiver will require all of these enrollees to document in some fashion that they are working the required hours. The state will have to pay for at least 50% of the administrative costs to make these changes, train staff, and absorb the costs of decreased productivity.³²

New Hampshire already has work requirements for the TANF and SNAP (Food Stamp) programs. The work rules and verification requirements for these programs are different than what is proposed for Medicaid in this waiver. NHDHHS has developed a

³⁰ *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Processes*, KAISER FAMILY FOUND. (Feb. 2018), <http://files.kff.org/attachment/Fact-Sheet-Implications-of-Emerging-Waivers-on-Streamlined-Medicaid-Enrollment-and-Renewal-Processes>.

³¹ Jennifer Wagner & Judith Solomon, *States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries*, CTR. ON BUDGET AND POL'Y PRIORITIES, (May 23, 2018), <https://www.cbpp.org/research/health/states-complex-medicaid-waivers-will-create-costly-bureaucracy-and-harm-eligible>.

³² Mattie Quinn, *Implementing States' Medicaid Wishes Won't be Cheap*, GOVERNING THE STATES AND LOCALITIES, Feb. 19, 2018, <http://www.governing.com/topics/health-human-services/gov-medicaid-work-requirements-states-cost-implement.html>.

customer service office and systems for beneficiaries to provide verification. Many beneficiaries have limited contact with local NHDHHS offices. NHLA clients report to us:

- difficulty understanding the NHDHHS notices because the verification requirements are often not clear;
- losing benefits because documents scanned were not timely or properly put into their electronic case file; and
- not understanding what verification is needed even after talking to someone at the customer service office.

2. Elimination of Retroactive Eligibility

The proposed waiver seeks elimination of retroactive eligibility under 42 U.S.C. § 1396a(a)(34), which requires retroactive coverage for the three months prior to the month of application, provided that the individual otherwise meets the eligibility requirements during the months and has incurred medical expenses. In the waiver application the state says eliminating retroactive coverage is intended to “increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, with the ultimate objective of improving beneficiary health.”³³ CMS previously approved the waiver of retroactive eligibility conditionally in New Hampshire. The approval dated May 4, 2015³⁴, required the state to provide data to demonstrate that this policy change actually produced the results it was testing—reduction of churn and gaps in coverage. The state has not provided that data, and yet is requesting a five-year extension of the provision.

Moreover, elimination of retroactive eligibility places providers, such as hospitals and ambulance services, at financial risk. Without the ability to retroactively claim for care provided to Medicaid-eligible individuals, providers will see an increase in

³³ Draft Granite Advantage 1115 Waiver Extension Application 12, May 30, 2018.

³⁴ *Id.*

uncompensated care, making it challenging for them to keep their doors open to serve our most vulnerable citizens. The result of this change would be more people subject to debt collection or declaring bankruptcy due to medical debt.

Finally, in its application, the state actually acknowledges the risks stating, “recognizing that a retroactive coverage waiver could lead to coverage disruptions and increased costs for the State...”³⁵ It is impossible to see what acceptable experimental purpose is being served by this proposal and how the inevitable outcomes will promote the objectives of the Medicaid Act.

3. Instituting an Asset Test

Congress expressly limited the Secretary’s authority to grant waivers like the one New Hampshire proposes to implement an asset test.³⁶ Thus, the Secretary has no authority to grant this portion of New Hampshire’s waiver. In addition, it is difficult to understand what experimental value this proposal could have. After decades of asset tests and research examining them, there is no experiment here. It is now well understood that asset tests are cumbersome to administer and complicated for applicants and recipients.³⁷ After considering the decades-long effect of asset tests, Congress eliminated asset tests for—among others—parents, children, and pregnant women, applying this policy to both state plan and waiver programs, and limited the States’ and the Secretary’s authority to revert to the old policy. Therefore, the proposed waiver to institute an asset test not only violates federal law, but it also has no merit as an experiment.

4. Citizenship/Residency Verification

³⁵ *Id.*

³⁶ 42 U.S.C. §§ 1396a(e)(14)(C) and (F).

³⁷ Vernon K. Smith, Eileen Ellis & Christina Chang, *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, KAISER COMM’N ON MEDICAID AND THE UNINSURED, Apr. 2001, <https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf>.

New Hampshire's changes to citizenship documentation requirements are inconsistent with federal law. Reverting to paperwork rather than electronic sources will have a negative impact on enrollment, as NH experienced after the 2006 citizenship documentation requirements were put in place. In the six months following, the completion rate dropped by half to an average of only 16% of applications.³⁸ Federal law allows electronic sources to verify citizenship pursuant to 42 CFR § 435.949. In addition, single, stand-alone evidence of citizenship, which federal regulation allows for, such as a US passport, should be sufficient for New Hampshire.³⁹

There are many adverse consequences to homelessness, including the inability to store personal effects and documents. Professionals among the homeless service provider community are concerned that the majority of people experiencing homelessness in New Hampshire will be unable to provide two forms of documentation of United States citizenship and proof of New Hampshire residency by either a New Hampshire driver's license or a non-driver's picture identification card. Requiring a photo ID creates additional barriers. A driver's license costs \$50 and a non-driver's photo ID costs \$10, and accessing the Department of Motor Vehicles can be very challenging. Days and hours are limited, and the 14 locations can be difficult to access geographically.⁴⁰

In addition to the waivers requested specifically regarding citizenship documentation and asset tests, there is more general, far-reaching language in the application that is concerning and seems intended to discourage applications:

“Granite Advantage applicants will be required to: 1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration

³⁸ Tricia Brooks, *Why is NH Proposing to Replace Proven Electronic Citizenship Verification with Burdensome Medicaid Paperwork Requirements?*, GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILDREN AND FAMILIES, Jun. 28, 2018, <https://ccf.georgetown.edu/2018/06/28/why-is-nh-proposing-to-replace-proven-electronic-citizenship-verification-with-burdensome-medicaid-paperwork-requirements/>.

³⁹ 42 USC 1396b(x)(3)(A)

⁴⁰ *Div'n of Motor Vehicles Hours and Locations*, N.H. DEP'T OF SAFETY, <https://www.nh.gov/safety/divisions/dmv/locations/index.htm>.

status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A; 2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change.”

Thank you for the opportunity to comment on the proposed Section 1115 Demonstration Waiver. Please contact me at the number below if you have any questions.

Sincerely,

Dawn McKinney

Policy Director

206-2228



6/29/18

Commissioner Jeffrey A. Meyers
NH Department of Health and Human Services
Attn: Granite Advantage Section 1115(a) Demonstration Waiver
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Commissioner Meyers:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on the New Hampshire Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients. In light of that mission, LLS is opposed to certain components of the state's proposed waiver and, on other components, has serious reservations, as addressed in these comments. Additionally, the schedule for comment on and subsequent submission of the waiver, as well as limited or unavailable data pertaining to components of the waiver application itself, is of concern, as we shall address in this letter.

As drafted, this waiver would make several significant changes to the Granite Health program. It would move New Hampshire's Medicaid expansion-eligible population from the current New Hampshire Health Protection Program (NHHPP) into the proposed, new Granite Advantage Health Care Program. It would extend the state's current demonstration waiver that requires enrollees to meet work and community engagement requirements in order to maintain their eligibility for health coverage. It would newly apply asset tests to applicants and enrollees. It would eliminate the current three-month retroactive coverage eligibility for enrollees. The waiver proposes new requirements for applicants to furnish extensive proof of citizenship and residency before being deemed eligible.

LLS believes firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care. Medicaid serves a vital role in making sure that no one is left without access to such coverage. While LLS is generally supportive of the flexibility offered by the Section 1115 waiver process, LLS believes that changes authorized through that process should not cause fewer people to receive or retain coverage or make it harder to obtain necessary health care.¹ It is on those grounds that LLS opposes New Hampshire's recently-proposed waiver, as detailed in the concerns outlined below.

¹ Judith Solomon and Jessica Schubel, "Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care," Center on Budget and Policy Priorities, August 29, 2017, <https://www.cbpp.org/sites/default/files/atoms/files/8-28-17health.pdf>.

MEDICAID: A VITAL SOURCE OF COVERAGE

Medicaid guarantees access to life-saving care for low-income Americans

As the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities, Medicaid covers 1 in 5 Americans.² Many of them have complex and costly health care needs, making Medicaid a critical access point for disease management and care for many of the poorest and sickest people in our nation.³ In New Hampshire alone, according to the most recent Medicaid enrollment data available from the New Hampshire DHHS (May 2018), over 183,000 residents in New Hampshire receive Medicaid benefits, including nearly 53,000 in the NHHPP.⁴

Thanks to Medicaid coverage, enrollees have access to screening and preventive care, which translates into well-child care and earlier detection of health and developmental problems in children, earlier diagnosis of cancer, diabetes, and other chronic conditions in adults, and earlier detection of mental illness in people of all ages.⁵ Medicaid also ensures access to physician care, prescription drugs, emergency care, and other services that – like screening and prevention – are critical to the health and well-being of any American.

Medicaid is a crucial source of coverage for specialty care too, including cancer care. In fact, evidence suggests that public health insurance has had a positive impact on cancer detection: researchers have determined that states that expanded Medicaid experienced a 6.4 percent increase in early detection of cancer from pre-Affordable Care Act (ACA) levels.⁶

WORK REQUIREMENTS

Making coverage contingent on work will disrupt access to care

Medicaid's core mission is to provide comprehensive coverage to low-income people so they can obtain the health care services they need.⁷ In service of that mission, the ACA streamlined Medicaid enrollment and renewal processes across all states.⁸ The intent was to reduce the number of uninsured and keep individuals covered over time by reducing the burden of paperwork. But in contrast, New Hampshire's

² Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 2018, <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

³ Paradise, Julia, "Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid," March 23, 2017, <https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/>.

⁴ New Hampshire Department of Health and Human Services, Office of Quality Assurance and Improvement, "New Hampshire Medicaid Enrollment: Demographic Trends and Geography, May 2018", June 2018 <https://www.dhhs.nh.gov/ombp/medicaid/documents/medicaid-enrollment-05312018.pdf>

⁵ Ibid.

⁶ Soni, A, Simon, K, Cawley, J, Sabik, L. Effect of Medicaid expansions of 2014 on overall and early-state cancer diagnoses [published online December 21, 2017]. *Am J Public Health*, doi: 10.2105/AJPH.2017.304166.

⁷ 42 U.S.C. 1396.

⁸ Kaiser Family Foundation, "Implication of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Processes," February 2018, <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/>.

proposal to extend its work requirement will perpetuate a return to increased bureaucracy and paperwork and, in turn, coverage losses. It's because of those losses that LLS firmly opposes making Medicaid coverage contingent on work requirements.

The State of Kentucky, for example, projects that its recently-approved waiver will yield a 15 percent drop (97,000 beneficiaries) in adult Medicaid enrollment by the waiver's fifth year of implementation and that well over 100,000 people will experience gaps in coverage due to lock-outs for failing to meet work requirements, report changes, or renew coverage in a timely manner.⁹

Indeed, work requirements will result in some enrollees losing coverage not because they failed to maintain employment but because of difficulty navigating compliance processes or satisfying the burden of additional paperwork. When Washington State required increased reporting as part of its Medicaid renewal process, approximately 35,000 fewer children were enrolled in the program, despite the fact that many remained eligible. Families reported that they had simply lost track of the paperwork.¹⁰ It's important to note that many in the Medicaid population face barriers associated with disability, mental illness, insecure work, frequent moves, and homelessness – all factors that pose significant challenges to successfully navigating any system.

This effect has been borne out in other contexts too: data shows that in Temporary Assistance for Needy Families (TANF), for example, many people who were working or should have qualified for exemptions from work requirements lost benefits because they did not complete required paperwork or were unable to document their eligibility for exemptions.¹¹

The fact is loss of coverage is a grave prospect for anyone, in particular a patient living with a serious disease or condition. People in the midst of cancer treatment, for example, rely on regular visits with healthcare providers, and many of those patients must adhere to frequent, if not daily, medication protocols. Thus LLS is seriously concerned that individuals who are unable to satisfy work requirements may end up going without necessary care, perhaps for an extended period of time. LLS is equally concerned about Medicaid enrollees who do not currently live with a cancer diagnosis; if during a lock-out period an individual develops blood cancer, it's likely the disease won't be diagnosed early enough to ensure the best possible health outcomes.

It's important to note that exempting some beneficiaries from having to comply with work requirements will not sufficiently mitigate the access barriers that will result from making coverage contingent on work. Under commercial health insurance, exemption and exceptions procedures have a long track record of limiting or delaying access to care for patients living with serious medical needs. At times this is due to the slow pace of the determination process. At other times, the challenge is simply understanding the exemption process itself or having the time and resources to pursue appeals. It's highly likely that, where

⁹ Solomon, Judith, "Kentucky Waiver Will Harm Medicaid Beneficiaries," Center on Budget and Policy Priorities, January 16, 2018, <https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiaries>.

¹⁰ Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning In It," *The New York Times*, January 18, 2018.

¹¹ Solomon, Judith, "Kentucky Waiver Will Harm Medicaid Beneficiaries," Center on Budget and Policy Priorities, January 16, 2018, <https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiaries>.

it concerns exemptions from work requirements, Medicaid enrollees will find it similarly complicated, time-consuming, and expensive to secure and maintain an exemption.

Implementation will strain already-limited government resources

Implementation of work requirements will obligate the state to devote significant resources to tracking work program participation and compliance or, alternatively, incur the cost of contracting out that function.¹² A draft operational protocol prepared for the implementation of Kentucky's proposed waiver illustrates the costs involved: nearly \$187 million in the first six months alone.¹³ Similarly, Tennessee estimates that the implementation of a Medicaid work requirement would cost the state an estimated \$18.7 million each year.¹⁴

Yet, critically, states are already working under the strain of limited budgets; according to the Center for Budget and Policy Priorities, 32 states operated with a budget shortfall in fiscal year 2017 or 2018 alone. If the state is willing to increase its spending on Medicaid, those additional dollars ought to be prioritized for uses that are directly related to access to care, not the creation of a work requirements bureaucracy.

RETROACTIVE ELIGIBILITY

Eliminating retroactive eligibility will increase the number of Medicaid enrollees forced to live with significant medical debt, despite having been eligible for Medicaid when those debts were incurred. Unfortunately, the state's draft waiver makes no mention of how many enrollees or applicants this provision is expected to impact, which makes it impossible for us to offer complete comment on the anticipated impact. While we do not know the number of enrollees or applicants impacted by this change, the consequences facing those individuals are potentially grave, including delays in diagnosis and/or treatment and increases in financial burden.

Delays in diagnosis and/or treatment

Securing an accurate cancer diagnosis can by itself involve time-sensitive and costly procedures, in addition to the cost and urgency that typically accompanies the onset of treatment. Simply put, whether it's for the purpose of diagnosis or treatment, patients with blood cancer often require immediate access to care. For those patients who begin that journey while simultaneously initiating Medicaid enrollment, their health and well-being will be put at grave risk if forced to delay seeking care until after enrollment has been formally processed.

LLS raises this concern partly in response to the lack of detail in the proposed waiver regarding how exactly the state would ensure that eligibility determinations are made in a timely manner. Again, LLS's

¹² MaryBeth Musumeci and Julia Zur, "Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience," Kaiser Family Foundation, August 2017, <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>.

¹³ *Roll Call*, "Medicaid Changes Require Tens of Millions in Upfront Costs," Feb. 26, 2018, <https://www.rollcall.com/news/politics/medicaid-kentucky>.

¹⁴ Ibid.

concern is that eliminating retroactive eligibility will force eligible individuals to go without coverage – and thus care – for any length of time, as cancer care is often very time-sensitive.

Increased financial burden

If/when eligible cancer patients pursue care prior to formal enrollment in Medicaid, the elimination of retroactive eligibility will require them to absorb a potentially substantial financial burden given the high cost of cancer care. Thus, what might seem like a small change in policy may, in reality, have a serious and long-lasting impact on patients and families left to carry debts that they may be unable to repay in full for several years or perhaps even longer. While financial burden threatens access to care for scores of patients, including those with private coverage, that threat is especially grave for Medicaid enrollees; they are among the most vulnerable Americans, living with low-incomes and often serious disease and disability.

CITIZENSHIP AND RESIDENCY DOCUMENTATION REQUIREMENT

The waiver proposes to require enrollees to present paper forms of identification (two forms of identification and a state driver's license or ID card) for the purpose of proving Medicaid eligibility. This would be in lieu of the state continuing to use the existing Federal Data Hub electronic database, which has been available since 2014 in order to coordinate and streamline eligibility and enrollment processes. The proposal states that potential enrollees who fail to present the appropriate forms of identification will be denied coverage. In short, this proposal puts yet another paperwork requirement on Medicaid enrollees which will jeopardize their access to care.

Securing a driver's license or state-issued ID card can be challenging for the low-income population, in part because obtaining the underlying documents, like a birth certificate, can be expensive. The waiver lacks details on what forms of ID, other than a driver's license or state-issued ID card will be valid for proving citizenship and residency.

The application makes no attempt at justification of this change beyond "improving the accuracy of the current Medicaid eligibility determination system." However, the state offers no evidence in the waiver application that the current matching system is inaccurate. Further, concern about accuracy of eligibility determinations should also take into account the increased likelihood of eligible applicants being denied coverage because of their inability to furnish identification, who might otherwise have been matched accurately, and more quickly, within the current electronic system.

Additionally, the state does not include an evaluation hypothesis to test this proposal as part of its waiver evaluation. The state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to coverage for individuals eligible for Medicaid as part of its application.

ASSET TEST

The waiver requests the authority to consider an individual's assets when determining Medicaid. Current Medicaid rules do not allow for asset tests when determining eligibility for the program – as the State is



no doubt aware, given that the application itself points out on page 14, “the State understands that this provision currently is not waivable under federal law.” Low income households’ assets typically include a home – which may be inherited – or a car. Owning a home can add to economic security and owning a car provides transportation to work and to medical appointments, and neither may be indicative of enrollees’ financial status or eligibility for Medicaid. Holding these resources against a person when they apply for Medicaid will not help people achieve upward economic mobility, health or promote the goals of the Medicaid program.

Similar to the citizenship and residency documentation requirements, there is no evaluation hypothesis to test this proposal in the waiver evaluation. Again, the state needs to include a hypothesis and outline how it plans to measure the proposal’s impact on access to care in the Medicaid program as part of its application.

PROPOSED TIMELINE

The proposed timeline set forth for this waiver process causes some concern. Public comment is due on June 29, 2018 and according to the timeline the proposal will be submitted to CMS for review on June 30, 2018. This timeline suggests that New Hampshire does not intend to incorporate public feedback into the waiver proposal. LLS encourages New Hampshire to push back the date the waiver will be submitted to CMS in order to review all the comments that are received by the deadline (June 29, 2018 at 5pm Eastern Time) and revise the waiver in response to the comments.

Ultimately, the requirements outlined in the New Hampshire Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver do not further the goals of the Medicaid program. Instead, they needlessly compromise access to care for a very vulnerable population. LLS urges you to focus instead on solutions that can promote adequate, affordable, and accessible Medicaid coverage for all New Hampshire residents.

Thank you for your consideration of LLS’s comments on this important matter. If we can address any questions or provide further information, please don’t hesitate to contact me at steve.butterfield@lls.org or 207-213-7254.

Regards,

Steve Butterfield
Regional Director, Government Affairs
The Leukemia & Lymphoma Society

June 29, 2018

Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

Hemophilia Federation of America (HFA) is the leading patient-led advocacy group representing those with hemophilia and other bleeding disorders. The New England Hemophilia Association (NEHA) is an organization dedicated to improving the quality of life for persons with bleeding disorders and their families through education, support and advocacy. HFA and NEHA appreciate the opportunity to submit comments on New Hampshire's Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

HFA and NEHA believe everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver as proposed will jeopardize patients' access to quality and affordable health coverage, and we therefore urge New Hampshire to withdraw this proposal.

Waiving Retroactive Eligibility

The 1115 waiver proposes to have coverage become effective on the day the Medicaid enrollee applies for coverage. This would be a departure from the current three-month retroactive eligibility period in Medicaid.

Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. Individuals are often unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been newly diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and oftentimes confusing. Medicaid enrollees may misunderstand (or simply not receive) their notices of Medicaid renewal. Those enrollees might only discover the coverage lapse when picking up their prescriptions or going to see their doctors. Without retroactive eligibility, individuals in this situation could then face substantial costs at their doctors' offices or pharmacies. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.ⁱ

Continuation of Burdensome Administrative Requirements

HFA and NEHA are concerned about New Hampshire's proposal to continue requiring enrollees to work 100 hours per month or lose their health coverage. Continuing this policy will increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked. Increasing administrative requirements will likely reduce the number of individuals with Medicaid coverage, even among beneficiaries who are exempt from the work requirements, or who are working the required number of hours. A recent Kaiser Family Foundation study estimates that Medicaid work requirements can be expected to result in disenrollment rates ranging from 6-17%, with most people losing coverage due to lack of reporting rather than not complying with the work requirement.ⁱⁱ

Failing to navigate these burdensome administrative requirements could have drastic – even life or death – consequences for people with serious, acute and chronic diseases including bleeding disorders. People with hemophilia and similar disorders need uninterrupted access to their medication and care in order to manage their conditions, and cannot afford to experience sudden gaps in their treatment.

Citizenship and Residency Documentation Requirement

The waiver proposes to require enrollees to present paper forms of identification (two forms of identification or a state driver's license or ID card) rather than the electronic database that is currently being used when applying for coverage. The proposal states that potential enrollees without the appropriate forms of identification will be denied coverage.ⁱⁱⁱ This proposal puts yet another paperwork requirement on Medicaid enrollees that could jeopardize their access to care. The waiver lacks details on what forms of ID, other than a driver's license or state ID card will be valid for proving citizenship and residency.

Even getting a driver's license or state ID card can be challenging for the low-income population. Obtaining the underlying documents, like a birth certificate, can be expensive. Conditioning healthcare on the ability to obtain paperwork does not promote the goals of the Medicaid program.

Additionally, the state does not include an evaluation hypothesis to test this proposal as part of its waiver evaluation. The state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to coverage for individuals eligible for Medicaid as part of its application.

Asset Test

The waiver requests the authority to consider an individual's assets when determining Medicaid eligibility. Current Medicaid rules do not allow for asset tests when determining eligibility for the program. Low income households' assets typically include a home – which may be inherited – or a car.^{iv} Owning a home can add to economic security and owning a car provides transportation to work and to medical appointments, and neither may be indicative of enrollees' financial status or eligibility for Medicaid. Holding these resources against a person when they apply for Medicaid will not help people achieve upward economic mobility, health or promote the goals of the Medicaid program.

Similar to the citizenship and residency documentation requirements, there is no evaluation hypothesis to test this proposal in the waiver evaluation. Again, the state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to care in the Medicaid program as part of its application.

Lack of Information on Impact of Waiver

HFA and NEHA note that New Hampshire's proposal does not predict the impact of the waiver on enrollment (with or without waiver baseline) or cost savings over 5 years. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. In order to meet these transparency requirements, New Hampshire must include these projections and their impact on budget neutrality. If New Hampshire intends to move ahead with this proposal, the state should at a minimum provide the required information to the public and reopen the comment period for an additional 30 days.

Proposed Timeline

Our organizations would also like to comment on the proposed timeline New Hampshire has set forth. Public comment is due on June 29, 2018, and according to the timeline the proposal will be submitted to CMS for review on June 30, 2018. This timeline suggests that New Hampshire does not intend to incorporate public feedback into the waiver proposal. HFA and NEHA encourage New Hampshire to push back the date the waiver will be submitted to CMS in order to review all the comments that are received by the deadline (June 29, 2018 at 5:00 p.m.) and revise the waiver in response to the comments.

HFA and NEHA believe that health care should be affordable, accessible, and adequate. New Hampshire's Section 1115 Demonstration Proposal does not meet that standard, and our organizations urge the state to withdraw this proposal. Thank you for the opportunity to provide comments.

If you have any questions, please do not hesitate to call Miriam Goldstein at 202.675.6984 or email m.goldstein@hemophiliafed.org.

Sincerely,



Miriam Goldstein
Associate Director, Policy
Hemophilia Federation of America



Richard Pezzillo
Executive Director
New England Hemophilia Association

ⁱ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

ⁱⁱ Rachel Garfield, Robin Rudowitz, and MaryBeth Musumeci, "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses," June 2018. (<http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses>)

ⁱⁱⁱ Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver: <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

^{iv} Balance Sheets of Low-Income Households: What We Know about Their Assets and Liabilities: <https://aspe.hhs.gov/execsum/balance-sheets-low-income-households-what-we-know-about-their-assets-and-liabilities>

June 29, 2018

Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

The American Lung Association in New Hampshire appreciates the opportunity to submit comments on New Hampshire's Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including 184,000 New Hampshire residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association in New Hampshire believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver as proposed will jeopardize patients' access to quality and affordable health coverage, and the Lung Association in New Hampshire therefore urges the state to withdraw this proposal.

Waiving Retroactive Eligibility

The 1115 waiver proposes to have coverage become effective on the day the Medicaid enrollee applied for coverage. This would be a departure from the current three-month retroactive eligibility period in Medicaid.

Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.¹

Continuation of Burdensome Administrative Requirements

The American Lung Association in New Hampshire is concerned about the continuation of New Hampshire's requirement for enrollees to work 100 hours per month or lose their health coverage. Continuing this policy will increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.²

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases including asthma and COPD. People who are in the middle of treatment for a life-threatening disease, like lung cancer, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Citizenship and Residency Documentation Requirement

The waiver proposes to require enrollees to present paper forms of identification (two forms of identification or a state driver's license or ID card) rather than the electronic database that is currently being used when applying for coverage. The proposal states potential enrollees without the appropriate forms of identification will be denied coverage.³ This proposal puts yet another paperwork requirement on Medicaid enrollees that could jeopardize their access to care. The waiver lacks details on what forms of ID, other than a driver's license or State ID card will be valid for proving citizenship and residency.

Even getting a Driver's License or State ID card can be challenging for the low-income population. Obtaining the underlying documents, like a birth certificate, can be expensive. Conditioning healthcare on the ability to obtain paperwork does not promote the goals of the Medicaid program.

Additionally, the state does not include an evaluation hypothesis to test this proposal as part of its waiver evaluation. The state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to coverage for individuals eligible for Medicaid as part of its application.

Asset Test

The waiver requests the authority to consider an individual's assets when determining Medicaid eligibility. Current Medicaid rules do not allow for asset tests when determining eligibility for the program. Low income households' assets typically include a home – which may be inherited – or a car.⁴ Owning a home can add to economic security and owning a car provides transportation to work and to medical appointments, and neither may be indicative of enrollees' financial status or eligibility for Medicaid. Holding these resources against a person when they apply for Medicaid will not help people achieve upward economic mobility, health or promote the goals of the Medicaid program.

Similar to the citizenship and residency documentation requirements, there is no evaluation hypothesis to test this proposal in the waiver evaluation. Again, the state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to care in the Medicaid program as part of its application.

Lack of Information on Impact of Waiver

The Lung Association in New Hampshire wishes to highlight that the proposal does not predict the impact of the waiver on enrollment (with or without waiver baseline) or cost savings over 5 years. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. In order to meet these transparency requirements, New Hampshire must include these projections and their impact on budget neutrality. If New Hampshire intends to move ahead with this proposal, the state should at a minimum provide the required information to the public and reopen the comment period for an additional 30 days.

Proposed Timeline

The Lung Association in New Hampshire would also like to comment on the proposed timeline New Hampshire has set forth. Public comment is due on June 29, 2018 and according to the timeline the proposal will be submitted to CMS for review on June 30, 2018. This timeline suggests that the New Hampshire does not intend to incorporate public feedback into the waiver proposal. The Lung Association in New Hampshire encourages the state to push back the date the waiver will be submitted to CMS in order to review all the comments that are received by the deadline (June 29, 2018 at 5pm eastern) and revise the waiver in response to the comments.

The American Lung Association in New Hampshire believes healthcare should be affordable, accessible, and adequate. New Hampshire's Section 1115 Demonstration Proposal does not meet that standard, and the Lung Association in New Hampshire urges the state to withdraw this proposal. Thank you for the opportunity to provide comments.

Sincerely,



Lance Boucher
East Division Senior Director, State Advocacy
American Lung Association

¹ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

² Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009Th.

³ Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver: <https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

⁴ Balance Sheets of Low-Income Households: What We Know about Their Assets and Liabilities: <https://aspe.hhs.gov/execsum/balance-sheets-low-income-households-what-we-know-about-their-assets-and-liabilities>



**The American College of
Obstetricians and Gynecologists**
WOMEN'S HEALTH CARE PHYSICIANS

*New Hampshire
Section*

June 29, 2018

Henry Lipman
Director
Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

**RE: New Hampshire ACOG Comments on Changes Requested to New Hampshire
Medicaid's Section 1115 Waiver**

Dear Director Lipman,

The New Hampshire Section of the American College of Obstetricians and Gynecologists (ACOG), representing more than 165 practicing obstetrician-gynecologists (ob-gyns), welcomes the opportunity to comment on the proposed changes to the New Hampshire Department of Health and Human Services' (NHDHHS) Section 1115 Waiver: Granite Advantage. As physicians dedicated to providing quality care to women, we are concerned that the proposed waiver amendments would place certain Medicaid beneficiaries at risk for financial harm and deter our patients from seeking necessary care. We urge the state to reconsider these amendments before submitting a final proposal to the Centers for Medicare and Medicaid Services (CMS).

Change from a Premium Assistance Program to a Managed Care Delivery System

ACOG supports New Hampshire's efforts to better align the State's health care system by moving all Medicaid beneficiaries to managed care. Managed care has become the dominant mode of service delivery for Medicaid beneficiaries over the last two decades. In 2011, more than 75 percent of women covered by Medicaid received care through a managed care arrangement.¹ State governments have a considerable amount of flexibility to establish their own managed care regulations and negotiate contracts with state-based Managed Care Organizations (MCOs). This can result in a wide range of state-based policies on the provision of family planning services and supports. As the State moves its new adult group to the managed care delivery system, we ask that it review all managed care contracts to ensure that women have access to enough ob-gyns in network, and that each MCO provides coverage for all Food and

Drug Administration (FDA)-approved methods of contraception. We also encourage the state to work with the plans to collect quality measures focused on family planning care.

We have additional concerns around continuity of coverage and care for pregnant and postpartum women during the State's transition from a premium assistance program to a managed care delivery system. In its amendments and extension application, the State indicates that it will use auto-assignment methodologies to transfer all expansion adults into managed care. Affected individuals will be given 90 days to select a different plan following the auto-assignment, if they so choose. All contracted MCOs will be required to "honor all pre-existing authorizations for care plans and treatments for all program participants for a period of no less than 90 days after enrollment in the MCO." While we appreciate that these grace periods are in place, we have concerns that these policies are not robust enough to guarantee that pregnant and postpartum women and individuals with substance use disorder (SUD) or other mental health conditions can continue to access their preferred providers or methods of treatment. We ask that the State include special dispensation for these vulnerable populations so that they may have a continuous treatment plan with their preferred providers during and after the State's managed care transition.

Waive Retroactive Coverage Requirement

Under current law, once an individual is determined eligible for Medicaid, coverage is effective on the first day of the month of application. Medicaid must also cover state plan-approved services obtained in the three months prior to application if the individual would have been eligible during that period.² With this waiver amendment request, NHDHHS seeks to end this long-standing protection for Medicaid beneficiaries. The State argues that this proposal is in line with current practices in the private insurance market, and that it will encourage individuals to receive primary and preventive care by seeking coverage when they are healthy, instead of waiting for medical expenses to incur before seeking coverage.

ACOG believes this proposal ignores the reality that many low-income individuals do not seek health care until the need is great – not because they are irresponsible, but because they cannot afford the cost of primary or preventive care without being enrolled in Medicaid. Many low-income individuals may not know that they are eligible for Medicaid, and may not seek care for a condition they can manage without medical attention until the condition becomes unmanageable. Ending retroactive eligibility may further encourage such self-imposed rationing of care because these Medicaid-eligible beneficiaries will have less opportunity to receive coverage for any health care costs they may incur while trying to nominally address their health needs, forcing them to take even more drastic measures to avoid incurring medical bills they cannot pay. We urge the State to remove this amendment from their waiver request and to continue to apply three months of retroactive coverage.

Extend Approved Work and Community Engagement Requirements Waivers and Authorities

Nationally, nearly eight in ten non-disabled adults with Medicaid coverage live in working families, and 60 percent are working themselves.³ Of those not working, more than one-third reported that illness or a disability was the primary reason, 30 percent reported that they were

taking care of home or family, and 15 percent were in school.⁴ In addition, according to an April 2017 post in *Health Affairs*, if work requirements were implemented nationwide, almost two-thirds (63 percent) of those at risk of losing coverage are women.⁵ As women's health care physicians, we must advocate against any policy that would jeopardize our patients' ability to access care.

On May 7, 2018, CMS approved NHDHHS's request to enforce a work and community engagement requirement on its Medicaid beneficiaries. The new program would require beneficiaries in the State's new adult group ages 19 through 64 to participate in 100 hours per month of community engagement activities, such as employment, education, job skills training, or community service. While we are thankful that the State and CMS exempted pregnant and postpartum women from such requirements, we continue to strongly oppose any efforts to make work a condition of Medicaid eligibility. The complexity of the requirements and how they interplay with the exceptions will likely increase the State's administrative burdens and costs without increasing employment rates. The experiences of TANF and federal housing assistance demonstrate that imposing such requirements on Medicaid beneficiaries would result in few, if any, long-term gains in employment rates.⁶

In addition to being ineffective in increasing employment over time, these types of requirements would add considerable complexity and costs to New Hampshire's Medicaid program. State experience in implementing similar TANF requirements suggests that adding such requirements to Medicaid could cost New Hampshire thousands of dollars per beneficiary.⁷ TANF caseworkers must spend significant time tracking and verifying clients' work activities and hours, and there is little indication that this 1115 waiver application would result in any less burden for the State's Medicaid staff.⁸ These additional costs would detract significantly from any anticipated savings and would divert much-needed funds from beneficiary care to cover unnecessary administrative costs.

Not only would there be a considerable administrative burden placed on the State's Medicaid staff and our Medicaid patients, but this requirement would also potentially impose administrative burdens on ob-gyns and other health care providers. We are troubled by the likelihood that physicians will have to provide documentation that proves our patients meet the exception that they are medically frail in order to maintain their coverage. Increasing our paperwork burden detracts from our ability to provide patient care and is antithetical to CMS' "Patients Over Paperwork" initiative. At a time when there are increasing reports of physician burnout and an anticipated growing physician shortage, placing more administrative burdens on New Hampshire's ob-gyns and other health care providers may make it more difficult to attract and retain health care workforce in the State.⁹

We believe that policymakers should be working to reduce barriers for ob-gyns to care for New Hampshire's Medicaid patients, not placing more in our way. It is premature to request an extension before we know the impact of this policy on beneficiaries' ability to access care and maintain or improve their health, as well as the cost to the State and its impact on the financial stability of the Medicaid program in New Hampshire. Therefore, we urge the state not to submit an extension request for the work and community engagement requirement.

Require Documentation of Citizenship to Determine Eligibility

ACOG believes in the many benefits of universal health care access for all U.S. residents, regardless of immigration status.¹⁰ Ob-gyns know from experience that many immigrant patients struggle to deal with the complexity of ever-changing laws and policies regarding eligibility for and access to health care. Fear of accessing care in the face of these complicated policies may inhibit many *legal* immigrants from seeking care. Indeed, the number of legal immigrants who access public health services and enroll in federally-subsidized insurance plans has dipped significantly since January 2017.¹¹ Fears that their information could be used to identify and deport relatives living in the United States illegally is the primary reason for not seeking care.¹² New Hampshire's proposed requirement to verify citizenship with two forms of paper identification as well as proof of state residency may instill fear in the immigrant community and deter Medicaid-eligible patients from applying for coverage. This in turn could lead to fewer immigrant women seeking prenatal care, as well as increases in uncompensated care under the Emergency Medical Treatment and Active Labor Act (EMTALA).

We further oppose this provision because departing from the federal standard for citizenship and alien status verification will create unnecessary complexity and confusion for women who are applying for Medicaid expansion benefits. The unnecessary variation between other Medicaid eligibility categories and the expansion category will confuse beneficiaries who may be used to the federally-required timeframes for submitting documentation, such as for pregnancy services. To mitigate the risk that fewer immigrant women will seek care for pregnancy, family planning, and other related services due to fear of legal repercussions for themselves or their families, we urge the State to remove this request from their waiver amendments and extension application.

Apply an Asset Test to the Expansion Population

Under current federal law, adults eligible for Medicaid through the Affordable Care Act's Medicaid expansion must have their eligibility determined using Modified Adjusted Gross Income (MAGI).¹³ The MAGI income methodology explicitly prohibits the use of resource or asset tests to determine income eligibility. Again, deviating from the federal standard for calculating income and household composition will create confusion for beneficiaries who have previous experience applying for other Medicaid benefits, including women who received Medicaid while pregnant. We strongly encourage NHDHHS to instead utilize MAGI for the Medicaid expansion population. We encourage the State to remove this request from their waiver amendments and extension application.

New Hampshire ACOG Recommendations:

- Work with MCOs to guarantee access to all FDA-approved methods of contraception and to collect data on quality measures related to family planning.
- Include special dispensation for pregnant and postpartum women and other vulnerable populations to receive uninterrupted access to the provider of their choice during and after the State's transition to managed care.
- Do not request to waive retroactive coverage.
- Do not request to extend the work and community engagement requirement.
- Do not request to strengthen documentation of citizenship requirements.

- Do not request to apply an asset test to the expansion population.

Thank you for the opportunity to provide comments on New Hampshire's proposed amendments to and extension of its Section 1115 Waiver: Granite Advantage. As explained above, New Hampshire ACOG believes each of the proposed amendments to be detrimental to health care access for New Hampshire Medicaid beneficiaries, in general, and New Hampshire women, in particular. As such, we do not support the State submitting these amendments for approval by CMS. We are happy to work with your office to develop solutions that both improve health outcomes and reduce the costs in the New Hampshire Medicaid program. To discuss these recommendations further, please contact Ellen Joyce, MD, FACOG, New Hampshire Section Chair, at ejoyce1961@gmail.com, or Emily Eckert, ACOG Health Policy Analyst, at eeckert@acog.org or 202-863-2485.

Sincerely,



Ellen M. Joyce, MD, FACOG
Chair, New Hampshire Section

¹ Kaiser Family Foundation. Medicaid managed care and the provision of family planning services. April 2017. Available at: <http://files.kff.org/attachment/Report-Medicaid-Managed-Care-and-the-Provision-of-Family-Planning-Services>

² 42 C.F.R. 435.915.

³ Kaiser Family Foundation. Understanding the intersection of Medicaid and work. Revised January 2018. Available at: <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>

⁴ Ibid.

⁵ Ku, Leighton and Brantley, Erin. Medicaid work requirements: who's at risk? Health Affairs Blog, Apr. 12, 2017. Retrieved May 4, 2018. Available at <http://healthaffairs.org/blog/2017/04/12/medicaid-work-requirements-whos-at-risk/>

⁶ Urban Institute. Work requirements in social safety net programs: a status report of work requirements in TANF, SNAP, Housing Assistance, and Medicaid. December 2017. Available at: <https://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf>

⁷ Gayle Hamilton *et al.*, "National evaluation of welfare-to-work strategies: how effective are different welfare-to-work approaches? Five-year adult and child impacts for eleven programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

⁸ Urban Institute. Work requirements in social safety net programs: a status report of work requirements in TANF, SNAP, Housing Assistance, and Medicaid. December 2017. Available at: <https://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf>

⁹ Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., and West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, 90:1600-1613.

¹⁰ Health care for unauthorized immigrants. Committee Opinion No. 627. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;125:755-9.

¹¹ Hoffman, Jan. "Sick and afraid, some immigrants forgo medical care." *New York Times*. June 26, 2017. Accessed June 29, 2018. Available at: <https://www.nytimes.com/2017/06/26/health/undocumented-immigrants-health-care.html>

¹² Ibid.

¹³ Section 1902(e)(14)



June 29, 2018

Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

The Epilepsy Foundation and Epilepsy Foundation New England appreciate the opportunity to submit comments on New Hampshire's Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime. For the majority of people living with epilepsy, epilepsy medications are the most common and most cost-effective treatment for controlling and/or reducing their seizures, and they must have meaningful and timely access to physician-directed care. Epilepsy medications are not interchangeable and treatment of epilepsy is highly individualized. Maintaining seizure control with minimal side effects requires careful evaluation and monitoring by physicians and their patients.

The Epilepsy Foundation and Epilepsy Foundation New England believe everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver as proposed will jeopardize patients' access to quality and affordable health coverage, and Epilepsy Foundation and Epilepsy Foundation New England therefore urge New Hampshire to withdraw this proposal.

Waiving Retroactive Eligibility

The 1115 waiver proposes to have coverage become effective on the day the Medicaid enrollee applied for coverage. This would be a departure from the current three-month retroactive eligibility period in Medicaid.

Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who



have been diagnosed with a serious illness, such as cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.ⁱ

Continuation of Burdensome Administrative Requirements

The Epilepsy Foundation and Epilepsy Foundation New England are concerned about the continuation of New Hampshire's requirement for enrollees to work 100 hours per month or lose their health coverage. Continuing this policy will increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.ⁱⁱ

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases including epilepsy. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Citizenship and Residency Documentation Requirement

The waiver proposes to require enrollees to present paper forms of identification (two forms of identification or a state driver's license or ID card) rather than the electronic database that is currently being used when applying for coverage. The proposal states potential enrollees without the appropriate forms of identification will be denied coverage.ⁱⁱⁱ This proposal puts yet another paperwork requirement on Medicaid enrollees that could jeopardize their access to care. The waiver lacks details on what forms of ID, other than a driver's license or State ID card will be valid for proving citizenship and residency.

Even getting a Driver's License or State ID card can be challenging for the low-income population. Obtaining the underlying documents, like a birth certificate, can be expensive. Conditioning healthcare on the ability to obtain paperwork does not promote the goals of the Medicaid program.



Additionally, the state does not include an evaluation hypothesis to test this proposal as part of its waiver evaluation. The state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to coverage for individuals eligible for Medicaid as part of its application.

Asset Test

The waiver requests the authority to consider an individual's assets when determining Medicaid eligibility. Current Medicaid rules do not allow for asset tests when determining eligibility for the program. Low income households' assets typically include a home – which may be inherited – or a car.^{iv} Owning a home can add to economic security and owning a car provides transportation to work and to medical appointments, and neither may be indicative of enrollees' financial status or eligibility for Medicaid. Holding these resources against a person when they apply for Medicaid will not help people achieve upward economic mobility, health or promote the goals of the Medicaid program.

Similar to the citizenship and residency documentation requirements, there is no evaluation hypothesis to test this proposal in the waiver evaluation. Again, the state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to care in the Medicaid program as part of its application.

Lack of Information on Impact of Waiver

The Epilepsy Foundation and Epilepsy Foundation New England wish to highlight that the proposal does not predict the impact of the waiver on enrollment (with or without waiver baseline) or cost savings over 5 years. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. In order to meet these transparency requirements, New Hampshire must include these projections and their impact on budget neutrality. If New Hampshire intends to move ahead with this proposal, the state should at a minimum provide the required information to the public and reopen the comment period for an additional 30 days.

Proposed Timeline

The Epilepsy Foundation and Epilepsy Foundation New England would also like to comment on the proposed timeline New Hampshire has set forth. Public comment is due on June 29, 2018 and according to the timeline the proposal will be submitted to CMS for review on June 30, 2018. This timeline suggests that the New Hampshire does not intend to incorporate public feedback into the waiver proposal. We encourage New Hampshire to push back the date the waiver will be submitted to CMS in order to review all the comments that are received by the deadline (June 29, 2018 at 5pm eastern) and revise the waiver in response to the comments.



The Epilepsy Foundation and Epilepsy Foundation New England believe healthcare should be affordable, accessible, and adequate. New Hampshire's Section 1115 Demonstration Proposal does not meet that standard, and we urge the state to withdraw this proposal. Thank you for the opportunity to provide comments.

Sincerely,

A black rectangular redaction box covering the signature of Susan Linn.

Susan Linn
President & CEO
Epilepsy Foundation New England

A black rectangular redaction box covering the signature of Phillip M. Gattone.

Phillip M. Gattone, M.Ed.
President & CEO
Epilepsy Foundation

ⁱ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

ⁱⁱ Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009Th.

ⁱⁱⁱ Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver:

<https://www.dhhs.nh.gov/ombp/medicaid/granite.htm>

^{iv} Balance Sheets of Low-Income Households: What We Know about Their Assets and Liabilities:

<https://aspe.hhs.gov/execsum/balance-sheets-low-income-households-what-we-know-about-their-assets-and-liabilities>



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June 29, 2018

NH Department of Health and Human Services
Attn: Granite Advantage Section 1115(a) Demonstration Waiver
129 Pleasant Street
Concord, NH 03301

Re: 1115 Waiver Amendment Granite Advantage Health Care Program

Dear Commissioner Meyers:

AARP welcomes the opportunity to submit comments on New Hampshire's proposed Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver. AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP New Hampshire is writing to comment on and express our concerns with certain amendments to New Hampshire's Granite Advantage Health Care Program (Granite Advantage) Section 1115(a) extension application. In particular, we are concerned with the following amendments that: authorize New Hampshire to require community engagement as a condition of eligibility for certain Premium Assistance Program beneficiaries; extend the current waiver of the requirement to provide three months' retroactive coverage to expansion adults and; give the state the authority to consider applicant or beneficiary assets in determining eligibility for the Granite Advantage program. AARP New Hampshire is concerned that these amendments have the potential to worsen health outcomes, create significant financial hardship for many Medicaid members in need of coverage, increase administrative costs to the state, and result in increased uncompensated care costs for New Hampshire health providers.

Community Engagement Requirements

This amendment authorizes the state to require community engagement as a condition of eligibility for certain Premium Assistance Program beneficiaries. Non-exempt beneficiaries in

AARP
Real Possibilities

the “new adult group” ages 19 through 64, with certain exemptions, are required to participate in 100 hours per month of community engagement activities such as employment, education, job skills training or community service.

AARP New Hampshire believes that the proposed waiver provision seeking to impose a community engagement requirement is not authorized by Section 1115 of the Social Security Act because it is not “likely to assist in promoting the objectives” of the Medicaid Act. 42 U.S.C. § 1315(a). Specifically, this provision is not likely to assist in promoting the objective of enabling the state of New Hampshire “to furnish medical assistance [to individuals and families] whose income and resources are insufficient to meet the costs of necessary medical services and rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1(1).

It would also present an unnecessary barrier to health coverage for a sector of New Hampshire’s population that is most in need of coverage. This includes the many individuals who have recurring periods of illness due to chronic and behavioral health conditions who may not be determined to be exempt from the work or job search/training requirements. Moreover, AARP New Hampshire is concerned that if exempt individuals are subject to the burden of needing to continually prove they are meeting the exemption requirements, it may lead to inappropriate denials of coverage.¹

In addition, because it is unclear how individuals will document that they have met the community engagement requirements, we are asking for clarification on the process by which individuals are expected to comply. However, regardless of the process, it is important to note that the implementation of community engagement requirements will impose new administrative costs on the state, including new staffing needs, the development or expansion of a reporting system, a means of verifying the accuracy of member reporting and the conducting of fact finding hearings.

While AARP welcomes the inclusion in the list of qualifying exemptions from the community engagement requirement those beneficiaries who are parents or caretakers where care of a dependent is considered necessary by a licensed provider, we would appreciate clarification as to whether this exemption includes caretakers of *non-dependents*, and would urge this to be the case. It would also be important to delineate the process and timeline of how the provider determination would be made.

Section 44 of CMS’ Special Terms and Conditions provides for a community engagement exemption for “Beneficiaries *residing* (emphasis added) with an immediate family member who has a disability as defined by the ADA, Section 504, or Section 1557, who are unable to meet the requirement for reasons related to the disability of that family member.” We believe that the community engagement exemption should also be applied in instances where the

beneficiary/caretaker and the family member with a disability live in separate residences and we ask that this be made explicit in your application.

We also draw your attention to section 45 of CMS' Special Terms and Conditions that spells out the qualifying activities for meeting the community engagement requirement. One of those qualifying activities is "Caregiving services for a non-dependent relative or other person with a disabling health, mental health, or developmental condition." There appears to be some contradiction between having caretaker exemptions and the ability to use caregiving as a qualifying activity. We believe it would be important to address and clarify this issue.

Furthermore, with respect to the community engagement non-compliance provision found in Section 47 of CMS' Special Terms and Conditions, whereby beneficiaries have an opportunity to demonstrate that they have good cause to excuse failure to meet the community engagement requirement, we ask that this provision be made further applicable to caretakers. In particular, we urge you to consider including caregiving under Section (a) viii, which allows the state the authority to approve additional good cause reasons not previously identified.

Retroactive Coverage

In its waiver extension application, the state seeks to amend and extend its current, limited waiver of the requirement to provide three months' retroactive coverage to expansion adults. Under current Medicaid law, eligibility may be made retroactive for up to three months prior to the month of application if the individual would have been eligible during the retroactive period had he or she applied then. CMS previously granted New Hampshire permission to conditionally waive retroactive coverage and the state is now seeking to remove this conditionality. According to the application, "Expansion adults will become eligible for coverage under Title XIX at the time of application; eligibility will be effective no earlier than the day all eligibility requirements are met."

AARP New Hampshire believes this proposal would adversely impact a large number of New Hampshire's Medicaid recipients, including individuals who rely on Medicaid for long-term services and supports. If implemented, waiving retroactive coverage would likely worsen health outcomes, create significant financial hardship for many Medicaid members in need of coverage and result in increased uncompensated care costs for New Hampshire's health providers.

AARP New Hampshire believes that without retroactive coverage, future low-income enrollees could incur crippling medical debt which would be exacerbated by their inability to take advantage of the more favorable provider reimbursement rates paid by Medicaid. In addition, limitations on retroactive coverage would increase the burden of uncompensated care on providers, and could cause future enrollees to forego needed care, resulting in higher medical costs than would otherwise have been the case once they are covered. For example, providers

June 29, 2018

may be reluctant to provide care if there is not retroactive eligibility. In this case, an individual's conditions may deteriorate, forcing them to rely on more expensive emergency room care, increasing uncompensated care costs.

Expansion Population Asset Test

Under current federal law, individuals eligible for Medicaid as expansion adults described in §1902(a)(10)(A)(i)(VIII) have their income determined using Modified Adjusted Gross Income (MAGI) income methodologies, which explicitly prohibit resource or asset tests. While the state recognizes that the application of an asset test cannot be waived under federal law, the state nonetheless is seeking authority to waive §1902(e)(14) in order to permit the state to consider assets when determining Medicaid eligibility. If approved, individuals with countable assets in excess of \$25,000 would not be eligible for the Medicaid program.

AARP New Hampshire believes that the imposition of an asset test will present a new, inappropriate and ineffective administrative barrier for potential applicants who often have minimal assets and we urge the state to withdraw its request to impose one. Studies show that asset tests "despite being cumbersome for agency staff to administer and onerous for applicants to document...actually kept few families from meeting Medicaid eligibility requirements and may have prevented some from completing the application process."² Conversely, state officials in states that had eliminated asset tests reported a number of benefits including the ability to streamline the eligibility determination process, improve the productivity of eligibility workers, and achieve Medicaid administrative cost savings.³

We thank you for the opportunity to express our thoughts on and concerns with this proposal, and we look forward to working with you to make improvements to this waiver request. If you have any questions, please contact Doug McNutt Associate State Director – Advocacy at dmcnutt@aarp.org or 603-230-4106.

Sincerely,




Todd Fahey, State Director
AARP New Hampshire

¹ https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/?utm_campaign=KFF-2017-Dec-Medicaid-work&utm_content=65347856&utm_medium=social&utm_source=twitter&stream=top-stories

² Vernon K. Smith, Eileen Ellis, and Christina Chang, Eliminating the Medicaid Asset Test for Families: A Review of State Experiences (Washington: Kaiser Commission on Medicaid and the Uninsured, April 2001), available online at <https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf>

³ Ibid.



Jeffrey Meyers
Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord NH 03301

June 29, 2018

RE: Granite Advantage 1115(a) Demonstration Waiver Extension Application

Dear Commissioner Meyers,

Thank you for the opportunity to provide public comment regarding the *Granite Advantage 1115(a) Demonstration Waiver Extension Application*.

Granite State Progress & Education Fund is a multi-issue advocacy organization working on issues of immediate state and local concern. For the last decade, our organization has engaged in activities to increase access to quality, affordable health care in New Hampshire, and to ensure consumers know about the programs and protections available to them.

Our organization has grave concerns about the impact to health care consumers on several aspects of the proposed waiver, in particular the work requirement and structure, asset tests, citizenship tests, and retroactive eligibility. Our comments on each section are as follows:

Medicaid expansion work requirements are impermissible under federal law.

Under 42 U.S.C. § 1315(a) Medicaid Section 1115 demonstration projects may only be approved if they promote the objectives of the Medicaid program. The objective of the Medicaid program is to enable states to furnish medical assistance to individuals who are too poor to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. Medicaid is a medical assistance program, and although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance to all individuals who qualify under federal law. As courts have held, additional eligibility requirements are illegal. ^[1] Creating and enforcing work requirements has also been found to be [cost-ineffective](#) and [burdensome](#). We express concern about New Hampshire implementing a program which may cost taxpayers more in the long run and which, in the short and long term, jeopardize health care coverage for low income Granite Staters.

¹ See, e.g., *Camacho v. Texas Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children were not getting immunizations, check-ups, or

were missing school because regulation was inconsistent with Medicaid and TANF statutes).

Work and community engagement requirements, if implemented, must include self-employed individuals and should be structured in a way to lower administrative burdens on state agencies, health care providers, and health care enrollees.

Self-employment should be included as a qualifying activity to satisfy work and community engagement requirements. Self-employed individuals, including 1099 independent contractors, significantly contribute to our local economy and should not be excluded from accessing critical health care coverage due to the type of employment they hold. Excluding these individuals increases barriers to health care coverage and calls into question discrimination based on employment classification.

Monthly verification of the work and community engagement requirement is a significant burden on Granite Health Advantage program enrollees, and could result in loss of health care coverage for a seasonal or temporary dip in hours from one month to the next. It is unlikely that DHHS will have the staffing levels to verify tens of thousands of enrollees work and community engagement requirements each month, or to issue good cause exemptions in a timely fashion. We suggest that a quarterly verification system would ease administrative burden, provide enrollees more time and opportunity to submit required paperwork, and lower concerns in the health care provider community about providing services for individuals who may or may not be enrolled from month to month.

Retroactive coverage is critical for both health care providers and enrollees.

Retroactive coverage is critical to ensure our most vulnerable Granite Staters have access to health care coverage when they need it, especially those with substance use disorder or mental health needs. Our health care providers should have the assurance that services provided will be covered, without passing large medical bills onto individuals who lack the ability to pay or will find themselves in even greater financial strife.

Asset and citizenship requirements should not be included.

These provisions are inconsistent with federal law and should be removed.

A strong public education and communications effort is needed to ensure eligible Granite Staters have and maintain access to health care coverage.

Last winter our organization conducted a statewide public education and publicity campaign to inform Granite Staters how to enroll in the private health insurance marketplace before the annual deadline, an effort which involved direct mail, digital content, neighbor to neighbor outreach, and enrollment fairs throughout the state. Medicaid expansion enrollees will not have the benefit of a massive public education drive to educate and inform them about the transition of the program, how to meet work and community engagement requirements, or what to do if they feel they are inappropriately denied enrollment. We encourage DHHS to create a system that helps enrollees sign up and reduces potential gaps in coverage.

As the State of New Hampshire works to implement the Granite Health Advantage Program, we ask that the focus remain on reducing barriers to coverage in order to improve the lives of Granite Staters and keep our state healthy and strong. We also encourage you to engage current Granite Health Advantage enrollees in the process as you finalize the New Hampshire Granite Advantage Health Care Program. These individuals provide first-hand insight to the opportunities and challenges facing them as they seek to meet the new requirements.

If our organization can be of any assistance, please do not hesitate to contact us.

Sincerely,
Zandra Rice Hawkins
Executive Director
Granite State Progress
(603) 225-2471
zandra@granitestateprogress.org



DISABILITY RIGHTS CENTER-NH

64 North Main Street, Suite 2, Concord, NH 03301-4913 • advocacy@drcnh.org • www.drcnh.org
(603) 228-0432 • (800) 834-1721 voice or TTY • FAX: (603) 225-2077

June 27, 2018

NH Department of Health and Human Services
129 Pleasant Street
Concord, N.H. 03301

Attn.: Granite Advantage Section 1115(a) Demonstration Waiver

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

To Whom It May Concern:

Please accept these comments to the proposed Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver on behalf of the Disability Rights Center – NH (“DRC”). The DRC is the federally mandated Protection and Advocacy agency for the protection of the civil rights of individuals with disabilities.

The DRC supports the comments submitted by New Hampshire Legal Assistance and submits additional comments specifically focused on individuals with disabilities and the proposed work requirements. It is the DRC’s position that such work requirements violate the Federal Medicaid law in that it does not promote the objective of the Medicaid program which is to provide healthcare services. This requirement serves only to undermine access, efficiency and the quality of care provided to Medicaid beneficiaries with disabilities as previously stated by CMS.¹

While the proposed 1115(a) Demonstration Waiver proposes to exempt individuals with disabilities from the work requirements, there is evidence from other States that there are usually obstacles which must be overcome in order to qualify for the exemption, including proof of disability, and difficulty meeting the requirements if not exempted.

First, many Medicaid enrollees who are not eligible for Medicaid based on disability, nonetheless may still have chronic and disabling conditions that preclude them from working. For example, “the National Health Interview Survey found that 48% of adults covered by the Affordable Care Act’s Medicaid Expansion are permanently disabled, have serious physical or mental limitations – caused by conditions like cancer, stroke, heart disease, cognitive or mental health disorders, arthritis, pregnancy, or diabetes, or are in fair or poor health.”² It is unknown at this point how the State intends to determine

¹ See letter dated November 1, 2016 from CMS to Commissioner Jeffrey Meyers.

² ² National Health Law Program citing Leighton, Ku and Erin Brantley, *Myths About the Medicaid Expansion and the ‘Able-Bodied’*, Health Affairs Blog (March 6, 2017) available at <http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicare-expansion-and-the-able-bodied/>.

which individuals will qualify for an exemption based on disability, but there is concern that many individuals with disabilities may not actually be exempted.

Second, there is concern over what proof will be required in order for an individual to obtain the disability exemption. It can be extremely burdensome for an individual with a disability to prove his/her disability. Obtaining testimony from doctors, medical records or other documentation can be very difficult. “Red tape and paperwork requirements have been shown to reduce enrollment in Medicaid and individuals coping with serious mental illness or physical impairments may face particular difficulty meeting these requirements.”³ Further it would be a violation of the Americans with Disabilities Act (ADA) for the State to take any action that has a discriminatory impact on people with disabilities.

Third, it is extremely difficult for individuals with disabilities to find employment. Individuals with disabilities face many barriers with employment at every stage including application, interviewing, hiring and retention of employment and many are unable to even consider employment without assistance from Vocational Rehabilitation (“VR”) and/or supports while on the job. Recently NHVR has announced that it will stop accepting new clients as part of the Order of Selection implementation due to lack of funding. This reduction in VR services will substantially impact those with disabilities’ ability to find and secure employment. NHVR estimates that 1,455 willing workers will be placed on a waiting list in 2018 and 1,699 in 2019. None of these individuals will receive the supports and services they need to become employed. Additionally, there is no indication and it is highly unlikely that the State will provide any support services such as transportation or job training for those required to work in order to receive Medicaid. Many individuals with disabilities are far likelier to be unemployed, working less than full time, or sporadically employed which means many will lose coverage unless they can show they are exempt.

Fourth, about sixty percent of people with disabilities who work and receive supports only work an average of two to nine hours a week, making it virtually impossible for these individuals to meet the minimum work hour requirements. Without meeting these strict requirements, individuals who are critically dependent on Medicaid will lose their healthcare inevitably resulting in increased use of expensive emergency rooms and hospitalizations.

Finally, it is unknown how NHDHHS intends to make disability exemption determinations and/or ensure that the monthly requirements are being met. Such work requirements would necessarily require time-consuming and costly verification procedures by a Department which has had its staff and budget dramatically reduced over the past several years. It can be anticipated that such burdensome oversight will reduce the number of individuals accessing healthcare. While losing health coverage harms all groups, it can be particularly devastating for individuals with disabilities who typically need regular care to manage their conditions. “Many people with serious health conditions require access to health care services to maintain their health and function. Requiring individuals to work to qualify for Medicaid would create a situation in which people cannot access the services they need to work without working – setting an impossible standard.”⁴

Overall, while it is difficult to comment on the proposed Demonstration Waiver given the lack of detail it contains, there is evidence from other States imposing the same work requirements that individuals with disabilities have difficulty proving disability to meet the exemption requirements, or, if

³ Center on Budget and Policy Priorities, *Harm to People with Disabilities and Serious Illnesses From Taking Away Medicaid for Not Meeting Work Requirements.*, May, 2018.

⁴ Id referencing The Arc, a leading advocacy organization for people with intellectual and developmental disabilities.

not exempt, meeting the strict work requirements. Additionally, there is concern that the lack of resources to effectively make exemption determinations and/or track compliance with the work requirements will result in loss of Medicaid benefits to the most critically needy.

Thank you for the opportunity to comment on the proposed 1115 Demonstration Waiver.

Sincerely,

A black rectangular redaction box covering the signature of Cindy Robertson.

Cindy Robertson
Senior Staff Attorney

Melby, Leslie

From: Siena Kaplan-Thompson <skaplan@whitemountainhealth.org>
Sent: Friday, June 29, 2018 5:33 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

To whom it may concern:

Thank you for the opportunity to submit comments regarding the 1115(a) Demonstration Waiver. White Mountain Community Health Center is an FQHC-LAL that aims to make healthcare accessible to all in Mt. Washington Valley, regardless of ability to pay. The expanded Medicaid program has helped us and our patients immensely, allowing our funding to stretch farther to address health needs beyond basic primary care access, and allowing our patients to get the care they need beyond our services. Being healthy allows our patients to stay in the workforce, to care for their children and other family members, to volunteer and contribute to community organizations, and in many other ways to add to the wellbeing of our community.

We do not support the proposals to add work requirements, end the 3-month retroactive coverage, or to add an asset test to expanded Medicaid eligibility. We support programs that genuinely assist people in getting back to work. Medicaid is one of those programs; it allows our patients to access healthcare they could not otherwise afford so that when illness or injury would otherwise prevent them from working, they can access the care they need to restore their health and get back to work.

The work requirement would make it more difficult for our patients to stay on Medicaid by adding additional onerous paperwork to an already difficult process. It would add to our administrative costs as we would need more staff to assist patients with the process, and cost us money as patients who would be eligible for Medicaid will fall off more often due to the additional documentation and instead use our sliding fee scale to access services. We suggest instead a voluntary referral to a state job counseling program instead, such as Montana's program, which has been shown to increase employment without reducing healthcare access for those who are already working.

Retroactive coverage helps cover gaps in coverage due to documentation difficulties, which will be even more essential if required documentation is increasing, and helps reduce medical debt in low-income patients who are struggling. It also reduces the amount of care organizations like ours provide for free, which reduces the cost of healthcare for all and allows our funding to stretch further.

Eliminating the asset test from Medicaid eligibility reduced administrative costs and made it easier for people to enroll. Adding it back will not save New Hampshire any money, and it will reduce Medicaid enrollments from those who would be eligible regardless. As explained above, this runs counter to the goal of supporting employment and a healthy community, and lowering administrative costs in healthcare. It also violates federal Medicaid law.

Thank you for considering these comments.

Siena Kaplan-Thompson
Executive Assistant
White Mountain Community Health Center
(603) 447-8900 x328



June 28, 2018

Jeffrey Meyers
Commissioner
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

Submitted electronically to nhmedicaidcaremanagement@dhhs.nh.gov

Re: Granite Advantage 1115 Waiver Extension Application; Amendment to Project #11-W-00298/1

Dear Mr. Meyers:

Thank you for your work on the New Hampshire Health Protection Program and the new Granite Advantage Health Care Program. Bi-State Primary Care Association continues to support the expansion of our Medicaid program. On behalf of Bi-State Primary Care Association and our members, I submit the following comments in response to the New Hampshire Department of Health and Human Services' Granite Advantage 1115 waiver extension application.

Bi-State Primary Care Association is a non-profit organization that advocates for access to primary and preventive care for all New Hampshire residents with a special emphasis on the medically underserved. We also represent New Hampshire's 16 community health centers, which are located in medically underserved areas throughout our state. Community health centers are non-profit organizations that provide integrated oral health, substance use disorder treatment, behavioral health, and primary care services to more than 113,000 patients, most of whom live below 200% of the federal poverty level or \$24,120 for an individual.¹ We support the expansion of Medicaid because it increases access to health insurance coverage and care. That being said, we are concerned that several provisions of the Granite Advantage Health Care Program as required by SB 313, its enacting legislation, are overly burdensome and will reduce low-income individuals' access to health insurance coverage.

The New Hampshire Health Protection Program enabled the state to provide much needed health insurance to uninsured people whose health conditions, such as chronic diseases or substance use disorder, have been a barrier to employment. Any amendment to the waiver and our Medicaid program should "increase and strengthen overall coverage of low-income individuals."² The draft waiver changes our current delivery system by moving Medicaid expansion enrollees into managed care; encourages healthy behaviors by using incentive programs; and continues and expands New Hampshire's current work and community engagement requirements as approved by the Centers for Medicare and Medicaid Services on May 7, 2018.

Transitioning of Medicaid Enrollees to Managed Care Organizations

Bi-State takes no position on returning the Medicaid expansion population to Medicaid managed care; however, we are concerned that the transition may result in enrollees losing coverage, providers losing

¹ Health Resources and Services Administration, Uniform Data System, NH Rollup (2016), federally qualified health centers are required to submit patient demographics, services offered and received, clinical data, and payer information to the Health Resources and Services Administration annually; BSPCA Survey of Membership (2016).

² *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html> (last visited Sept. 26, 2017).

reimbursement for services provided to Medicaid enrollees, and the auto-assignment of enrollees to providers that beneficiaries have no relationship with. Our concerns are based on past experiences that Medicaid enrollees and our health centers had during the transition to Medicaid managed care, the creation of the NHHPP, its Bridge Program, and the Premium Assistance Program. During each transition, patients fell off health center rolls, patients lost access to health center clinicians that they have an established relationship with, and health centers were not reimbursed in a timely fashion. We respectfully request that the Department set aside funding for the timely reimbursement of clinicians for services provided to Medicaid expansion enrollees in order to avoid delays in care and reimbursement.

Citizenship Requirement

New Hampshire's waiver amendment includes a verification of citizenship requirement that requires newly eligible adults to verify United States citizenship by providing two forms of identification and proof of New Hampshire residency. This will create an undue burden on enrollees and the low-income patients served by community health centers, specifically the patients of the three health care for the homeless programs in New Hampshire. Like many health center patients, patients served by these particular health centers have complicated socioeconomic backgrounds and experience high rates of severe mental illness and substance use disorders, in particular alcohol related disorders. Studies indicate that citizenship and residency verification requirements create barriers to accessing necessary health care services and coverage, particularly for vulnerable populations.³ We ask you ask that the state not require proof of citizenship and residency because it will increase barriers to care for low-income New Hampshire residents.

Incentive Programs and Cost Effectiveness

We were pleased to see the inclusion of incentive programs and cost effectiveness provisions to promote healthy behaviors in SB 313 and look forward to partnering with the Department and managed care organizations on the development of these programs. We hope the programs will include health education classes and information, as well as incentives for lifestyle changes. The language included in SB 313 pertaining to "lower cost medical providers" v. "lower cost medical procedures" gives us pause, as federally qualified health centers are required to receive their encounter rate pursuant to federal and state law. We hope that the interpretation of this language will not drive patients away from health centers. Community health centers provide high-quality integrated primary care, oral health services, behavioral health services, and substance use disorder treatment regardless of insurance status or ability to pay. Studies show that each patient seen by community health centers saves the health care system approximately 24% annually.⁴ Health centers' culturally competent, integrated care models are adept at serving patients with complex socioeconomic backgrounds and the state should encourage patients to access care from providers who are skilled at treating complex patients.

Work and Community Engagement Requirement

Bi-State does not believe that requiring individuals to engage in "at least 100 hours per month" of work or other community engagement activities increases or strengthens insurance coverage.⁵ We agree that poverty facing those at and below 200% FPL is an important issue our state needs to address; however, research shows most recipients subject to work requirements stayed poor and the employment increases were modest.⁶ In addition, it is our understanding that the Department interprets SB 313 to exclude self-employment as one of the qualifying activities by which a person can satisfy the work and community

³ See The Impact of Citizenship Doc. Req. on Access to Medicaid for Pregnant Women in Oregon, 2 (August 2011); States Reported that Citizenship Doc. Req. Resulted in Enrollment Declines for Eligible Citizens and Posed Admin. Burdens, 4-6 (June 2007).

⁴ Richard et al. "Cost Savings Associated with the Use of Community Health Centers," *Journal of Ambulatory Care Management*, Vol. 35, No. 1, 50-59 (Jan./March 2012).

⁵ See NH Senate Bill 313 (2018); See also Draft Section 1115 Demonstration Amendment, Granite Advantage Health Care Program #11-W-00298/1, 8 (May 30, 2018). See Center on Budget and Policy Priorities, "Policy Basics: An introduction to TANF," (June 15, 2015).

⁶ See N.H. Fiscal Policy Institute, "New Hampshire Poverty Rate Continues to Decline, but Many Granite Staters still struggle with very limited income" (September 14, 2017). Center on Budget and Policy Priorities, "Medicaid work requirements would limit health care access without significantly boosting employment," (July 13, 2017), stating implementation of TANF work requirements cost states thousands of dollars per beneficiary and they were unsuccessful in increasing long-term employment.

engagement requirement. If self-employment were excluded, independent contractors, such as construction workers, home-health workers, hair stylists, and more would be excluded from the program. Regardless of the type of self-employment, it is difficult to reconcile the inclusion of community service or public service as a qualifying activity, when no income can be earned, with the exclusion of self-employment, which has a potential for income. We ask the Department to clarify its stance on this important issue and seek an administrative or legislative resolution if necessary. Ultimately, we do not believe that a work requirement furthers the purpose of the Medicaid program.

Waiver of 90-day Retroactive Coverage

The State seeks permission to continue to waive the Medicaid 90-day retroactive coverage requirement and limit coverage to the beginning of Medicaid coverage with the date of the application. As previously noted, the Medicaid expansion enrollees often have complex socioeconomic backgrounds, including homelessness. Our health care system is complicated and patients often delay accessing care because of a perceived inability to afford the care. We believe waiving retroactive coverage will exacerbate this. Also, if a provider serves an uninsured patient who is eligible for coverage 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. Medical debt is the most cited reason as to why a person files for bankruptcy in the US.⁷ The 90-day retroactivity coverage requirement should not be waived given the significant financial impact it will have on potential Medicaid enrollees and providers.

Reimbursement for Behavioral Health Services

Senate Bill 313 the Department to establish "behavioral health rates sufficient to ensure access to, and provider capacity for, all behavioral health services."⁸ Bi-State and our members hope that the growth we made in substance use disorder treatment and behavioral health services capacity through the Premium Assistance Program will not be lost by moving the expansion population

Need for Real-Time Enrollment Data

The last concern we want to draw attention to is access to timely data. The waiver application does not include any information regarding health care provider access to real-time data on beneficiary eligibility for the Granite Advantage. We hope that the Department can and will ensure that health care providers will have access to real-time eligibility data. The work and community engagement requirement complicates the eligibility and enrollment processes for both the clinicians and the patients, and it is important that the clinicians have accurate information before seeing a patient and when submitting claims to ensure proper reimbursement for services provided Medicaid enrollees in good faith.

Again, Bi-State and our members support the expansion of Medicaid. We look forward to working with the Department on this next iteration of such a crucial program.

Sincerely,



Kristine E. Stoddard, Esq.
Director of NH Public Policy
603-228-2830, ext. 113
kstoddard@bistatepca.org

⁷ Karen Pollitz and Cynthia Cox, "Medical Debt Among People with Health Insurance," 18 (January 2014).

⁸ NH Senate Bill 313, 2 (2018).



THE
NH PROVIDERS
ASSOCIATION

Representing
Alcohol & Other Drug Service Providers
in New Hampshire

June 29, 2018

Via Email Only: nhmedicaidcaremanagement@dhhs.nh.gov

Jeffrey Meyers

Commissioner

Department of Health and Human Services

129 Pleasant Street

Concord NH 03301

Re: Granite Advantage 1115(a) Demonstration Waiver Extension Application

Dear Commissioner Meyers:

The NH Providers Association is a non-partisan, non-profit membership organization for substance use disorder (SUD) providers seeking ensure high quality substance use prevention, treatment, intervention, and recovery support services. With this in mind, we offer the following comments on the Granite Advantage 1115(a) Demonstration Waiver Extension Application.

Behavioral Health Rates Sufficient to Ensure Access to and Capacity for Behavioral Health Services

With the Premium Assistance Program (PAP), SUD providers experienced enhanced payment rates. These rates encouraged growth in the behavioral health field such that New Hampshire was able to double its treatment capacity. Even with this enhanced capacity, there are still individuals who are not able to access treatment when they need treatment. The NH Providers Association is concerned that if the rates under the Granite Advantage Health Care Program are not sufficient, providers will either refuse to serve Medicaid patients, or be forced to leave the field, reducing the treatment capacity and further exacerbating New Hampshire's addiction crisis.

Waiver of the Requirement to Provide 90-day Retroactive Coverage

The NH Providers Association has concerns that obtaining a waiver of the 90-day retroactive coverage requirement could cause significant financial strain for providers and beneficiaries alike. Without retroactive coverage, providers will not be able to bill Medicaid for services rendered to individuals in the process of signing up for Medicaid. Individuals with behavioral health conditions often face unique circumstances and homelessness, which pose challenges for collecting documentation required to complete a Medicaid application. It is not unusual for these providers to encounter a patient three or four times, slowly gathering required information, before a complete an application can be processed. Retroactive coverage allows these providers to bill for services rendered during this period, while preventing beneficiaries from being left with additional medical bills they simply cannot afford. Threats to reimbursement may pressure some providers to reduce care or assistance provided to individuals in the process of signing up for Medicaid expansion, missing important treatment opportunities. These delays in treatment would only exacerbate the existing mental health and substance use crises.

Citizen or Documentation Requirements

As described above, many individuals struggling with behavioral health challenges are at increased risk for homelessness and other situations that may reduce access to documentation. According to professionals among

the homeless service provider community, the majority of people experiencing homelessness in New Hampshire will be unable to provide two forms of documentation of United States citizenship and proof of New Hampshire residency by either a New Hampshire driver's license or non-drive picture identification card. The NH Providers Association is concerned that this barrier may prevent beneficiaries from enrolling in the program and maintaining coverage.

The Transition from the Premium Assistance Program to the Managed Care Organizations

When the PAP ends on December 31, 2018 and Granite Advantage begins on January 1, 2019, all the beneficiaries receiving insurance through the individual market will need to be transitioned to the Managed Care Organizations (MCO). If the numbers stay roughly the same as they are currently, more than 41,000 beneficiaries will need to be transitioned from the individual market to the MCOs. This may necessitate providers assisting beneficiaries. The NH Providers is concerned about this transition and encourages DHHS to ensure there are ample procedures in place to assure that the transition goes as seamless as possible.

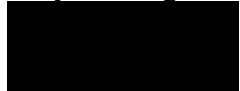
Work and Community Engagement Requirement Regarding Self-employed Individuals

The waiver application proposes to continue and extend the work and community engagement requirement as approved by the Centers for Medicare and Medicaid Services (CMS) approved on May 7, 2018. The special terms and conditions (STC) outlined by CMS do not specifically include self-employment, and it is The NH Providers Association understanding that DHHS has interpreted this to exclude self-employment as one of the qualifying activities by which a person could satisfy the work and community engagement requirement. If this understanding of DHHS' interpretation is correct, The NH Providers Association questions whether all self-employment activities, including those of 1099 independent contractors, such as home health workers, carpenters, plumbers, contractors, etc., are excluded as one of the qualifying activities that satisfy the work and community engagement requirement. If so, The NH Providers Association fears this would prohibit many per diem care providers, substitute teachers and other independent contractors from accessing critical health care coverage.

Finally, the NH Providers Association is concerned about the procedures for non-compliance with the community engagement requirement. It is our understanding that individuals who fail to participate in the requirement may be eligible for "good cause" exemptions, but it is unclear how long the appeals process would take and whether the beneficiary would lose health coverage during the process. The NH Providers Association encourages DHHS to ensure that providers rendering services are compensated for services provided during appeals, probationary, or other transitional processes.

Thank you for your serious consideration of these important issues.

Very best regards,



Sarah Freeman
Executive Director
The NH Providers Association
(603) 225-9540 ext. 113



John P. Kacavas

CHIEF LEGAL OFFICER & GENERAL COUNSEL

Dartmouth-Hitchcock Medical Center

One Medical Center Drive

Lebanon, NH 03756-0001

Phone (603) 650-5160

Dartmouth-Hitchcock.org

June 28, 2018

BY ELECTRONIC DELIVERY

NH Department of Health and Human Services
Attn: Granite Advantage Section 1115(a) Demonstration Waiver
129 Pleasant Street
Concord, NH 03301

Dear Sir or Madam:

Dartmouth-Hitchcock Health is pleased to submit comments on the State of New Hampshire's Granite Advantage Section 1115(a) Demonstration Waiver.

Dartmouth-Hitchcock Health is a nonprofit academic health system that services a population of 1.9 million in northern New England. Our health system provides access to more than 1,400 primary care doctors and specialists in almost every area of medicine, at Dartmouth-Hitchcock Medical Center in Lebanon and also at our member hospitals in Lebanon, Keene, New London and Windsor, Vermont. We also provide care at the Norris Cotton Cancer Center, one of 49 comprehensive cancer centers in the country, at the Children's Hospital at Dartmouth-Hitchcock, and at 24 clinics across the region that provide primary care and ambulatory services in their communities. Our flagship hospital, Mary Hitchcock Memorial Hospital, is New Hampshire's only academic medical center and serves as the safety net hospital for New Hampshire and southern Vermont, treating some of the region's most vulnerable patients.

Dartmouth-Hitchcock Health has supported the New Hampshire Health Protection Program ("NHHPP") and supports the Granite Advantage Health Care Program (the "Program"), which has provided, and will provide, respectively, coverage to more than 52,000 Granite State residents. This coverage enables eligible individuals access to primary and preventive care, cost-effective management of chronic conditions, as well as vital mental health and substance use disorder services.

While we support access to coverage that helps assure access to care, we appreciate the opportunity to comment on components of the Program with which we have concern, specifically:

- Transition of expansion adults from NHHPP premium assistance program's QHP to Medicaid MCOs. This transition will result in significant rate reductions for providers; it has been estimated that hospitals alone will lose between \$35 and \$45 million annually.¹ As NH Medicaid reimburses hospitals at the lowest end of the reimbursement spectrum, we are concerned that additional negative rate pressure will have implications for patient access.
- Waiver of Retroactive Coverage Requirement. The State seeks to withdraw the conditional nature of the waiver of the requirement to provide three months of retroactive coverage. Expansion adults will become eligible for coverage at the time of application (eligibility will be effective no earlier than the day all eligibility requirements are met). While this may enable the State to test whether eliminating retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy, without negatively impacting churn in and out of the program, it may do so at a financial cost to hospitals, which will continue to provide care that will likely be uncompensated for that portion of the expansion population. This seems inconsistent with the ongoing effort to reduce uncompensated care costs, which Medicaid expansion has so successfully impacted for those without insurance.
- We understand that CMS has approved a prior amendment to the NHHPP concerning work and community engagement eligibility requirements that will be continued in the Program. While we are not commenting directly on the policy determination underlying such eligibility requirements, we have concerns with *any* administrative impediment to access to timely care since delays in seeking appropriate care early often lead to much more expensive care later. Our principle concern surrounds the potential adverse implications for the health of our patients but, coupled with the waiver of retroactive coverage discussed above, this will likely also have adverse financial implications for providers.
- Incentivize Healthy Behaviors and Cost Effectiveness Policies for MCOs and individuals. While we support providing the right care in the right place at the right time, every time, the incentives to improve care quality and utilization and to lower the total cost of care require additional clarity and suggest an opportunity for alignment with existing efforts.² Traditional efforts to "control" utilization

¹ For Dartmouth-Hitchcock Health members, who together treat the largest proportion of NH Medicaid beneficiaries, this amount would constitute an estimated \$7 million reduction.

² We recognize that the State is engaged in a re-procurement process with the MCOs – a process on which we also intend to comment - and that these policies will be effectuated through those contracts. However, we raise these issues here as well to emphasize our desire to work collaboratively with the NH Department of Health and Human Services to promote the best approaches possible for patient care

through prior authorizations and utilization management are dated and often impact care to patients while imposing unnecessary administrative burdens on the provider.

Among the initial areas enumerated in the relevant legislation are:

- Timeliness of prenatal care and reductions in neonatal abstinence births;
- Timeliness of follow-up after a mental illness or substance use disorders admissions; and
- Appropriate use of emergency departments relative to low acuity non-emergent visits.

Dartmouth-Hitchcock Health has been working across multiple clinical disciplines to address these areas. For example, Dartmouth-Hitchcock's Moms in Recovery Program has implemented a program for pregnant women with opioid use disorders, which provides integrated addiction, psychiatric, obstetric and pediatric care as well as connection to community resources. The program is set to be expanded to other health systems across the State.

In addition to the work in which Dartmouth-Hitchcock is engaged as lead for Region 1 of the State's DSRIP Medicaid Waiver to integrate behavioral health into primary care, we also have begun utilizing Recovery Coaches in the Emergency Department so those with substance use disorders can receive the additional assistance necessary to successfully engage in appropriate behavioral health care and/or peer-recovery-based follow-up services after discharge from the emergency department.

In connection with emergency department utilization, we note that the State Legislature passed HB 1809 this session, which adopts a prudent layperson standard in connection with Emergency Department utilization. Accordingly, any incentive along these lines should require consistency with this policy.

We understand that the Program will be evaluated on an annual basis to assess accountability to beneficiaries and the overall program, as well as the effectiveness of chosen incentives to lower costs while maintaining quality and access. We reiterate our desire to work toward alignment of the proposed measures with existing programs and requirements to increase the likelihood of success with the required evaluation – keeping the health of our patients paramount.

A final concern – though not contemplated in the waiver – is that the State continues to employ a spend-down policy to its Medicaid beneficiaries. It seems starkly inconsistent to us for the State to continue this policy while simultaneously expanding coverage through the Program. As one of only a few states retaining this requirement, we would be

remiss if we did not take this opportunity to urge the State to reconsider this policy or refine the existing program to reduce the number of “spend-down” clients. Patients who move in and out of a managed care organization on a monthly basis are nearly impossible to properly manage and often end up unnecessarily in emergency room departments each month. This type of program is incongruent with the State’s goal of providing the right care at the right time and the right place.

Thank you for your consideration.

Sincerely,

A black rectangular box redacting the signature of John P. Kacavas.

John P. Kacavas
Chief Legal Officer and General Counsel

JPK/am



NH Chapter

7 North State Street Concord, NH 03301-4018
Telephone: 603-224-1909

June 29, 2018

Deborah Fournier JD
Medicaid Director
New Hampshire Department of Health and Human Services
Fred H. Brown Building
129 Pleasant Street
Concord, NH 03301

RE: **Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver**

Dear Ms Fournier,

The New Hampshire Chapter of the American Academy of Pediatrics (NHPS), a nonprofit organization representing 256 pediatricians from across the state, dedicated to the health, safety and well-being of all New Hampshire infants, children, adolescents and young adults, thanks you for the opportunity to provide comments on the proposed amendments and extension of the **Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver**.

We write today to express our concerns with some of these proposed amendments, which could create significant barriers for some low-income parents and other adult family members here in New Hampshire. While we appreciate that the state is taking steps to streamline care provided in the Medicaid program and eliminate inconsistencies between coverage categories, we remain concerned with the following waiver provisions:

- **The requirement that adult enrollees account for 100 hours of work/community engagement per month, or risk losing their Medicaid coverage.** As pediatricians, we know how important adult health insurance coverage is for a child. Parents enrolled in coverage are more likely to have children enrolled in coverage, and parents with coverage are also more likely to maintain children's coverage over time.ⁱ Moreover, parent-child interactions are critical to a child's healthy development. An uninsured, sick parent is less able to care for a child, and parent and other adult family members with untreated medical needs can have a profound impact on the family as a whole.ⁱⁱ

We understand the important role work has in the success of the family. We want families to have meaningful work and the opportunity to move up the economic ladder. We want working adults to model positive behavior for children. We therefore as a state should promote strategies to support work and family income, which has been shown to have an impact on child outcomes.ⁱⁱⁱ

The truth however is that the clear majority of adult Medicaid enrollees already work. Nationally among Medicaid eligible adults, 8 in 10 live in working families and almost 60% work themselves.^{iv} The majority of those who do not work have health conditions that prevent them from doing so, are caring for family members, or are in school.^v

While we appreciate that this proposal seeks to move more adults to employment and employer-sponsored insurance, it is not clear that either will occur because of this requirement. Research shows that tying Medicaid eligibility to work or work-related activities are likely to fail to increase long-term employment or reduce poverty.^{vi} Moreover, those with low-wage jobs are unlikely to have other sources of coverage—a 2014 study

showed that only 28 percent of employees of private firms with low average wages obtain health insurance through their jobs, and 42 percent are not even eligible for employer-sponsored coverage.^{vii}

We understand that the proposal contains exemptions for specific categories of adults, and that the state will allow for “good cause” exemptions not enumerated. However, we remain concerned that this work documentation requirement will cause enrollees – potentially a significant number of parent and other adult enrollees – to unnecessarily lose much needed coverage.

Moreover, we highlight the likely costs associated with this policy. As more New Hampshire adults lose coverage, they will begin to visit emergency departments, a much more expensive source of care. As emergency care would be provided regardless of the patient’s ability to pay, the state would therefore see increased uncompensated care costs and place a greater strain on our safety net hospitals and clinics. The state is also likely to see additional financial burdens because of the administrative costs of implementing this policy. For all these reasons, we urge the state to strongly reconsider this work documentation requirement.

- **The imposition of an asset test that would make adults with assets of \$25,000 ineligible for Medicaid.** We are highly concerned with any provision that would implement an asset test for Medicaid beneficiaries. Over time, asset tests have been eliminated for most populations in Medicaid to better align eligibility for Medicaid, the Children’s Health Insurance Program (CHIP), and marketplace coverage, to make it easier for beneficiaries to move between coverage programs as their incomes change. Moreover, Congress chose to eliminate asset tests for most Medicaid enrollees based on decades of experience with them that demonstrated their elimination streamlines eligibility and saves on enrollment costs.^{viii ix}

Requiring an asset test of \$25,000 would create a significant barrier for low-income individuals to obtain health insurance coverage and would further contradict the notion that families should save any limited dollars they may have to increase their chances of financial self-sufficiency. Financial savings supply families with a buffer against unexpected costs, allow them to plan for their children’s futures, and allow them to better prepare for sudden crises. Medicaid must not be used as a lever to punish families—particularly those at low incomes—for their abilities or aspirations to build a measure of financial security. It should also not punish those who may have assets who lose a job or face some other financial event that pushes their family into an income category making them eligible for Medicaid.

- **The elimination of retroactive eligibility for adults.** Retroactive eligibility ensures that Medicaid will pay for services provided up to 3 months before a final eligibility determination is made, if an individual would have been eligible for Medicaid during that time. The elimination of this important protection will put families at risk for medical debt and will increase uncompensated care costs for hospitals and providers.

We are particularly concerned about the impact of this provision on children and families. In instances where families are unaware of their eligibility for Medicaid and face significant illness or injury, they may end up responsible for tens of thousands of dollars in medical bills, putting even more financial stress on families already living in poverty. Poverty and related social determinants of health can lead to adverse health outcomes in childhood and across the life course, negatively affecting physical health, socioemotional development, and educational achievement.^x We must not create policies that serve to exacerbate the effects of poverty on low-income families. In lieu of eliminating the important protection retroactive eligibility provides, the state should focus its efforts on outreach and enrollment and streamlining and optimizing re-enrollment to ensure continuity of coverage.

- **The requirement that enrollees provide two forms of documentation of US citizenship and either a New Hampshire driver’s license or state ID card for proof of state residency.** These documentation requirements may cause an undue burden on New Hampshire’s low-income population as those of low-incomes are much more likely to lack such documentation. As an example, one study has found that citizens earning less than \$25,000 per year are more than twice as likely to lack documentation of their citizenship as those earning more

than \$25,000.^{xi} Citizens with low incomes are also considerably less likely to possess photo identification.^{xii} These documentation requirements will also have a significant impact on New Hampshire's homeless population, who face many obstacles to obtaining such documents.

- **The quick transition to Medicaid managed care.** The state proposes to move 41,000 New Hampshire adults from qualified health plan coverage to Medicaid managed care by January 1, 2019, using auto-assignment to enroll individuals in one of the Medicaid program's contracting managed care organizations (MCOs). As experience has recently shown in other states, fast transitions to managed care can cause numerous problems for enrollees and the state.^{xiii} While we appreciate and applaud New Hampshire's efforts to streamline coverage and ensure wrap-around benefit protections, we urge that efforts be undertaken maintain continuity of care and provide for real time monitoring of this change, to ensure parents and other adult family members do not face undue burdens in obtaining medically necessary care while the state makes this transition.

The Medicaid program plays a critical role in the health of children and the health and stability of New Hampshire families. We hope you take into consideration the thoughts of New Hampshire's pediatricians as you contemplate these changes to this proposal. If you have any questions about our concerns, please contact Catrina Watson at 603-224-1909 or catrina.watson@nhms.org.

Sincerely,

Catrina Watson
Executive Director

ⁱ <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf>

ⁱⁱ *Ibid.*

ⁱⁱⁱ <http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf>

^{iv} <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicare-and-work/>

^v <https://www.cbpp.org/blog/medicaid-work-requirement-would-harm-unemployed-not-promote-work>

^{vi} LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016, <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>.

^{vii} https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

^{viii} <https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicare-asset-test.pdf>

^{ix} https://www.clasp.org/sites/default/files/publications/2018/04/2018_eliminatingassetlimits.pdf

^x <http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf>

^{xi} https://www.brennancenter.org/sites/default/files/legacy/d/download_file_39242.pdf

^{xii} *Ibid.*

^{xiii} <https://khn.org/news/kentucky-medicare-managed-care/>

^{xiv} <https://www.desmoinesregister.com/story/news/2017/05/09/complaints-iowa-privatized-medicare-spiking/315066001/>

June 28, 2018

Commissioner Jeffrey Meyers
NH Department of Health and Human Services
Attn: Granite Advantage Section 1115(a) Demonstration Waiver
129 Pleasant Street
Concord, NH 03301;

Dear Commissioner Meyers,

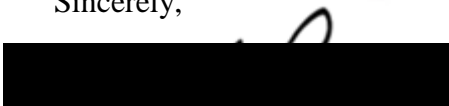
On behalf of the Medical Society and the some 50,000 plus individuals who are to be served by the new Medicaid expansion program, I am writing to respectfully ask that the Department and resulting Medicaid managed care contracts result in significantly increased reimbursement rates for primary care, obstetrics and gynecological, mental health and substance use disorders services – even if this should require a supplemental funding request from the legislature.

While this case was repeatedly made to the General Court and New Hampshire lawmakers concurred, we believe that the success or failure of Senate Bill 313 and the Granite Advantage Program will hinge on this issue.

The current low rates from New Hampshire's Health Protection Program were clearly a contributing factor to the closure of obstetrical and prenatal services in the Lake Region and other more rural parts of the Granite State. While the Medical Society has been very supportive of the continuation of the Medicaid expansion program, we believe that if appropriate increases are not made for these services, more hospitals and physicians will be forced to withdraw from the program. It has been one of the top reoccurring themes when I travel across the state meeting with medical staffs.

Thank you for your time and thoughtful consideration.

Sincerely,


James G. Potter
Executive Vice President



NH Department of Health and Human Services
ATTN: Granite Advantage Section 1115(a) Demonstration Waiver
129 Pleasant Street
Concord, NH 03301

June 29, 2018

Re: Granite Advantage Health Care Section 1115(a) Demonstration Waiver

Dear Ms. Melby,

Thank you for the opportunity to comment on New Hampshire's 1115 Demonstration Waiver Amendment. On behalf of people with cystic fibrosis (CF), we write to express our concern with the state's proposals to add work and community engagement requirements as a condition of Medicaid eligibility and eliminate retroactive coverage. We urge you to consider the Cystic Fibrosis Foundation as a resource as the state plans for and implements these policies. Work and community engagement requirements create an additional barrier to accessing the high-quality care that people with chronic conditions like CF need. As such, we ask the state to specifically and automatically exempt people with cystic fibrosis from these requirements. Retroactive coverage in Medicaid helps ensure continuous access to high-quality, specialized CF care which is essential to the health and well-being of people with cystic fibrosis and we therefore ask the state to reject the proposal to eliminate this policy.

Cystic fibrosis (CF) is a life-threatening genetic disease that affects 209 people in New Hampshire and 30,000 children and adults in the United States. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. Medicaid is a crucial source of coverage for patients with serious and chronic health care needs, including approximately 24 adults living with cystic fibrosis in New Hampshire. Medicaid plays an important role in helping this patient population access the high-quality care and treatment necessary to maintain or improve health. Continuous access to high-quality, specialized CF care is essential to the health and well-being of people with cystic fibrosis.

Within the state's 1115(a) Demonstration Waiver Amendment, we are concerned with the following provisions:

Work and Community Engagement Requirements

Making work a condition of Medicaid eligibility threatens access to care for people with CF, as their ability to work vary greatly over time with changes in health status. Declines in health status due to pulmonary exacerbations, infections, and other events are common and can take someone out of the workforce for significant periods of time. Patients bear a significant treatment burden as well, amounting to hours of chest physiotherapy, delivery of nebulized treatments, administration of intravenous antibiotics, and/or other activities required to maintain or improve their health. Sustained

employment may not be possible due to the time required to undergo necessary treatment, which includes an intense and time-consuming daily regimen.

While we appreciate the state's decision to exempt from work requirements a person who is "medically frail" or temporarily unable to participate due to illness or incapacity—which reflects the important reality that health status can significantly affect an individual's ability to search for and sustain employment—we urge the state to work with us to specifically exempt people with CF. We also ask the state to use its own data to identify people with CF for exemptions in order to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

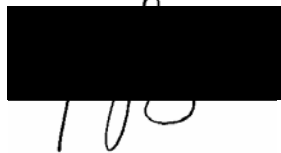
As experts in cystic fibrosis care and research, the CF Foundation is a partner to states during the rulemaking and implementation process. Our goal is to ensure people with CF are exempt from work requirements and help states minimize unintended errors. In particular, we can provide clinical expertise on service utilization, co-morbidities, and other factors that may help the state identify people with CF through claims data.

Waiving Retroactive Coverage Requirement

We oppose the proposal to waive retroactive coverage. Retroactive coverage allows individuals with chronic conditions, like cystic fibrosis, to receive care and treatment immediately, rather than waiting for their official Medicaid eligibility determination and without incurring medical debt. A medical complication could be serious enough to make someone with CF eligible for Medicaid by health status or preclude them from working, jeopardizing their employer-sponsored insurance coverage. We therefore ask the state to continue to provide three months of retroactive coverage for individuals, especially those with serious medical conditions like cystic fibrosis.

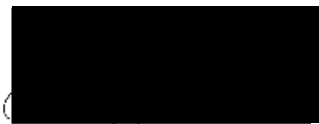
The Cystic Fibrosis Foundation appreciates the opportunity to provide input on these important policy changes. As the health care landscape continues to evolve, we look forward to working with the state of New Hampshire to ensure access to high-quality, specialized CF care and improve the lives of all people with cystic fibrosis.

Sincerely,



Mary B. Dwight

Senior VP of Policy & Patient Assistance Programs
Cystic Fibrosis Foundation



Lisa Feng, DrPH

Senior Director of Access Policy & Innovation
Cystic Fibrosis Foundation



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

June 28, 2018

Henry Lipman
Medicaid Director, Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Re: Granite Advantage Health Care Program Section 1115(a) Demonstration Waiver

Dear Director Lipman:

On behalf of the American Heart Association (AHA) and the American Stroke Association, I would like to thank you for the opportunity to provide written comments on the proposed Granite Advantage Health Care Program Section 1115 demonstration waiver. As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, we write to express our concerns and urge the state to withdraw this proposal.

The AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care.¹ In fact, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease.² Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Because low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid is the coverage backbone for the healthcare services these individuals need.

The connection between health insurance and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance, or are underinsured, have higher mortality rates³ and poorer blood pressure control than their insured counterparts.⁴

¹ RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.

² Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.

³ McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs* 2004; 23(4): 223-233.

⁴ Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. *Am J Hypertens* 2007;20:348-353.

*"Building healthier lives,
free of cardiovascular
diseases and stroke."*

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Please remember the American Heart Association in your will.

Further, uninsured stroke patients suffer from greater neurological impairments, longer hospital stays,⁵ and higher risk of death⁶ than similar patients covered by health insurance. Cardiovascular disease is also costly and burdensome for the individual, their families, and for communities.

The intent of the 1115 Demonstration Waiver program is to increase access and test innovative approaches to delivering care. As written, the Granite Advantage Program does not appear to satisfy either requirement but instead could significantly harm patients and their families. Additionally, there are several areas that the state proposed, but include no accompanying evaluation hypothesis to test the proposal as part of the waiver evaluation. In order for the association, as well as CMS, to fully evaluate this proposal, the state needs to include these hypotheses and outline how it plans to measure their impacts on access to coverage for individuals eligible for Medicaid as part of its application.

Retroactive Eligibility

Retroactive eligibility is critical to preventing gaps in care by providing coverage up to 90 days prior to application. Many individuals are unaware they are eligible for Medicaid until a medical event occurs and this policy allows patients who have suffered a serious or sudden medical condition, such as heart attack or stroke, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

The request to waive retroactive eligibility puts both beneficiaries and providers at risk of incurring medical debt. Prior to 2010, one of the most common reasons for medical bankruptcy was cardiovascular disease.⁷ Since that time, Medicaid has continued to provide an essential service for low-income Americans who require care to treat disease and maintain their health. Retroactive eligibility is an important part of the support service offered by Medicaid as it protects low-income beneficiaries who may already be under financial pressure.

While uncompensated care costs to providers are a legitimate concern for both patients and providers, there is little evidence to show that eliminating retroactive eligibility requirements will help resolve this issue. In fact, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.⁸ The AHA is committed to developing strong, evidence-based policies that serve the millions of Americans with CVD in the United States and use those as the basis for our recommendations.

Continuation of Work Requirements

As we have previously stated in written comments and legislative testimony, the association is deeply troubled by the continuation of a work requirement. This provision

⁵ Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Med Care Res Rev* 2005; 62(1): 231-249.

⁶ McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. *JAMA*. 2007; 298:2886 –2894.

⁷ David U. Himmelstein et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, W5 Health Affaris, 63, 69 (2005)

⁸ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", *Modern Healthcare*, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

could significantly harm patients, including those with CVD, by reducing their access to healthcare services both in the short and long term. To treat and prevent heart disease and stroke, it is critically important that everyone in New Hampshire – regardless of employment status – has access to affordable, quality healthcare. The Medicaid statute currently defines the factors states can consider in determining eligibility for Medicaid, such as income, citizenship and immigration status, and state residence. The statute does not include an individual's employment status or ability to work, whether or not they are seeking work, or their ability to engage in work-related activities as a permissible factor in determining Medicaid eligibility.⁹

Most people on Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage are members of working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason; 28 percent reported that they were taking care of home or family; and 18 percent were in school.¹⁰ Additionally, individuals with CVD often experience lapses in employment due to their condition or may have been directed by a physician to take time away from work as part of their treatment and recovery. Therefore, participation in work or work searches as a condition of Medicaid eligibility could discriminate against these individuals and create inappropriate and unwarranted barriers to medical care.

The process of documenting eligibility and compliance is likely to create barriers to accessing or maintaining coverage for patients. Battling administrative red tape in order to keep coverage should not detract from a patients' focus on maintaining their or their family's health. Implementing work requirements will also necessitate new administrative processes and programs, which will require considerable state financial resources that would be far better used to provide care. For example, the application fails to specify how or how often beneficiaries will need to report their hours worked. Furthermore, programs similar to this proposal, when implemented, have not been proven to increase employment or access to care.¹¹ According to the Medicaid and CHIP Payment and Access Commission (MACPAC), any employment gains that followed TANF work requirements tended to be temporary and short-lived, with limited positive effect on income.¹² We therefore oppose this measure and strongly recommend that the state refocus its Medicaid resources on improving the health of the patients it serves, rather than imposing additional and unjustified administrative burdens with little or no proven return on investment.

⁹ Jane Perkins, "Medicaid Work Requirements: Legally Suspect," National Health Law Program, (March 2017).

¹⁰ Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

¹¹ Garfield, R, Rudowitz, R, Damico, A. Kaiser Family Foundation Issue Brief: Understanding the Intersection of Medicaid and Work. Revised December 2017. Accessed January 5, 2018 at: <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>

¹² Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF. MACPAC. October 2017. At: <https://www.macpac.gov/wp-content/uploads/2017/10/Work-as-a-Condition-of-Medicaid-Eligibility-Key-Take-Aways-from-TANF.pdf>

Citizenship and Residency Documentation Requirement

The waiver proposes to require enrollees to present two forms of identification, rather than the electronic database that is currently being used, when applying for coverage. The proposal states potential enrollees without the appropriate forms of identification will be denied coverage. This puts yet another paperwork hurdle in front of Medicaid enrollees that could jeopardize their access to care. The waiver lacks details on what forms of ID, other than a driver's license or State ID card will be valid for proving citizenship and residency.

Even getting a Driver's License or State ID card can be challenging for the low-income population. Obtaining the underlying documents, like a birth certificate, can be expensive. Conditioning healthcare on the ability to obtain paperwork does not promote the goals of the Medicaid program.

The state does not include an evaluation hypothesis to test this proposal as part of its waiver evaluation. The state needs to include a hypothesis and outline how it plans to measure the impact on access to care for individuals eligible for Medicaid as part of its application.

Asset Test

The waiver requests the authority to consider an individual's assets when determining Medicaid eligibility. Current Medicaid rules do not allow for asset tests when determining eligibility for the program. Low income households' assets typically include a home – which may be inherited – or a car.¹³ Owning a home can add to economic security and owning a car provides transportation to work and to medical appointments, and neither may be indicative of enrollees' day-to-day financial status and eligibility for Medicaid. Holding these resources against a person when they apply for Medicaid will not help people achieve upward economic mobility, health or promote the goals of the Medicaid program.

Similar to the citizenship and residency documentation requirements, there is no evaluation hypothesis to test this proposal in the waiver evaluation. Again, the state needs to include a hypothesis and outline how it plans to measure the proposal's impact on access to care in the Medicaid program as part of its application.

Impact of the Waiver and Timeline

Lastly, the association is concerned that the waiver application is not complete and that the proposed timeline would suggest that there will not be time to make changes based on public input. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. In order to meet these transparency requirements, we request that the state provide the required information to the public and reopen the comment period for an additional 30 days.

¹³ Balance Sheets of Low-Income Households: What We Know about Their Assets and Liabilities: <https://aspe.hhs.gov/execsum/balance-sheets-low-income-households-what-we-know-about-their-assets-and-liabilities>

According to the timeline the proposal will be submitted to CMS for review on June 30, 2018, one day after public comment closes. This timeline suggests that the New Hampshire does not intend to incorporate public feedback into the waiver proposal. We strongly encourage the state to review these and other public comments and take the time to alter the application accordingly or withdraw it altogether.

In closing, affordable, quality healthcare access is critically important for the Granite State and Americans across the country. If you have any additional questions, please contact me at nancy.vaughan@heart.org or 603-263-8329. We appreciate the opportunity to offer comments on this waiver request.

Sincerely,

A black rectangular redaction box covering the signature of Nancy Vaughan.

Nancy Vaughan
Director of Government Relations – New Hampshire
American Heart Association



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

TO: NH Department of Health and Human Services
Attn: Granite Advantage Section 1115(a) Demonstration Waiver
129 Pleasant Street, Concord, NH 03301
nhmedicaidcaremanagement@dhhs.nh.gov

June 28, 2018

RE: Granite Advantage Health Care Program - Section 1115(a)
Demonstration Waiver

The NH Community Behavioral Health Association, representing the state's ten community mental health centers (CMHCs), wishes to be on record with the following comments on the proposed waiver:

As a part of our existing work with consumers, the CMHCs offer supported employment services. Being engaged in the community through employment is an important part of recovery for those with mental illness; but for many, there is a need for meaningful supports. These support services help to reduce barriers to work and community engagement but are not undertaken without costs to the CMHCs. As the State embarks on the new Medicaid work requirements, we would urge that meaningful investments be made in developing and funding

supports, to help consumers meet the requirements and ensure that their Medicaid eligibility is maintained and their health conditions are improved. To this end, we would ask that as part of this new requirement, the State develop a transparent process to measure the health benefits related to the requirement. We further suggest that individuals deemed eligible per He-M 401 be exempted from the work requirement given that Evidence Based Supported Employment is a priority service currently measured under the Community Mental Health Agreement.

In addition to the need to fund supports for consumers who must meet the new community engagement requirement, the CBHA would ask that the Department of Health and Human Services make a specific finding which acknowledges that the requirement will impose additional administrative burdens on the non-profit mental health providers. We are particularly concerned that as these administrative burdens increase, access to care might be restricted, creating a negative outcome which is not consistent with the spirit of the Medicaid program.

The work requirement will create an additional administrative burden for community mental health center staff. The CMHCs already have a workforce problem, with over 9.2% of positions vacant as of the end of May. In exit interviews with staff, the issues of duplicative audit, data collection and reporting requirements imposed by the State and/or MCOs are often cited as the reason staff leave CMHCs for other employment. Having staff monitor and report on individuals' work and community engagement records will be burdensome.

We fear that the work requirement has the very real potential to jeopardize care for individuals with mental illness if they lose their Medicaid coverage. The CMHCs work hard to ensure that services for adults and children do not see unnecessary or abrupt changes and that care is provided consistently and regularly. People with mental illness will lose ground in their path to recovery if their services stop and start. Asking people struggling with mental illness to document their work by keeping track of every week's pay stubs is an onerous requirement. As was addressed above, there is a need to monitor the health impacts of this requirement, and CBHA asks that in developing a method for measuring and reporting these impacts, special care be given to those with mental illness for whom disruptions in care could be quite harmful.

Next, we are especially concerned with how the work requirements will impact continued concerns about consumer spend downs. The activity and financial reporting of this new requirement risk both the addition of burdens on the CMHCs, as well as more erratic income situations for consumers, which might make the management and financial harm to the Centers worse.

Finally, the issue of retroactive eligibility is a major concern. The waiver proposes to eliminate retroactive eligibility to "increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, with the ultimate objective of improving beneficiary health." We understand that CMS approved this waiver of retroactive eligibility for NH conditionally, contingent upon the State demonstrating that the policy change actually produced the results it was testing. But no data demonstrating this has been provided, so the request for a five year extension seems

unreasonable. We believe this provision, if approved, will lead to increased uncompensated care for CMHCs and other providers, and greater medical debt for individuals, or worse, barriers to access for medically necessary services.

In conclusion, New Hampshire's experiment with community engagement and work requirements is based on a new interpretation of the Social Security Act, which the Commissioner of the NH Department of Health and Human Services and the Centers for Medicaid and Medicare Services argue will improve health outcomes. It is necessary to ensure that this claim be measured and reported. As DHHS advances its waiver application, we would stress that the existing documentation in the waiver is not yet clear with regards to measurement and reporting and we would ask that more information be made available on this front.

Melby, Leslie

From: Kathy Staub <kathy@radnh.org>
Sent: Friday, June 29, 2018 1:33 PM
To: DHHS: nhmedicaidcaremanagement
Subject: Medicaid Expansion work requirements will not improve the program

Rights and Democracy NH
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June 28, 2018

Work requirements will not improve health care access or outcomes

New Hampshire's Medicaid Expansion program has been a great success since it was implemented in 2014. The program has provided access to health care to more than 100,000 New Hampshire residents since the program began.

Currently there are 50,000 people who are enrolled in the program. Most of them (65%) are employed in low wage or part-time jobs that don't offer health insurance or pay enough to access health insurance on the ACA marketplace. The rest are between jobs, caring for young children or other family members, or too ill to work. The Medicaid Expansion program has proven to be a transitional program for most enrollees, only a very small percentage of people have been on the program for the entire time it has been available.

The federal 1115 waiver program is designed to allow states to test innovative approaches to providing services that will improve outcomes for recipients. Work requirements are not innovative. They have been tried repeatedly over the last several decades. A [comprehensive review of data from work requirements](#) associated with TANF by the Center on Budget and Policy Priorities indicates that it is not likely that implementing work requirements will move people out of poverty or eliminate their need for health coverage. On that basis the request for a waiver to add work requirements as a condition of receiving Medicaid Expansion coverage is in conflict with the intent of the 1115 waiver.

In fact, imposing work requirements for people who need Medicaid Expansion to gain access to health care will likely cause many people to lose coverage and increase levels of uncompensated care.

New Hampshire's proposed 100 hour per month work requirement would be the most onerous in the country. The Center on Budget and Policy Priorities [looked at the proposed 80 hour per month work requirement about to be enacted in Kentucky](#) and determined that *46 percent* of low-income workers who could be affected by Medicaid work requirements would be at risk of losing coverage for one or more months under a work requirement policy like Kentucky's.

New Hampshire has many people who work in low wage or seasonal jobs. People in the hospitality industry, logging, farming, and construction jobs experience gaps in employment and many have irregular hours. While enrollees who fail to reach the 100 hour threshold for one month are allowed to make it up the next month, failing to reach the 100 hour threshold in two consecutive months would mean loss of coverage. Many workers have no control over their schedule and are at the mercy of their employers. A 2 or 3 week period of unemployment or curtailed hours spanning two months could make someone ineligible.

Similarly a brief illness, like a cold or the flu; a family crisis; or a broken down vehicle could prevent someone from working enough hours in a two month period and they would lose their coverage.

In addition, some enrollees who are actually meeting Medicaid work requirements will likely lose coverage because they get tripped up by the paperwork required to prove it. An [analysis](#) by Kaiser Family Foundation found that 41% of adults on Medicaid don't use email. What is the plan for reporting? How cumbersome will it be for people without access to computers or the internet?

The impact that implementing these work requirements will have on rural parts of the state is of particular concern. [Economic recovery after the recession](#) has been more robust in some areas of the state than others. Finding employment opportunities in rural and northern sections of the state may be difficult due to the decline in jobs and lack of transportation and child care.

A [study by the Boston University School of Public Health](#) found that Medicaid Expansion particularly improved health care access and treatment in rural areas. If significant numbers of people in those areas lose coverage due to the work requirement, the stability of Community Health Centers in rural areas may suffer. This will impact access to health care for everyone in the area.

New Hampshire is an aging state. We have the second highest median age in the country. Many people who are on Medicaid Expansion have medical conditions that do not meet the threshold for disability. People in their 50s and 60s [are much more likely than younger people](#) to have serious, chronic health conditions, including heart disease, diabetes, or back pain; these conditions are even more common among lower-income older people. Finding employment opportunities for people with these challenges will be difficult and taking away their coverage can be costly. For people with serious health needs, coverage interruptions lead to increased emergency room visits and hospitalizations, admissions to mental health facilities, and health care costs, [research](#) has shown.

The Medicaid Expansion program in New Hampshire has worked very well. Adding a work requirement is unlikely to improve it and will probably undermine its success by taking away coverage and access to health care for people who need it and will benefit from it. It will not make New Hampshire a healthier state.

Submitted by,
Kathy Staub
Health care organizer
Rights and Democracy.

--

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She/her/hers

The revolution continues.

APPENDIX D

New Hampshire Health Protection Program (NHHPP) Interim Evaluation Report (March 2018)



State of New Hampshire
Department of Health and Human Services

Premium Assistance Program (PAP)

Evaluation Plan Implementation

Interim Evaluation Report

March 2018

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) approved the New Hampshire Health Protection Program (NHHPP) Premium Assistance Program (PAP) for a 3-year demonstration in 2015 with service coverage beginning on January 1, 2016. The PAP is a Medicaid waiver program that provides premium assistance to Medicaid members to purchase insurance on the New Hampshire health insurance marketplace (the Marketplace) through a Qualified Health Plan (QHP). Premiums are paid directly to the QHP by New Hampshire Medicaid. Prior to the PAP, NHHPP members in the PAP received insurance through a Bridge program from Medicaid Managed Care Organizations (MCOs).

This Interim Evaluation Report is required by CMS as part of the waiver's terms and conditions and evaluates the first full year of the PAP, calendar year (CY) 2016. After the conclusion of the Demonstration period of the PAP a Final Evaluation Report will include an analysis of the full 3-year demonstration period. The Final Report is expected to be complete by December 31, 2019. The New Hampshire Department of Health and Human Services (DHHS) has contracted with the external vendor Health Services Advisory Group, Inc. (HSAG) and their subcontractor, Milliman, to conduct the evaluation and produce the CMS required reports.

Summary of the Goals of the Demonstration

The New Hampshire Demonstration goals are centered on the following domains:

- Continuity of coverage,
- Plan variety,
- Cost-effective coverage,
- Uniform provider access, and
- Cost neutrality.

Fourteen research hypotheses were selected to evaluate the achievement of the waiver goals and compare results for members in the PAP population with beneficiaries who received Medicaid Managed Care (MMC). Each hypothesis was evaluated through a set of process and outcome measures collected throughout the demonstration period.

Key Findings

The PAP fully met the Continuity of Coverage, Cost-Effective Coverage, and Uniform Provider Access waiver goals during CY 2016. The Plan Variety waiver goal was partially met, and the Cost Neutrality waiver goal was not met during CY 2016.¹ Table 1 below provides details of the results.

Continuity of Coverage

The Demonstration allowed for continuity of health plans and provider networks for individuals whose income fluctuated.

¹ The term "cost neutrality" used herein does not refer to the formal Budget Neutrality test required under the Section 1115 Waiver Demonstration program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved. See the Cost Neutrality section below for additional information.

Plan Variety

The Demonstration has encouraged MMC carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, but only one of the two MMC carriers has offered a QHP.

Cost-Effective Coverage

The Demonstration increased QHP enrollment and resulted in increased competition among QHPs, although no evidence was available to test the existence of economies of scale.

Uniform Provider Access

The premium assistance population largely had comparable access to primary, specialty, and behavioral health care services to what had been provided by the Bridge program. Data was not available to compare provider access with the general New Hampshire population.

While the goal was met, the results of the hypothesis associated with this goal suggest that the QHPs are struggling to accommodate the higher rates of chemical dependency among the Medicaid population.

Cost Neutrality

Based on the analysis conducted by Milliman, the PAP does not meet the waiver goal of cost neutrality. The term “cost neutrality” used herein does not refer to the formal Budget Neutrality test required under the Section 1115 Waiver Demonstration program, but is based on a hypothetical continuation of the Bridge program.²

Conclusion

The analysis of the New Hampshire PAP has demonstrated that the public marketplace approach can achieve health outcomes at least as good as traditional MMC; however, the analysis has not validated that the same quality of care can be achieved at an equal or lower cost.

Table 1: Summary of Continuity of Coverage Hypotheses Results

Continuity of Coverage Waiver Goal: For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.		
Hypothesis	Hypothesis Description	Supported by Analysis
1	Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage than non-PAP members enrolled in Medicaid.	Yes
2	Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.	Yes
Plan Variety Waiver Goal: The Demonstration could also encourage Managed Care Management (MCM) carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek MMC contracts.		
Hypothesis	Hypothesis Description	Supported by Analysis
3	Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.	Yes

² The CMS approved budget neutrality target for 2016 is \$701.53 per member per month (PMPM). The actual PAP cost under both approaches described in the rest of this report is below the \$701.53 PMPM target.

4	The Demonstration could lead to an increase in plan variety by encouraging MMC carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek MMC contracts.	Partially
Cost-Effective Coverage Waiver Goal: The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.		
Hypothesis	Hypothesis Description	Supported by Analysis
5	Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.	Yes
6	Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department (ED) and hospital admissions.	Yes
7	Implementation of the program will result in more Medicaid plans deciding to enter the New Hampshire health insurance marketplace.	Yes
Uniform Provider Access Waiver Goal: The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.		
Hypothesis	Hypothesis Description	Supported by Analysis
8	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.	Yes
9	Premium assistance beneficiaries will have equal or better access to preventive care services.	Yes
10	Premium assistance beneficiaries will report equal or better satisfaction in the care provided.	Yes
11	Premium assistance beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.	No
12	Premium assistance beneficiaries will have appropriate access to Non-Emergency Medical Transportation (NEMT).	Yes
13	Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.	Yes
Cost Neutrality Waiver Goal: The premium assistance program will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.		
Hypothesis	Hypothesis Description	Supported by Analysis
14	The premium assistance program will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.	No

1. Purpose of the Interim Evaluation Report

This Interim Evaluation Report assesses the Premium Assistance Program (PAP) waiver demonstration after its first full year of implementation. The report presents the results of selected process and outcome measures, as well as an evaluation of the costs and cost-effectiveness of the program during 2016. Health Services Advisory Group, Inc. (HSAG) provides an in-depth analysis of the progress, results, conclusions, and policy implications of the PAP to date.

2. Background

States are provided an opportunity to design and test their own methods for providing and funding health care services that meet the objectives of the federal Medicaid and Children's Health Insurance Programs (CHIP) through the Section 1115 demonstrations and waiver authorities set out in Section 1915 of the Social Security Act. The Centers for Medicare & Medicaid Services (CMS) has designed a national evaluation strategy to compare the approaches used by different states in its Section 1115 Medicaid expansion waivers, requiring that each demonstration meet the program objectives of increasing and strengthening coverage for low-income individuals, increasing access to providers, improving health outcomes, or increasing the efficiency and quality of care, while maintaining budget neutrality.

The Premium Assistance Program (PAP) is one element of the State of New Hampshire's approach to the expansion of Medicaid made available to the states through the Affordable Care Act (ACA); this element must be evaluated in the context of the fundamental changes taking place as the nation adjusted to the mandate that individuals obtain health insurance and the creation of the state health insurance marketplace exchanges. A critical factor in the New Hampshire legislature's decision to accept the Medicaid expansion was the PAP's incorporation of the private sector and traditional market principals in its approach.

New Hampshire designed a "Bridge" program that enrolled the newly insured adults in the Medicaid Managed Care Organizations (MCOs) from December 2013 through December 2015. New Hampshire's Medicaid Managed Care (MMC) program began operating with three providers, or MCOs, including New Hampshire Healthy Families and Well Sense, which both continue to provide MMC services today.²⁻¹ The PAP waiver application was developed in 2014 over several months, with input from stakeholders and was designed to move the non-medically frail population from managed care into the private health insurance marketplace beginning January 2016.

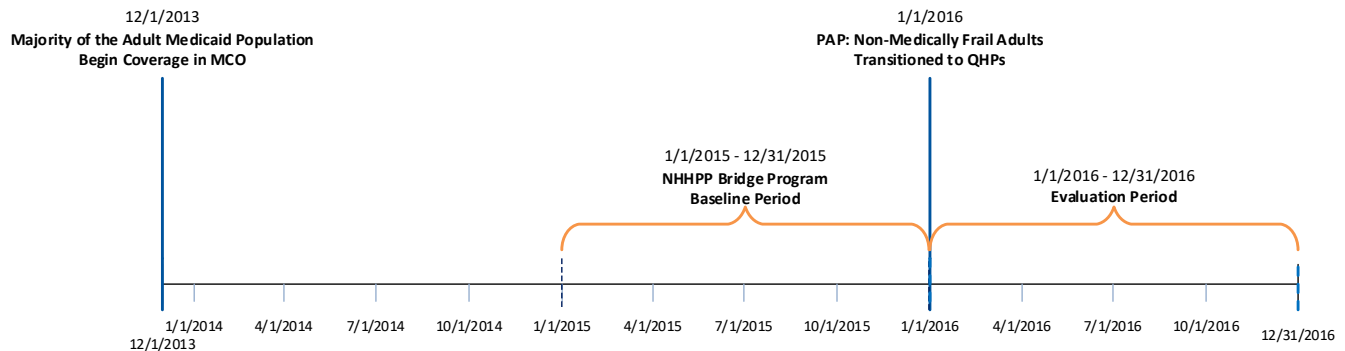
Overview of PAP

As mentioned in the Executive Summary, CMS approved New Hampshire's application for a 3-year Section 1115 demonstration project for the New Hampshire Health Protection Program (NHHP) Premium Assistance Demonstration (the PAP) in March 2015, effective January 1, 2016. The PAP automatically enrolled individuals in the new adult group covered by the expansion in one of the state's Qualified Health Plans (QHPs) approved to sell insurance on the state's exchange. New Hampshire used premium assistance to support the purchase of health insurance coverage for the Medicaid expansion population from the QHPs offered on the individual health care marketplace created pursuant to the ACA. Most New Hampshire residents who gained eligibility for health insurance through the state's decision to expand Medicaid coverage under the ACA began receiving Medicaid benefits through the PAP on January 1, 2016.

Milestones in the progression from the Bridge program to the period evaluated for this report are illustrated in Figure 2-1.

²⁻¹ The third MCO, Meridian, elected to leave the program in approximately August 2014.

Figure 2-1: Milestones from Bridge to PAP



Demonstration Description

The purpose of the New Hampshire PAP was to provide mandatory health insurance to the new adult expansion population through the QHPs, which would further continuity of coverage for individuals as they transitioned from different sources of coverage, or into coverage for the first time. The state hypothesized that the program would perform an important service by integrating low-income, usually uninsured New Hampshire residents into the health insurance system. At the same time, by enabling an estimated 45,000 persons to purchase health insurance on the New Hampshire health insurance marketplace (the Marketplace), the program would foster a stronger and more competitive individual insurance market, possibly attracting new or additional carriers, while providing continuity of care and access to care for the Bridge population.²⁻²

More specifically, the PAP was designed to support the purchase of health insurance coverage on the commercial market for beneficiaries eligible for the expansion of benefits, aged 19 through 64 years of age with incomes up to 133 percent of the Federal Poverty Level (FPL) who were neither enrolled in nor eligible for Medicare, did not identify as medically frail, and were not incarcerated or eligible for cost-effective employer sponsored insurance. Members who met the criteria were presented with a choice of qualified health plans in the Marketplace and received financial assistance to defray payment of premiums, via sums paid directly to the QHP on their behalf.²⁻³ Once determined eligible and enrolled, the individual would be covered for a year absent a change in circumstances, with annual redetermination of eligibility by the state.

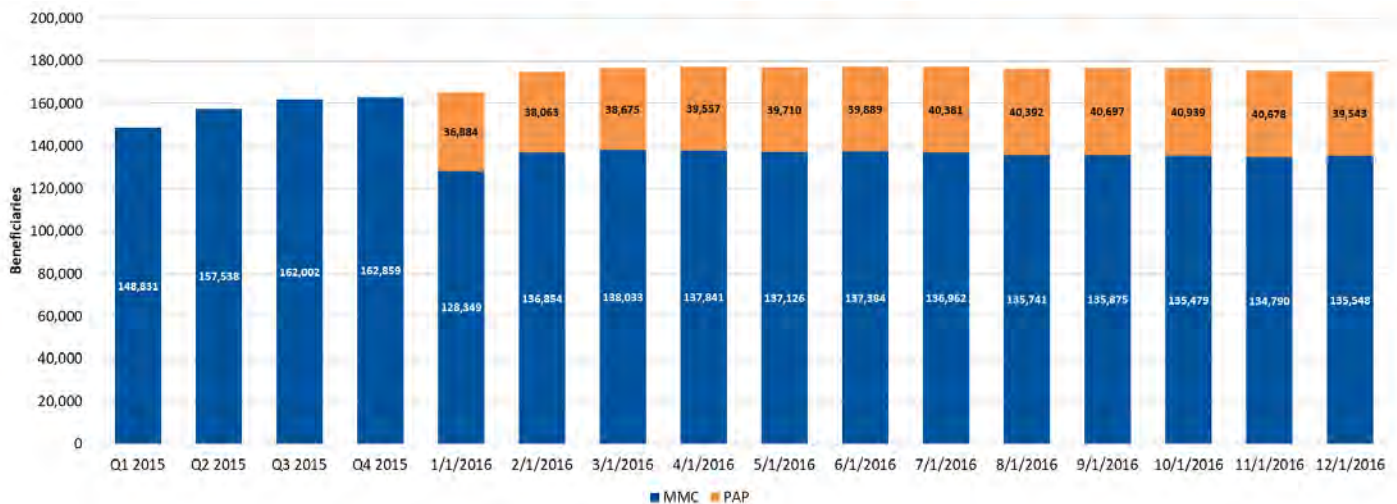
Members in the Bridge population who qualified for the PAP would continue automatically with their MCO if it elected to create a QHP offering on the Marketplace; otherwise, members were automatically assigned at random to one of the QHPs with the right to choose a different plan if they so desired. New members seeking Medicaid in 2016 who were qualified for the PAP were required to enroll in a QHP unless they were medically frail, or fit within other specific exceptions or opt out provisions.

Figure 2-2 illustrates the changes in enrollment in the MCOs and the PAP/QHPs from 2015 through 2016.

²⁻² Submission of Waiver Application by Governor of New Hampshire, November 20, 2014. Available at: <https://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf>. Accessed on October 27, 2017.

²⁻³ Members who did not choose a QHP were automatically assigned to one of the QHPs operating on the Marketplace.

Figure 2-2: Combined MCO and PAP Enrollment 2016



Source: New Hampshire Department of Health and Human Services, Medicaid Services, Quarterly Reports.²⁻⁴

CMS' approval of the Section 1115 waiver application was contingent on annual review and reauthorization of the PAP by the New Hampshire legislature.

Program Goals and Strategies and Relation to Cost Neutrality

The core strategies of the PAP demonstration, like the Medicaid program in general, have been chosen to work together to improve patient health and reduce health care costs. Continuity of care recognizes the importance of maintaining a usual primary source of care in order to coordinate preventive care and screening as well as to prevent or lessen the worsening of health conditions. Nationwide, one of the major concerns about the newly insured population covered by the Medicaid expansion was that coverage and care would be interrupted frequently due to changes in eligibility as work status or schedules changed from month to month. The PAP aimed to smooth out this fluctuation by paying premiums directly on behalf of eligible members, and re-determining eligibility annually. It was believed that this would result in a healthier population with lower health care costs.

At the same time, directing the newly insured population into the private sector to the extent possible meant an increase of 45,000 individuals eligible to purchase insurance on the Marketplace. It was believed that this pool of customers would attract insurers to offer plans who might not otherwise have been willing to go through the process of obtaining approval to sell health insurance on the relatively small health insurance exchange in New Hampshire compared to many other states. The New Hampshire legislature's strong belief in the ability of private enterprise to settle on the most competitive and efficient products would naturally bring down costs and limit government involvement in the health care system. At the same time, the right to choose among plans preserved the individuals' right to direct their own care, honoring the importance of patient-centered decisions in health care.

It was hypothesized that a significant portion of the newly covered Medicaid population would be relatively healthy, employable, and able to thrive without the need for intensively managed MMC that was provided by the MCOs. People who needed this level of care could still opt out by self-identifying as medically frail, but the rest of the population could be responsible for its own health care decisions and navigation of the health care system.

²⁻⁴ Available for download through CMS website at <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=29927>. Accessed on November 9, 2017.

3. Evaluation Design

The following section describes Health Services Advisory Group, Inc.'s (HSAG's) approach to assessing the impact of the Premium Assistance Program (PAP).

Research Questions and Hypotheses

Fourteen research hypotheses were identified to guide the evaluation of the program consistent with the broad goals of the waiver approved by the Centers for Medicare & Medicaid Services (CMS). These hypotheses are presented here with the waiver program goals they were designed to evaluate.

Continuity of Coverage

CMS required that waiver projects demonstrate continuity of coverage for beneficiaries that was at least as good as that provided to Medicaid beneficiaries nationwide. Specifically, for New Hampshire's PAP evaluation, the research hypotheses were:

- Hypothesis 1—PAP beneficiaries will have equal or fewer gaps in insurance coverage.
- Hypothesis 2—PAP beneficiaries will maintain continuous access to the same health plans and provider networks.

Plan Variety

CMS required that Medicaid beneficiaries be offered a choice in the insurance plan, networks, and providers that would provide their health care. For New Hampshire's PAP evaluation, the research hypotheses were:

- Hypothesis 3—PAP beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
- Hypothesis 4—The Demonstration leads to an increase in plan variety by encouraging Medicaid Managed Care (MMC) carriers to offer Qualified Health Plans (QHPs) in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek MMC contracts.

Cost-Effective Coverage

CMS required that attention be paid to the value of waiver programs, and cost-effectiveness of plans offered by the states should be at least as good as that seen in the general Medicaid population. For New Hampshire's PAP evaluation, the research hypotheses were:

- Hypothesis 5—PAP beneficiaries will have equal or lower non-emergent use of emergency room services.
- Hypothesis 6—PAP beneficiaries will have equal or lower rates of potentially preventable emergency department (ED) and hospital admissions.
- Hypothesis 7—Implementation of the program will result in more Medicaid plans deciding to enter the New Hampshire health insurance marketplace.

Uniform Provider Access

CMS required that provider access offered by the states in waiver demonstrations be at least as good as that seen in the general Medicaid population. For New Hampshire's PAP evaluation, the relevant research hypotheses were:

- Hypothesis 8—PAP beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
- Hypothesis 9—PAP beneficiaries will have equal or better access to preventive care services.
- Hypothesis 10—PAP beneficiaries will report equal or better satisfaction in the care provided.
- Hypothesis 11—PAP beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.
- Hypothesis 12—PAP beneficiaries will have appropriate access to non-emergency transportation.
- Hypothesis 13—Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.

Cost Neutrality

For New Hampshire's PAP evaluation, the research hypothesis regarding cost neutrality was:

- Hypothesis 14—The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with Special Terms and Conditions (STC) #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.

Study Design

HSAG employed multiple data sets and methodologies—including both qualitative and quantitative analyses—to understand more fully the impact of the PAP. HSAG and New Hampshire Department of Health and Human Services (DHHS) selected a portfolio of measures that captured health outcomes, expenditures, consumer satisfaction, and access to insurance and health care.³⁻¹ HSAG collected, reviewed, prepared, and analyzed data from a variety of sources, calculated measure performance based on the agreed-upon specifications, and performed statistical analyses to estimate the performance of the New Hampshire Health Protection Program (NHHPP) PAP relative to the hypotheses described above. Measure results and costs expended were compared to matched control groups for some measures, and/or to baseline periods prior to initiation of the PAP where appropriate. Trends over time were examined using difference-in-differences analyses where possible.

A difference-in-differences approach is a widely used method that aids in isolating the effect of a particular program or policy on measurable outcomes.³⁻² At its core, a difference-in-differences analysis consists of two groups—one being an intervention or treatment group (i.e., the PAP population) and the other being a comparison group who is similar to the treatment group, but did not receive the treatment—and two time periods—one before the intervention (i.e., baseline period) and the other after the intervention began (i.e., evaluation period). Outcomes for both groups are measured over both time periods. The change in the outcome between the baseline

³⁻¹ As mentioned, a detailed table of measure specifications is provided in Appendix B.

³⁻² See, for example, Imbens/Woodridge. Difference-in-Differences Estimation. Lecture Notes 10, Summer 2007. Available at: http://www.nber.org/WNE/lect_10_diffindiffs.pdf. Accessed on: December 7, 2017.

period and the evaluation for the comparison group is subtracted from the change in the outcome between the two time periods for the treatment group. The result is an estimated effect of the program controlling for changes due to other causes over time as represented by the change in the comparison group. A more detailed description of the methodology used can be found in Appendix A.

Impacted Populations and Stakeholders

Stakeholders included the PAP beneficiaries who were directly impacted by the program and Medicaid beneficiaries who were not eligible for the PAP. Other stakeholders included the Medicaid Managed Care Organizations (MCOs) and QHPs who provided health insurance in New Hampshire, their provider networks, and other members. New Hampshire policy makers, the DHHS, and the Department of Insurance all maintained a high level of engagement in the process of oversight and annual reauthorizations of the demonstration program. CMS and the United States taxpayers had significant interest in the outcome of the project, as did the population of New Hampshire.

Data Sources and Measures

Data sources used in this evaluation included administrative claims and encounter data for both PAP and Medicaid MCO members, secondary data (e.g., non-emergency transportation authorization data), survey data (Healthcare Effectiveness Data and Information Set [HEDIS[®]], Consumer Assessment of Healthcare Providers Systems [CAHPS[®]] survey), and qualitative data obtained during semi-structured interviews with representatives of several of the QHPs and MCOs who provided coverage for Medicaid beneficiaries in New Hampshire.^{3-3,3-4}

Administrative Measures

Most measures were calculated from administrative claims and encounter data. Sources included fee-for-service (FFS) claims extracted from DHHS's Medicaid Management Information System (MMIS), Electronic Data Interchange (EDI) transactions provided by the MCOs, and the State's Comprehensive Health Care Information System (CHIS). These three data sources were used to collect, manage, and maintain Medicaid recipient files (i.e., eligibility, enrollment, and demographics), FFS claims extract from MMIS, MCO encounter data from the EDI transactions, and CHIS. HSAG excluded voided and revised claims from the analysis based on information provided by the State indicating that these claims do not represent services rendered to or received by members. HSAG entered appropriate data use agreements and obtained access to and use of Medicaid claims and encounter data, member demographics and eligibility enrollment, and provider data. In addition, supplemental data from hospital discharge records were utilized as part of the analysis of Follow-Up After Hospitalization for Mental Illness (Measure 13-1).

³⁻³ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

³⁻⁴ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Survey Measures

A second group of measures was based on a consumer survey, CAHPS. CAHPS surveys were used to assess satisfaction with provided health care services, and were adapted to elicit information addressing the research hypotheses related to members' continuity of health care coverage and health plan market diversity. HSAG in collaboration with its subcontractor, DataStat, obtained approval from the State to supplement its annual CAHPS administration with evaluation-specific questions addressing continuity of health coverage and access to the same health plan and providers. The State cooperated in flagging whether respondents were part of the traditional managed care group (the MMCs), the NHHPP Bridge group (during the baseline period), or the NHHPP PAP (during the evaluation period).

The CAHPS survey was administered to 1,350 Medicaid MCO members and 1,350 PAP members from July 2017 to September 2017. HSAG and DataStat used a mixed mode methodology by enhancing the CAHPS mailing protocol and conducting computer assisted telephone interviewing (CATI) to maximize response rates. Upon the closing of the CAHPS survey, the overall response rate was 24.34 percent with approximately 21.19 percent being PAP respondents and 27.54 percent being Medicaid MCO respondents.

Semi-Structured Interviews

Two measures were based on data obtained during a series of semi-structured interviews with representatives of most of the health insurance plans who served the Medicaid population in New Hampshire in 2016. Individuals knowledgeable about the plan perspective on continuity of enrollment and administrative costs and the impact of the PAP were identified by the plans for interview. Data were synthesized to provide a high-level survey of the operation of the PAP that will better inform future policy in this complex area.

Other Data Sources

The MCOs and health insurance carriers offering QHPs for sale on the New Hampshire health insurance marketplace (the Marketplace) were identified from state sources and confirmed through internet research.

Time Periods for Data Collection and Evaluation

The data used to calculate the non-survey measures compared measure rates and outcomes for two time periods: a baseline period and an evaluation period. The baseline period selected was the 12-month period prior to implementation of the PAP, January 1, 2015, through December 31, 2015. The evaluation period was January 1, 2016, through December 31, 2016.

The survey-based measures required a slightly different time period due to the lag between the time at which beneficiaries received services and the collection and analysis of survey data as part of the national NCQA schedule for administering the CAHPS surveys. Thus, the baseline period was identified as the results from CAHPS 2015 administration, and the evaluation period was identified as results from the CAHPS 2017 administration covering services provided during 2016.

The interviews for the interview-based measures were conducted by HSAG in October 2017. HSAG interviewed representatives of 4 of 5 QHPs who offered coverage on the Marketplace in 2016, and the two MCO providers active during that time period.

Analysis Techniques

The approach used to assess the impact of the PAP included statistical analysis of the differences in health and financial outcomes between members who were part of the PAP plan and those who were covered by Medicaid. The techniques are summarized in this section of the report, as well as the reasons for a handful of revisions to the original CMS-approved evaluation plan, and are described in detail in Appendix A.

Health Outcomes

Eligible Populations

To evaluate the health-related outcomes, two eligible populations were identified, the treatment and comparison groups as described below.

Treatment Group

The treatment group (i.e., the Bridge/PAP population) for the health outcomes measures was composed of a subset of members who were in New Hampshire Medicaid's NHHPP, and who did not identify themselves as medically frail. All childless adults between the age of 19 through 64 with incomes at or below 133 percent of the FPL, and many parents with incomes in that range, were automatically assigned to the PAP and covered by a QHP. Parents who were in a lower income group could remain in managed care rather than transition to a QHP.³⁻⁵

Since individuals were not assigned to the PAP if they were enrolled in or eligible for Medicare, were incarcerated, or were eligible for cost-effective employer sponsored health insurance, these same exclusions were applied to the treatment group.

To fairly evaluate health outcomes, the treatment group was also restricted by the length of time a member was enrolled in the PAP because brief periods of enrollment were less likely to generate substantial or sustained improvements in outcomes that could be attributed to enrollment in the PAP. Therefore, members who did not exhibit a continuous enrollment of 6 months or longer in the PAP during the evaluation period were excluded from the analysis.

Some measures used in this evaluation required additional enrollment criteria. The measure specifications contained in Appendix A describe these requirements and the type of enrollment necessary (e.g., PAP, Medicaid).

Health outcomes for the treatment group were evaluated only during the time the member was enrolled in the PAP. If the member transitioned in or out of the PAP (either leaving Medicaid entirely or transitioning to or from an MCO) but still met the 6 months continuous enrollment requirements, only claims during the member's time in the PAP were to be used to evaluate outcomes.³⁻⁶

Finally, to adequately identify health conditions and outcomes at baseline, eligible treatment group members had to have continuous enrollment during calendar year (CY) 2015 with no more than one gap of up to 45 days.

³⁻⁵ Parents between the age of 19 through 64 with incomes between 38 percent (for non-working parents) or 47 percent (for working parents) and 133 percent of the FPL were excluded from the PAP.

³⁻⁶ To the extent an outcome measure requires historical claims data (e.g., year prior to the evaluation period) or for purposes such as identification of members with relevant chronic conditions, all claims will be used to assess the historical claims.

Comparison Group

The comparison group for the health outcomes analysis was composed of adult MCO members who were never enrolled in the Bridge or PAP programs and were continuously enrolled in a single MCO for 6 months or more during the evaluation period who were sufficiently similar to the Bridge/PAP members to provide a valid comparison (see Propensity Score-Based Matching below).

Again, to adequately identify health conditions and outcomes at baseline, members of the comparison group had to demonstrate sufficient enrollment throughout the baseline period. Eligible comparison group members had to have continuous enrollment during CY 2015 with no more than one gap of up to 45 days.

Exclusions

Given that the PAP excluded certain groups of enrollees, it was necessary to exclude the same groups from the eligible comparison group. This included dual Medicare/Medicaid enrollees, members younger than 19 and older than 65, and members who self-identified as medically frail. The methodology used to identify the population to be excluded from the comparison group comparable to those who declared themselves medically frail was based on an analysis of demographic and disease characteristics, and is set out in detail in Appendix A.

Propensity Score-Based Matching

Since the evaluation sought to examine how the PAP fared compared to what would have happened if the population had remained with the MCOs, several measures required determination of expected rates for the PAP group during the evaluation period had PAP not been implemented. To do this, a non-Bridge/PAP sample with characteristics similar to the Bridge/PAP sample was identified. Propensity score-based matching is a common methodology used to select a comparison group that is statistically similar to a treatment group. Members were matched based on demographic characteristics including age, gender, race and ethnicity, plan enrollment, and relevant health condition covariates. The complete methodology is provided in detail in Appendix A.

Propensity scores were derived and used to match individuals in the Bridge/PAP and non-Bridge/PAP populations, allowing the construction of a comparison group that was similar to the treatment group (i.e., the Bridge/PAP population) without the use of randomized selection. Thus, the propensity score reduced biased results and controlled for multiple confounders. An assessment of covariate balance was conducted to evaluate how closely the matched Bridge/PAP and non-Bridge/PAP samples aligned in composition of measured demographics and health conditions. The matched comparison group was statistically equivalent to the matched PAP group across all measured demographics and health conditions as a whole. Additionally, 80 percent of the eligible Bridge/PAP population was matched to a non-Bridge/PAP comparison group member.

Statistical Testing

Once the populations were matched, a series of tests and analyses assessed the impact of the NHHPP PAP on the selected measures. The statistical test or method applied depended on the measure construct and underlying data used for measure calculation. A difference-in-differences analysis was performed on all measures for which baseline and evaluation period data were available for both the treatment and comparison groups. This analysis compared the changes in the rates or outcomes between the baseline period (CY 2015) and the evaluation period for the two populations, based on the estimation of expected rates for the matched treatment group (i.e., matched Bridge/PAP members) to be calculated by considering expected changes in costs and rates had the PAP not been implemented. The significance of differences in measure results between populations were analyzed using a regression-based *t*-test or two-proportion *z*-test, as discussed fully in Appendix A.

Financial Outcomes

Financial outcomes were evaluated using a separate methodology, an overview of which is presented below. Details of the methodology are presented in Appendix A.

Treatment Group

The treatment group (i.e., the Bridge/PAP population) was defined in the same manner as for the health outcomes measures.

Comparison Group

For the financial measures, the comparison group was composed of members who became eligible for the Bridge program from September 2014 through December 2015. The Bridge program ended on January 1, 2016, when most members were enrolled in PAP coverage and others remained in NHHPP medically frail and transitional population coverage. The comparison group excluded the medically frail members who were not eligible to enroll in PAP coverage.

For the cost-effectiveness analyses, an estimate was developed of what the comparison group would have cost the State if the Bridge program had continued past December 2015, adjusting for items such as medical cost trends, demographic differences, acuity differences, and changes to targeted Bridge program provider reimbursement levels. This process included developing hypothetical capitation rates for the Bridge program for time periods after December 2015.

Thus, the financial outcomes measures were calculated based on differences across time for essentially the same population, while the health outcome measures were generally calculated based on differences between the treatment group (PAP participants) and a separate comparison group (Medicaid MCO members) at the same point in time.

The comparison group is different from that described above for health outcomes for a number of reasons. First, the Waiver Evaluation Design Plan approved by CMS specifically required a financial comparison of the “Bridge to actual PAP costs” with the “estimated costs if the Bridge program were continued.” This methodology paralleled the methodologies employed for the initial budget neutrality calculations submitted to CMS for approval of the PAP waiver. In addition, there were practical reasons for the different approaches. Current Medicaid MCO capitation rates are calculated differently and are significantly different from those used while the Bridge program was in existence. Using current MCO capitation rates to measure costs would require significant adjustments for which little supporting data exists. The result would be less accurate cost estimates.

However, comparing health outcomes across time for the same group of clients presents significant issues in identifying PAP impacts. Health outcomes can change over time in the absence of any programmatic changes simply as individuals age and standards of care and practice evolve. When the same clients are tracked over time, it becomes difficult to distinguish the impact of the PAP from those changes that occur as a result of changes to the entire health care system and individuals aging. By using a comparison group separate from the treatment group, changes unrelated to participation in the PAP can be controlled for and the result is a more accurate evaluation of PAP estimates.

Since the financial measures will be effectively comparing the experience of the same groups of individuals over time, the comparability of the treatment and comparison groups is virtually assured. For this reason, matching methods, such as the propensity score matching method described above, are not necessary for the financial populations.

Analytical Approach—Financial Measures

Milliman used two methods to compare the *actual* medical cost experience of the Bridge program population to the *actual* medical cost experience of the PAP. These two methods allow for a comprehensive picture of the relative costs associated with the PAP population. Full details of the method are in Appendix D.

The first method compares the medical cost component from the hypothetical Bridge program capitation rate to the average medical cost component from PAP carrier premiums, cost sharing reduction (CSR) payments, deductible funding, and the cost of wraparound services for the PAP population.

For the study group, Milliman calculated the average PAP medical cost in the PAP carriers' filed premium rates as well as other documents prepared for DHHS to estimate medical costs. There are also adjustments for other medical cost components such as CSR payments, deductible funding, and the cost of wraparound services. For the comparison group, Milliman projected medical costs based on CY 2015 Bridge program encounter data adjusted for trend, demographic changes, acuity differences, etc.

The second method compares the medical cost component from the hypothetical Bridge program capitation rate to the PAP carriers' actual CY 2016 medical cost for the PAP population. It is important to note that this approach does not represent a true measure of cost neutrality since the actual PAP claims do not represent actual DHHS expenses. Milliman provided this comparison because DHHS specifically requested a comparison using the "actual experience of the PAP."

For the PAP population, Milliman used the average PAP medical cost from the 2016 New Hampshire *CHIS* database to determine the medical cost (which already reflects reduced cost sharing and deductible funding) and added the cost of wraparound services. The hypothetical Bridge program medical cost projections were developed from CY 2015 Bridge program encounter data adjusted for trend, demographic changes, acuity differences, etc.

For the study group, Milliman estimated the PAP administrative costs based on the administrative amounts included in PAP premium rate filings. For the comparison group, the administrative cost ratio from the historical Bridge program capitation rate was used as this ratio would have been used if the program had continued.

The total costs for both the study and comparison groups is the sum of the medical and administrative cost components. This results in two different total cost estimates for the study group, one for each of the approaches used to estimate medical costs.

Limitations of the Study

The limitations surrounding this evaluation center on the lack of truly comparative data for the NHHPP PAP beneficiaries for outcome variables beyond the all-payer hospital data. As a new and empirically different group of patients added to the Medicaid program, there was no pre-existing comparison group with data to assess potential programmatic differences. Every effort was made to compensate for this through analyzing encounter data, and other data sources, but there were limitations in the degree of accuracy that can be expected from that data.

Standard techniques were used to estimate and project data on costs, as discussed more fully in the appendices, but again, there is a degree of uncertainty inherent in the methodologies.

Self-selection bias. The design of the study was not randomized; all individuals who met the eligibility criteria for the PAP were automatically enrolled in the program, but had the opportunity to remain in MMC by declaring themselves medically frail. This self-determination made reconstruction of the group to be excluded from the comparison group more uncertain. The use of a matched comparison population for the comparison group

mitigated any bias caused by the lack of randomization of the study, but no method to adjust for this bias in an observational study, such as the PAP evaluation, can completely remove the effect of self-selection bias.

Confounding causes. A number of different health care settings and insurance providers within the region (hospitals, health insurers, etc.) have implemented strategies to improve patient access and quality of care which, undoubtedly, have impacted those residing in New Hampshire. These efforts may have contributed to any improvements in access or quality of care for the intervention group. Clearly, reducing readmissions and improving coordination across transitions of care are also the subjects of extensive safety and quality improvement activities, both formal and informal. Similarly, unexpected events during the evaluation period could have negatively affected the health or health care statewide, including the intervention group. The use of difference-in-differences analyses were used wherever possible to control for such confounders, both positive and negative.

4. Findings and Conclusions

The following section summarizes the measure findings and conclusions for the evaluation of New Hampshire's Premium Assistance Program (PAP). For details on the measure definitions and specifications, reference Appendix B.

The hypotheses presented in this section postulate that the PAP group performed equal to or better than the alternative (either non-PAP comparison group members or a hypothetical extended Bridge program). In addition, statistical testing is presented using one-tailed confidence levels (i.e., 1 minus the p -value) under the alternative hypothesis that the PAP group performed worse than the non-PAP comparison group. Therefore, confidence levels lower than 95 percent are generally viewed as favorable to the PAP. At this confidence level, there is insufficient statistical evidence to suggest the PAP group performed worse than the non-PAP comparison group. Conversely, with confidence levels greater than 95 percent, there is sufficient statistical evidence to suggest the PAP group performed worse than the non-PAP comparison group (Table 4-1).

Table 4-1: Confidence Level Interpretation

Confidence Level	Interpretation
Less than 95%	The PAP performed as well as or better than the non-PAP comparison group.
95% or greater	The PAP group performed worse than the non-PAP comparison group.

Summary of Key Findings and Outcomes

The findings are organized by waiver goal, hypothesis, and measure results in the following sections.

Waiver Goal: Continuity of Coverage

For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.

One of the basic tenets for design of the PAP was the belief that continuity of coverage would improve members' health and health care as well as reduce costs. Commentators expected that the newly covered Medicaid population would be likely to have high rates of "churn," or frequent changes in eligibility and coverage due to month-to-month changes in financial eligibility. The PAP provided financial assistance to purchase private coverage on the New Hampshire health insurance marketplace (the Marketplace) on behalf of PAP members, expecting a decrease in the number of times an individual might lose health insurance coverage due to changes in financial eligibility for coverage under Medicaid, leading to greater continuity of coverage for individuals and plans. Thus, for individuals whose incomes fluctuate, the goal of the Demonstration was to improve continuity of health plans and provider networks. This goal was studied through two hypotheses.

Hypothesis 1

Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage than non-PAP members enrolled in Medicaid.

This hypothesis was tested in several ways:

- The average number of gaps in Medicaid coverage per 100 members (Measure 1-1). It was predicted that if the PAP was effective to improve or maintain continuity of coverage, that PAP members would have a lower average number of gaps in Medicaid coverage per 100 members than non-PAP members.
- The percentage of eligible members with gaps in Medicaid coverage (Measure 1-2). It was predicted that if the PAP was effective to improve or maintain continuity of coverage, that the percentage of PAP members with gaps in Medicaid coverage would be equal or lower than the percentage of non-PAP members with gaps in Medicaid coverage.
- The proportion of Consumer Assessment of Healthcare Providers and Systems (CAHPS) respondents who reported that they had been without health insurance at any time during the previous 12 months (Measure 1-3). It was predicted that if the PAP was effective to improve or maintain continuity of coverage, the proportion of PAP members who responded to CAHPS surveys reporting that they had been without health insurance at any time during the previous 12 months would be lower than the proportion of non-PAP CAHPS respondents.

Results of Measure 1-1

Health Services Advisory Group, Inc. (HSAG) employed a difference-in-differences model for Measure 1-1 (Continuity in Member Health Insurance Coverage) to estimate the effect of implementation of the PAP on the average number of gaps in Medicaid coverage per 100 members during the measurement period (Table 4-2).

PAP members experienced more gaps in Medicaid coverage per 100 members than did members in the non-PAP comparison group during both the baseline and evaluation periods; however, after controlling for changes due to other causes over time, the results support Hypothesis 1. During the baseline period, the average number of gaps in coverage was 11.765 per 100 PAP members, while the average for non-PAP comparison group members was 11.272 per 100 members. During the evaluation period, the average number of gaps was 4.914 per 100 PAP members while the average per 100 members for the non-PAP comparison group was 4.022.

The change in the average gaps in Medicaid coverage per 100 PAP members between the baseline and evaluation periods was -6.851 ($4.914 - 11.765$). For the non-PAP comparison group, the change was -7.250 per 100 members ($4.022 - 11.272$) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was an increase of 0.399 gaps in Medicaid coverage ($-6.851 - (-7.250)$).

If Hypothesis 1 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with a decrease or no change in Measure 1-1. A statistical test of the hypothesis that the Measure 1-1 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 1-1 support Hypothesis 1.

Table 4-2: The Average Number of Gaps in Medicaid Coverage per 100 Members (Measure 1-1)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	11.272 <i>N</i> =22,932	4.022 <i>N</i> =23,570	0.399 (0.497)	78.88%
PAP	11.765 <i>N</i> =32,808	4.914 <i>N</i> =36,386		

Source: Eligibility and Enrollment Data

Results of Measure 1-2

HSAG employed a difference-in-differences model for Measure 1-2 (Continuity in Member Health Insurance Coverage) to estimate the effect of implementation of the PAP on the percentage of eligible members with gaps in Medicaid coverage, including Bridge and PAP coverage (Table 4-3).

A larger percentage of the PAP members experienced a gap in coverage than did members in the non-PAP comparison group in both the baseline and evaluation periods; however, after controlling for changes due to other causes over time, the results support Hypothesis 1. During the baseline period, 10.23 percent of PAP members experienced a gap in coverage, while only 6.66 percent of non-PAP comparison group members experienced a gap. During the evaluation period, the difference is much smaller. About 4.49 percent of PAP members experienced a gap while about 3.11 percent of non-PAP comparison group members experienced a gap.

The change in the percentage of PAP members experiencing a gap in coverage between the baseline and evaluation period was -5.74 (4.49 – 10.23) percentage points. Non-PAP comparison group members experienced a reduction of 3.55 percentage points (3.11 – 6.66) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 2.19 percentage points (-5.74 – (-3.55)).

If Hypothesis 1 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with a decrease or no change in Measure 1-2. A statistical test of the hypothesis that the Measure 1-2 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Given that the confidence level is less than 5 percent, statistical testing also rejects the hypothesis that the impact is equal to zero, indicating that the measure shows a statistically significant improvement. Therefore, the results for Measure 1-2 support Hypothesis 1.

Table 4-3: The Percentage of Eligible Members with Gaps in Medicaid Coverage (Measure 1-2)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	6.66% <i>N</i> =22,932	3.11% <i>N</i> =23,570	-2.19 (0.28)	<0.01%
PAP	10.23% <i>N</i> =32,808	4.49% <i>N</i> =36,386		

Source: Eligibility and Enrollment Data

Results of Measure 1-3

To address the extent to which implementation of the PAP impacted individuals being without health insurance, HSAG used a question included in its administration of the 2017 CAHPS. HSAG asked a sample populations of PAP members and non-PAP members if “in the last 12 months, were you without health insurance at any time?” Allowable responses included “Yes” and “No” (Table 4-4).

Of PAP members, 8.12 percent indicated that they were without health insurance at any time during the last 12 months. The figure was somewhat smaller for the non-PAP group members with 7.16 percent indicating that they had been without health insurance at some time during the previous 12 months.

If Hypothesis 1 is true, the percent of PAP members who answered “Yes” to the survey question in Measure 1-3 (Patient Perspective on Continuity in Health Insurance Coverage) should be less than or equal to the percent of non-PAP members who answered “Yes.” A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 1-3 support Hypothesis 1.

Table 4-4: In the Last 12 Months, Were You Without Health Insurance at Any Time? (Measure 1-3)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	No	Yes			
Non-PAP	92.84% N=324	7.16% N=25	100% N=349	0.446 (0.021)	67.20%
PAP	91.88% N=249	8.12% N=22	100% N=271		

Source: 2017 CAHPS

Summary and Conclusions for Hypothesis 1

The results of the measures related to Hypothesis 1 all support the hypothesis (Table 4-5).

While more PAP members experienced gaps in coverage than did non-PAP members, the implementation of the PAP was associated with a decrease in the number of gaps that was large enough to compensate for the reduction in the comparison group during the same period. In effect, this suggests that a reduction in the number of gaps experienced by PAP members was less than or equal to what would have occurred even in the absence of the PAP.

The results of Measure 1-2 show that not only have the number of gaps been reduced during the implementation of the PAP, but also the number of members experiencing a gap in coverage. The reduction is sufficient, in a statistical sense, to indicate that the reduction experienced by PAP member was greater than what would have been experienced in the absence of the PAP.

The survey results in Measure 1-3 indicate that more PAP members were without insurance in the 12 months prior to the survey. While the raw figures do not support the hypothesis of a reduction in PAP members experiencing a gap in coverage, the difference is not of sufficient magnitude as to allow rejection of the hypothesis that a smaller percentage of the PAP population reported an equal or fewer number of gaps in coverage as did the non-PAP. Thus, the statistical testing suggests that Measure 1-3 supports Hypothesis 1, albeit weakly, when the raw scores are considered in isolation.

Taken together, the results from measures presented in this section suggest that premium assistance beneficiaries did have equal or fewer gaps in insurance coverage than non-PAP members enrolled in Medicaid.

Table 4-5: Hypothesis 1 Results

Measure ID	Measure Description	Supports Hypothesis 1
1-1	Average Number of Gaps in Medicaid Coverage per 100 Members	Yes
1-2	Percentage of Eligible Members with Gaps in Medicaid Coverage	Yes
1-3	In the Last 12 Months, Were You Without Health Insurance at Any Time?	Yes

Hypothesis 2⁴⁻¹

Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.

It was hypothesized that the financial assistance provided to PAP beneficiaries would permit them to maintain continuous access to, and enrollment in, the same health plan. The rationale for this hypothesis was that premium assistance for a large population of members would invite Managed Care Organizations (MCOs) to offer Qualified Health Plans (QHPs) and vice versa, allowing PAP members (adults) to have the same plan and providers as their children or other family members enrolled in Medicaid. The provision that PAP members received the premium assistance from enrollment until determined by the state to be ineligible was also expected to smooth out “churn” and keep beneficiaries from being dropped and reinstated with their QHP frequently.

Research questions proposed to test this hypothesis measured the following:

- The percentage of members who maintained continuous enrollment in one Medicaid MCO during the measurement year (Measure 2-1). It was predicted that if the PAP was effective, the percentage of members who maintained continuous enrollment in one MCO during the measurement year would be greater among PAP members than non-PAP members.
- The proportion of CAHPS respondents who reported that they had switched health plans in the prior six months (Measure 2-2). It was predicted that if the PAP was effective to improve or maintain continuity of coverage, the proportion of PAP members who responded to CAHPS surveys reporting that they had switched health plans in the prior 6 months would be lower than the proportion of non-PAP CAHPS respondents.
- The proportion of CAHPS respondents who reported that they had been able to get appointments for checkups and routine care as soon as needed (Measure 2-3). It was predicted that if the PAP was effective to improve or maintain continuity of coverage, the proportion of CAHPS respondents who were PAP members who reported that they had been able to get appointments for checkups and routine care as soon as needed would be higher than the proportion of non-PAP CAHPS respondents.
- The percentage of members who transitioned from New Hampshire Healthy Families Medicaid coverage to Ambetter QHP, and vice versa (Measure 2-4). It was assumed that when a member transitioned from a Medicaid plan to a QHP, both the Medicaid plan and QHP would incur costs in processing that member’s enrollment. However, Ambetter QHP is a subsidiary of New Hampshire Healthy Families and, therefore, its members should reduce administrative costs for the plan upon transition. This could encourage other health plans to offer both a Medicaid plan and a QHP. Measure 2-4 evaluates, of the members who transitioned out of New Hampshire Healthy Families, the percentage who went to Ambetter, and vice versa. If the PAP was successful in encouraging dual plan offerings, more members would transition within the same parent plan than to a different plan.

⁴⁻¹ As of result of changes to the evaluation plan, there is no Measure 2-3.

Results of Measure 2-1

HSAG employed a difference-in-differences model for Measure 2-1 (Continuous Access to the Same Health Plan) to estimate the effect of implementation of the PAP on the percentage of members with continuous access to the same health plan (Table 4-6).

Fewer PAP members had continuous access to the same health plan than did members in the non-PAP comparison group in the baseline period. During the baseline period, 84.67 percent of PAP members had access to the same health plan, and 86.90 percent of non-PAP comparison group members had continuous access. During the evaluation period, however, a smaller percentage of PAP members had access to the same health plan while the non-PAP comparison group remained steady. Specifically, 80.35 percent of PAP members had continuous access to the same plan while about 92.07 percent of non-PAP comparison group members had similar access.

The change in the percentage of PAP members experiencing a gap in coverage between the baseline and evaluation period was -4.32 (80.35 – 84.67) percentage points. Non-PAP comparison group members experienced an increase of 5.17 percentage points (92.07 – 86.90) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 9.49 percentage points (-4.32 – 5.17).

If Hypothesis 2 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 2-1. A statistical test of the hypothesis that the Measure 2-1 PAP impact is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for Measure 2-1 do not support Hypothesis 2.

Table 4-6: The Percentage of Members with Continuous Access to the Same Health Plan (Measure 2-1)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	86.90% <i>N</i> =19,407	92.07% <i>N</i> =23,570	-9.49 (0.43)	>99.99%
PAP	84.67% <i>N</i> =26,398	80.35% <i>N</i> =36,386		

Source: Eligibility and Enrollment Data

Results of Measure 2-2

To estimate the effect of the PAP on members' access to the same health care plan during the previous six months, HSAG conducted an analysis on a question included in its administration of the 2017 CAHPS. Samples of both the PAP and non-PAP populations were asked "In the last six months, did you switch to a different health care plan?". Allowable responses were "Yes" and "No" (Table 4-7).

Of PAP members, 4.64 percent reported they had switched to a different health care plan during the past 6 months. Only 2.87 percent of non-PAP members reported switching plans during the last 6 months.

If Hypothesis 2 is true, the percent of PAP members who answered "Yes" to the survey question in Measure 2-2 (Patient Perspective on Continuity in Same Plan Coverage) should be less than or equal to the percent of non-PAP members who answered "Yes." A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 2-2 support Hypothesis 2.

Table 4-7: In the Last Six Months, Did You Switch to a Different Health Care Plan? (Measure 2-2)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	No	Yes			
Non-PAP	97.13% N=339	2.87% N=10	100% N=349	1.180 (0.015)	88.11%
PAP	95.36% N=267	4.64% N=13	100% N=280		

Results of Measure 2-4

To measure continuity of same health plan coverage, HSAG evaluated two groups of members who made plan transitions, Measure 2-4 (Continuous Care During Marketplace Transition). First, HSAG identified all New Hampshire Healthy Families members who transitioned to a Medicaid QHP and measured the percentage of those who transitioned to Ambetter QHP. Second, HSAG identified all Ambetter QHP members who transitioned to a Medicaid MCO and measured the percentage of those who transitioned to New Hampshire Healthy Families.

Out of members transitioning out of New Hampshire Healthy Families into the PAP during CY 2016, a total of 18,052 had been members of New Hampshire Healthy Families.⁴⁻² Of these former New Hampshire Healthy Families members, 17,526, or 97.09 percent, gained coverage with Ambetter QHP. During calendar year (CY) 2016, there were 1,463 members who transitioned out of Ambetter QHP into a Medicaid MCO. Of these, 975, or 66.64 percent, gained coverage with New Hampshire Healthy Families.

The percentage of members who gained same-plan coverage moving from a Medicaid MCO to the PAP is substantially greater than the percentage of members with same-plan coverage moving from the PAP to a Medicaid MCO (Table 4-8).

Table 4-8: Continuous Care During Marketplace Transition (Measure 2-4)

Measure	Number Meeting Criteria	Eligible Population	Percentage Meeting Criteria
1) Number of New Hampshire Healthy Families members who gained coverage under Ambetter	17,526	18,052	97.09%
2) Number of Ambetter members who gained coverage under New Hampshire Families	975	1,463	66.64%

Summary and Conclusions for Hypothesis 2

The measures associated with Hypothesis 2 are mixed in their support of the hypothesis (Table 4-9).

Measure 2-1 indicates that with the implementation of the PAP, there was a decrease in the number of members with continuous access to the same plan that there would have been in the absence of the PAP. Measure 2-2 results show that more PAP members indicated they had switched to a different health plan in the six months prior to the survey than did non-PAP members. However, statistical testing is unable to reject the hypothesis that the number for PAP members is greater than or equal to the number for non-PAP members. The impact of the results of Measure 2-4 are less clear in their support for Hypothesis 2. Nearly all members who left New Hampshire Healthy Families received their PAP coverage from Ambetter. In this regard, the evidence strongly supports Hypothesis 2. However, only about two thirds of Ambetter members who transitioned from the PAP into

⁴⁻² Including those who transitioned out of Medicaid on December 31, 2015, and into the PAP on January 1, 2016.

Medicaid moved into New Hampshire Healthy Families. In this aspect of the measure, the evidence does provide weak support for Hypothesis 2.

Based on these results it appears that premium assistance beneficiaries did maintain continuous access to the same health plans, and did maintain continuous access to providers

Table 4-9: Hypothesis 2 Results

Measure ID	Measure Description	Supports Hypothesis 2
2-1	Percentage of Members with Continuous Access to the Same Health Plan	No
2-2	In the Last Six Months, Did You Switch to a Different Health Care Plan?	Yes
2-4	Continuous Care During Marketplace Transition	Yes

Summary and Conclusion for Waiver Goal: Continuity of Coverage

Hypotheses 1 and 2 are part of evaluating the extent to which the PAP has achieved the waiver goal of Continuity of Coverage. Hypothesis 1 is supported by the analysis of two its three measures. Hypothesis 2 is also supported by two of its three measures. Based on this evidence, it appears that for individuals whose incomes fluctuate, the Demonstration did permit continuity of health plans and provider networks.

Waiver Goal: Plan Variety

The Demonstration could also encourage Medicaid Care Management (MCM) carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid Managed Care (MMC) contracts.

Another major underpinning of the PAP design was the belief that the Demonstration's infusion of an estimated 50,000 beneficiaries into the Marketplace would encourage both MCOs and QHPs to offer more plans on the Marketplace. The goal was assessed through Hypothesis 3.

Hypothesis 3

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

The measures selected to test this hypothesis examined differences in continuity of plan enrollment and administrative costs between MCOs and QHPs. The measures were:

- The average number of gaps in enrollment from any MCO or PAP QHP per 100 enrollee years (Measure 3-1).
- The percentage of eligible members with continuous access to any Medicaid MCO or PAP health plan during the measurement period (continuous enrollment for 6 months or more in one plan) (Measure 3-2).
- The proportion of CAHPS respondents who reported that their personal doctor seemed informed and up-to-date about the care they had gotten from their doctors or other health providers (Measure 3-3).
- The perspective of the individual MCO and QHP plans on administrative costs, and whether implementation of PAP reduced those costs and/or the proportion of members changing plans (Measure 3-4a).
- The extent to which the implementation of the PAP reduced the number/percent of members changing plans (Measure 3-4b).

Results of Measure 3-1

HSAG employed a difference-in-differences model for Measure 3-1 (Continuity in Plan Enrollment) to estimate the effect of implementation of the PAP on the average number of gaps in enrollment in any MCO or PAP QHP per 100 enrollee years (Table 4-10).

PAP members experienced a greater number of gaps in enrollment than did members in the non-PAP comparison group in both the baseline and evaluation periods; however, after controlling for changes due to other causes over time, the results still support Hypothesis 3. During the baseline period, PAP members experienced an average of 18.911 gaps in coverage per 100 enrollee years, while non-PAP comparison group members experienced an average of 14.891. During the evaluation period, the average number of gaps per 100 enrollee years for PAP members was 11.796 percent while the average number of gaps for non-PAP comparison group members was 8.443.

The change in the average number of gaps in enrollment in any MCO or PAP QHP per 100 enrollee years between the baseline and evaluation period was -7.115 (11.796 – 18.911). Non-PAP comparison group members experienced a reduction of 6.448 (8.443 – 14.891) in the average during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 0.667 (-7.115 – (-6.448)) in the average number of gaps per 100 enrollee years. The sharp reduction in the average number of gaps for the non-PAP population is likely the result of the implementation of a passive enrollment policy through which members meeting specified criteria have fewer eligibility re-certifications.

If Hypothesis 3 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with a decrease or no change in Measure 3-1. A statistical test of the hypothesis that the Measure 3-1 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 3-1 support Hypothesis 3.

Table 4-10: The Average Number of Gaps in Enrollment in Any MCO or PAP QHP per 100 Enrollee Years (Measure 3-1)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	14.891 <i>N=19,407</i>	8.443 <i>N=23,570</i>	-0.667 (0.527)	10.28%
PAP	18.911 <i>N=26,398</i>	11.796 <i>N=36,386</i>		

Source: Eligibility and Enrollment Data

Results of Measure 3-2

HSAG employed a difference-in-differences model for Measure 3-2 (Continuity in Plan Enrollment) to estimate the effect of implementation of the PAP on the percentage of eligible members with continuous access to any Medicaid MCO or PAP health plan during the measurement period (Table 4-11).

The percentage of PAP members continuously enrolled in an MCO was smaller than the percentage of non-PAP members continuously enrolled in an MCO during the baseline period, at 85.60 percent and 88.19 percent, respectively. In the evaluation period, these figures increased for both groups to 88.95 percent of PAP members with continuous access to a PAP health plan and 92.69 percent of non-PAP members with continuous access to a Medicaid MCO. The change in the percentage of PAP members with continuous coverage was 3.35 (88.95 –

85.60) percentage points between the baseline and the evaluation period. Non-PAP comparison group members experienced an increase of 4.50 percentage points (92.69 – 88.19) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 1.16 percentage points (-3.35 – (4.50) plus rounding error).

If Hypothesis 3 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 3-2. A statistical test of the hypothesis that the Measure 3-2 PAP impact is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for Measure 3-2 do not support Hypothesis 3.

Table 4-11: The Percentage of Eligible Members with Continuous Access to Any Medicaid MCO or PAP Health Plan (Measure 3-2)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	88.19% <i>N</i> =19,407	92.69% <i>N</i> =23,570	-1.16 (0.40)	99.83%
PAP	85.60% <i>N</i> =26,398	88.95% <i>N</i> =36,386		

Source: Eligibility and Enrollment Data

Results of Measure 3-3

To measure the extent to which the PAP affected members’ personal doctors seemed informed and up-to-date about the care members received from other doctors or health providers, HSAG analyzed a question included in its administration of the 2017 CAHPS. Samples of both PAP and non-PAP members were asked “In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?”. Allowable responses included “never,” “sometimes,” “usually,” and “always” (Table 4-12).

Of PAP members, 83.52 percent indicated that in the last 6 months, their personal doctor usually or always seemed informed and up-to-date about the care they had received from other doctors and health providers. For non-PAP members, the percentage reporting the same for their personal doctors was 80.31 percent.

If Hypothesis 3 is true, the percent of PAP members who answered “usually” or “always” to the survey question in Measure 3-3 (Patient Perspective on Continuity of Care) should be greater than or equal to the percent of non-PAP members with similar answers. A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 3-3 support Hypothesis 3.

Table 4-12: In the Last 6 Months, How Often Did Your Personal Doctor Seem Informed and Up-To-Date About the Care You Got from These [Other] Doctors or Other Health Providers? (Measure 3-3)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	Never + Sometimes	Usually + Always			
Non-PAP	19.69% <i>N</i> =25	80.31% <i>N</i> =102	100% <i>N</i> =127	0.602 (0.053)	27.35%
PAP	16.48% <i>N</i> =15	83.52% <i>N</i> =76	100% <i>N</i> =91		

Source: 2017 CAHPS

Results of Measure 3-4

To what extent did members changing plans increase your administrative costs?

In the semi-structured interviews, HSAG found that each plan's ability to observe the PAP's impact on continuity of care and administrative costs (Measure 3-4) was limited by its specific experience prior to and during the PAP. Only one plan actually had experience with the Medicaid expansion population in New Hampshire both prior to and during the PAP, offering an MMC throughout, and adding a PAP plan. That insurer reported a high rate of retention of its MMC population in its PAP offering, and felt that the increased continuity with each member provided important opportunities to intervene and assist members with issues. While it acknowledged higher administrative costs for members in the PAP population, it felt that the cost of items such as additional new member packets, outreach, or welcoming phone calls were outweighed by the savings in medical costs achieved by the opportunity for long-term management of the population provided by the PAP.

The other plans could not directly compare administrative costs or the rate of members dropping, adding, or changing plans before and after the PAP; those offering QHPs on the Marketplace had not served the Medicaid population in New Hampshire prior to PAP and had no point of reference. The other MMC provider did not add a commercial offering under the PAP.

The plans identified several features of the PAP that they felt contributed more to their costs than administrative costs. These included the extra costs driven by claims and utilization; the need to build up infrastructure to accommodate the population that needed more care coordination; the training of call center and case management staff experienced with commercial products in the needs of the population; and in the details of handling enrollment, finances, member services, and the internet portal required by Department of Health and Human Services (DHHS). There were also additional costs of monitoring and reporting on elements of performance for the PAP population that were not required for other commercial plans. All agreed that the cost savings they stood to achieve from better management of claims and care were far greater than any administrative cost savings.

Savings on administrative costs did not appear to have been viewed by the carriers as the major driver of the economic success or failure of their experience with PAP.

To what extent did implementation of PAP reduce the number or percentage of members changing plans?

There was no consensus on how to define "churn" or what constituted a "normal" rate of churn before or after implementation of the PAP. When asked whether the PAP had reduced the number or percentage of members changing plans, or churn, the plans' responses ranged from "churn did not affect a significant percentage of the population," to "churn among PAP members was significant, and consistent over time." One plan mentioned that roughly 9 percent of its PAP members experienced at least one break in coverage and then returned. Another plan estimated that the average enrollment for PAP members was 6 months, compared to 9 months for non-PAP commercially insured members.

Only one plan could actually comment from experience on whether implementation of the PAP reduced churn, and it appeared that the PAP worked as intended in that most of that carrier's Bridge population was retained and covered in its QHP after the PAP was introduced.

In summary, the carriers did not have a standardized definition of administrative costs, or a normal or acceptable level of churn, making comparisons difficult. Most of the carriers lacked pre- and post- experience with the PAP population, and could not comment on how administrative costs or the rate of churn changed as a result of the PAP. There was a consensus that however administrative costs were defined, they were not a major factor in the economic viability of covering the population, lagging far behind other factors that contributed to costs such as claims, care management, and the unique requirements of the PAP. There was also broad support for the

proposition that continuity of care is crucial to better outcomes for this population and, ultimately, to the most cost-effective care.

Summary and Conclusions for Hypothesis 3

The majority of measures associated with Hypothesis 3 generally support the hypothesis (Table 4-13).

The results for Measure 3-1 showed a decrease in the number of enrollment gaps per 100 member months after controlling for changes over time external to the PAP. Although the results for Measure 3-2 showed a reduction in the percentage of eligible members with continuous access to any Medicaid MCO or PAP plan, the statistical hypothesis that there was no change resulting from the PAP could not be rejected. The results for Measure 3-3 showed evidence that a greater percentage of PAP members thought their personal doctor was usually or always informed about the care they received from other providers. The results of Measure 3-4a pertaining to the extent to which members changing plans increased administrative costs, were largely inconclusive due to the fact that most plans did not have the sufficient information to address the question. The results of Measure 3-4b regarding the extent to which the PAP reduced members changing plans weakly supported Hypothesis 3. Only one plan had the data to address the question, but the response was that the PAP had reduced the number of members changing plans.

Based on these results, it appears that premium assistance beneficiaries, including those who become eligible for Marketplace coverage, did have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.

Table 4-13: Hypothesis 3 Results

Measure ID	Measure Description	Supports Hypothesis 3
3-1	Average Number of Gaps in Enrollment in Any MCO or PAP QHP per 100 Enrollee Years	Yes
3-2	Percentage of Eligible Members with Continuous Access to Any Medicaid MCO or PAP Health Plan	No
3-3	In the Last 6 Months, How Often Did Your Personal Doctor Seem Informed and Up-To-Date About the Care You Got from These [Other] Doctors or Other Health Providers?	Yes
3-4a	To what extent did members changing plans increase your administrative costs?	No
3-4b	To what extent did implementation of PAP reduce the number or percentage of members changing plans?	Yes

Hypothesis 4

The Demonstration leads to an increase in plan variety by encouraging MMC carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek MMC contracts.

HSAG tested this hypothesis through direct research and qualitative interviews with the MCOs and QHPs active in New Hampshire during 2016.

- The number of MMC carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter (Measure 4-1).

- The number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO plans at the start of the waiver and annually thereafter (Measure 4-2).

Results of Measure 4-1

The New Hampshire DHHS website identified two insurers offering MMC plans at the beginning of the waiver and throughout 2016, Measure 4-1 (MMC Carriers Offering QHPs in the Marketplace). In the semi-structured interviews with the plans conducted for Measure 3-4, HSAG learned that one MMC specifically attributed its decision to create a commercial product for offer on the exchange to the presence of the PAP. The other MMC decided not to offer a QHP for reasons unrelated to the PAP.

Results of Measure 4-2

The quarterly reports published by the New Hampshire Department of Health and Human Services, Medicaid Services indicated that five insurers (Ambetter, Anthem, Community Health Options, Harvard Pilgrim Health Care, and Minuteman Health) offered QHPs on the Marketplace at the beginning of the waiver, Measure 4-2 (QHPs in the Marketplace Offering Medicaid MCO Plans). None of the commercial carriers added an MMC plan during 2016.

Summary and Conclusions for Hypothesis 4

The results of the measures associated with Hypothesis 4 are mixed in their support for the hypothesis (Table 4-14). The desk audit results of Measure 4-1 for the first year of the waiver provides little information on the extent to which the PAP encouraged health plans to pursue new market opportunities. However, during the plan interviews, one plan indicated that the PAP was a major factor in their decision to pursue new market opportunities. Although this evidence is strictly not part of Measure 4-1, the evidence is compelling enough to warrant its inclusion with the measure and its consequent support of Hypothesis 4. The results of Measure 4-2 are largely inconclusive, providing no evidence for or against Hypothesis 4. While Measure 4-2 presents an important picture of the status of the MCO and PAP markets, a single year of the measure does not provide enough history to support or refute Hypothesis 4. Subsequent analyses with additional years may provide more conclusive evidence.

Based on these results it appears that the Demonstration did lead to an increase in plan variety by encouraging MMC carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, but did not encourage QHP carriers to seek MMC contracts.

Table 4-14: Hypothesis 4 Results

Measure ID	Measure Description	Supports Hypothesis 4
4-1	Desk audit for the number of MMC carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter for which dual participation could be an option	Yes
4-2	Desk audit for the number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO Plans at the start of the waiver and annually thereafter	No

Summary and Conclusion for Waiver Goal: Plan Variety

Hypotheses 3 and 4 are a part of evaluating the extent to which the PAP met the waiver goal of Plan Variety. Hypothesis 3 is supported by the results of the analysis of the measures associated with it. However, Hypothesis 4 is only partially supported by the analysis of the measures associated with it. As a result, based on the analysis of the measures described above, it appears that the Demonstration has encouraged MMC carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, but has not yet encouraged QHP carriers to seek MMC contracts.

Waiver Goal: Cost-Effective Coverage

The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.

The third goal of the Demonstration was to provide cost-effective coverage for the newly covered adult Medicaid population. Three hypotheses were developed to evaluate whether this goal was met.

Hypothesis 5

Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.

To test this hypothesis, HSAG calculated the number of ambulatory emergency department (ED) visits for conditions potentially treatable in primary care per 1,000 member months, stratified for age 19–44 years and age 45–64 years (Measure 5-1).

Results of Measure 5-1

HSAG employed a difference-in-differences model for Measure 5-1 (Ambulatory Care: ED Visits Potentially Treatable in Primary Care) to estimate the effect of implementation of the PAP on the number of ambulatory ED visits for conditions potentially treatable in primary care per 1,000 member months (Table 4-15). For a more refined perspective, the measure was analyzed for two separate age groups: 19–44 years of age and 45–64 years of age on the last day of the month the service was received.

Age 19–44 Years of Age

PAP members between 19 and 44 years of age had slightly more ED visits potentially treatable in primary care than non-PAP members in both the baseline and the evaluation periods, but after controlling for changes due to other causes over time, this measure supports Hypothesis 5. During the baseline period, there were 16.643 qualifying ambulatory ED visits per 1,000 PAP member months compared to 14.923 qualifying ambulatory ED visits per 1,000 non-PAP comparison group member months. During the evaluation period, there were 15.608 qualifying ambulatory ED visits per 1,000 PAP member months compared to 15.113 qualifying ambulatory ED visits per 1,000 non-PAP comparison group member months.

For members 19–44 years old, the change in qualifying ambulatory ED visits per 1,000 PAP member months between the baseline and evaluation period was -1.035 (15.608 – 16.643). Non-PAP comparison group members in the same age range experienced an increase of 0.190 (15.113 – 14.923) qualifying ambulatory ED visits per 1,000 member months during the same period. The estimated impact of the PAP on members in the 19–44 age group, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of -1.225 (-1.035 – 0.190) qualifying ED visits per 1,000 member months.

If Hypothesis 5 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with a decrease or no change in Measure 5-1. A statistical test of the hypothesis that the Measure 5-1 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for members 19–44 years old for Measure 5-1 support Hypothesis 5.

Age 45–64 Years of Age

PAP members 45–64 years of age had fewer ED visits potentially treatable in primary care than the non-PAP comparison group in both the baseline and evaluation periods. During the baseline period, there were 13.622 qualifying ambulatory ED visits per 1,000 PAP member months compared to 18.431 qualifying ambulatory ED visits per 1,000 non-PAP comparison group member months. During the evaluation period, there were 10.669 qualifying ambulatory ED visits per 1,000 PAP member months compared to 15.659 qualifying ambulatory ED visits per non-PAP comparison group member months.

For members 45–64 years old, the change in qualifying ambulatory ED visits per 1,000 PAP member months between the baseline and evaluation periods was -2.953 (10.669 – 13.622). Non-PAP comparison group members in the same age range experienced a decrease of 2.772 (15.659 – 18.431) qualifying ambulatory ED visits per 1,000 member months during the same period. The estimated impact of the PAP on members in the 45–64 age group, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 0.181 (-2.953 – (-2.772)) qualifying ED visits per 1,000 member months.

If Hypothesis 5 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with a decrease or no change in Measure 5-1. A statistical test of the hypothesis that the Measure 5-1 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for members 45–64 years old for Measure 5-1 support Hypothesis 5.

Table 4-15: Ambulatory Care: ED Visits Potentially Treatable in Primary Care (Per 1,000 Member Months) (Measure 5-1)

Age Category	Group	Time Period		PAP Impact (Standard Error)	Confidence Level
		Baseline	Evaluation		
19–44	Non-PAP	14.923 <i>N</i> =53,808	15.113 <i>N</i> =49,757	-1.225 (1.151)	14.37%
	PAP	16.643 <i>N</i> =51,373	15.608 <i>N</i> =61,185		
45–64	Non-PAP	18.431 <i>N</i> =24,795	15.659 <i>N</i> =24,714	-0.181 (1.644)	45.62%
	PAP	13.622 <i>N</i> =29,364	10.669 <i>N</i> =35,897		

Note: Reported sample sizes are member months.

Source: PAP encounter data, Electronic Data Interchange (EDI) transaction encounters, and Medicaid Management Information System (MMIS) FFS claims data.

Summary and Conclusions for Hypothesis 5

Hypothesis 5 is supported by the results of Measure 5-1. (Table 4-16) The PAP was associated with decreases in the number of ED visits for conditions potentially treatable in primary care for members in both the 19–44 and 45–64-year-old age groups. These decreases were in addition to the changes that would have been expected in the absence of the PAP.

Based on these results, it appears that premium assistance beneficiaries did have equal or lower non-emergent use of emergency room services.

Table 4-16: Hypothesis 5 Results

Measure ID	Measure Description	Supports Hypothesis 5
5-1a	Ambulatory Care: ED Visits Potentially Treatable in Primary Care – Members 19–44 Years Old	Yes
5-1b	Ambulatory Care: ED Visits Potentially Treatable in Primary Care – Members 45–64 Years Old	Yes

Hypothesis 6

Premium assistance beneficiaries will have equal or lower rates of potentially preventable ED and hospital admissions.

Two measures were selected to test Hypothesis 6:

- The quarterly rate of inpatient hospital utilization for ambulatory care sensitive conditions for overall AHRQ Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members (Measure 6-1).
- The quarterly rate of ED utilization for ambulatory care sensitive conditions for Overall PQI Composite per 1,000 adult Medicaid members (Measure 6-2).

Results of Measure 6-1

HSAG employed a difference-in-differences model for Measure 6-1 (Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members) to estimate the effect of implementation of the PAP on the rate of inpatient hospital utilization for ambulatory care sensitive conditions per 1,000 adult Medicaid member months (Table 4-17).

During the baseline period, PAP members had higher rates of inpatient admissions for sensitive conditions than the non-PAP comparison group. During the baseline period, PAP members had an average of 0.742 admissions per 1,000 member months while the non-PAP comparison group had 0.473 admissions per 1,000 member months. In the evaluation period, however, PAP members had lower rates. During the evaluation period, the rate of inpatient admissions for the PAP group declined by 0.114 to 0.628 per 1,000 member months, while the non-PAP comparison group increased by 0.244 to 0.717 admissions per 1,000 member months. The estimated impact of the PAP on inpatient admissions for sensitive conditions, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 0.357 (-0.114 – 0.244 plus rounding error) visits per 1,000 member months.

If Hypothesis 6 is true, the implementation of the PAP controlling for changes due to other causes over time should be associated with a decrease or no change in Measure 6-1. A statistical test of the hypothesis that the Measure 6-1 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Because the confidence level is less than 5 percent, statistical testing also rejects the hypothesis that the impact is equal to zero, indicating that the measure shows a statistically significant improvement. Therefore, the results for Measure 6-1 support Hypothesis 6.

Table 4-17: Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members (Measure 6-1)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	0.473 <i>N=84,576</i>	0.717 <i>N=78,145</i>	-0.357(0.177)	2.19%
PAP	0.742 <i>N=83,573</i>	0.628 <i>N=97,082</i>		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 6-2

HSAG employed a difference-in-differences model for Measure 6-2 (ED Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members) to estimate the effect of implementation of the PAP on the rate of ED utilization for ambulatory care sensitive conditions per 1,000 adult Medicaid member months (Table 4-18). PAP members had about the same rates of ED visits for sensitive conditions than the non-PAP comparison group in the baseline period and lower rates in the evaluation period. During the baseline period, PAP members had an average of 3.314 ED visits per 1,000 member months while the non-PAP comparison group had 3.311 ED visits per 1,000 member months. In the evaluation period, the rate of ED visits for the PAP group declined by 0.533 to 2.781 per 1,000 member months while the non-PAP comparison group increased by 0.323 to 3.634 ED visits per 1,000 member months. The estimated impact of the PAP on ED visits for sensitive conditions, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 0.857 (-0.533 – 0.323 plus rounding error) visits per 1,000 member months.

If Hypothesis 6 is true, the implementation of the PAP controlling for changes due to other causes over time should be associated with a decrease or no change in Measure 6-2. A statistical test of the hypothesis that the Measure 6-2 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Because the confidence level is less than 5 percent, statistical testing also rejects the hypothesis that the impact is equal to zero, indicating that the measure shows a statistically significant improvement. Therefore, the results for Measure 6-2 support Hypothesis 6.

Table 4-18: ED Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members (Measure 6-2)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	3.311 <i>N=84,576</i>	3.634 <i>N=78,145</i>	-0.857 (0.435)	2.45%
PAP	3.314 <i>N=83,573</i>	2.781 <i>N=97,082</i>		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Summary and Conclusions for Hypothesis 6

Both measures associated with Hypothesis 6 support the hypothesis (Table 4-19). The results of Measure 6-1 found a decrease in the rates of inpatient admissions for sensitive conditions than what would have been expected in the absence of the PAP. Similarly, Measure 6-2 found a decrease in the rates of ED visits for sensitive conditions for the PAP group than what would have been expected in the absence of the PAP.

Based on these results, premium assistance beneficiaries did have equal or lower rates of potentially preventable ED and hospital admissions.

Table 4-19: Hypothesis 6 Results

Measure ID	Measure Description	Supports Hypothesis 6
6-1	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	Yes
6-2	ED Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	Yes

Hypothesis 7

Implementation of the program will result in more Medicaid plans deciding to enter the New Hampshire health insurance marketplace.

This hypothesis was assessed through qualitative review of interview responses. Plan representatives were asked:

- Whether implementation of the PAP program influenced their decision to enter the Marketplace (Measure 7-1).

Results of Measure 7-1

In conducting the semi-structured interviews for Measure 7-1 (Plan Perspective on Program Impact on Marketplace Entry), HSAG identified the following:

MMCs: One of two MMC's active in New Hampshire prior to 2016 cited the PAP as the reason for its decision to offer a commercial product on the Marketplace. The second plan chose not to offer a commercial plan under PAP, although its stated reasons were unrelated to the PAP.

OHPs: The three remaining insurers interviewed had all developed commercial products for sale on the Marketplace in New Hampshire before the PAP was implemented; all decided to continue with their plans after the PAP was implemented, knowing that to do so they had to agree to offer coverage for the PAP population. One plan described significant reservations about offering a product under the PAP; the others were more confident that the increased numbers of beneficiaries would more than offset the increased costs and other burdens of creating an additional plan for the PAP population.

Summary and Conclusions for Hypothesis 7

Since providing a policy consistent with the PAP was a requirement to offer health insurance on the Marketplace in New Hampshire, it may have been effective in enticing five insurance companies to offer policies that would cover this population. Although not all plans were represented in the interviews, those who were had all been contemplating entering the Marketplace prior to the PAP and none changed their plans as a result. There is no way of knowing whether other insurers considering entering the Marketplace in New Hampshire were deterred by the requirement to comply with the PAP.

Consequently, the PAP succeeded in that it induced one MMC to offer a plan on the Marketplace. It had a more limited influence on the insurers who provided QHPs on the Marketplace, since their decisions to offer products on the Marketplace had been in development prior to the PAP. All were willing to comply with the PAP in order to be able to offer their QHPs on the Marketplace (Table 4-20).

Table 4-20: Hypothesis 7 Results

Measure ID	Measure Description	Supports Hypothesis 7
7-1	Whether implementation of the PAP program influenced their decision to enter the New Hampshire Marketplace	Yes

Summary and Conclusion for Waiver Goal: Cost-Effective Coverage

Hypotheses 5, 6, and 7 fall under the cost-effective waiver goal. Both Hypotheses 5 and 6 are supported by the measures under each hypothesis. Hypothesis 7 is supported in as much as one Medicaid plan entered the commercial exchange. There was insufficient data to determine if plans experience any economies of scale as a result of the implementation of the PAP. Based on the evidence, it appears that the premium assistance approach increased QHP enrollment and did result in increased competition among QHPs, although there was no evidence to support or refute the existence of economies of scale related to the PAP.

Waiver Goal: Uniform Provider Access

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

The PAP demonstration project's performance with respect to this waiver goal was assessed through five different hypotheses, with multiple measures used for each.

Hypothesis 8

Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.

Six measures were used to examine Hypothesis 8:

- The percentage of members who were identified as having persistent asthma who were dispensed appropriate medications that they remained on at least 75 percent of the treatment period (Measure 8-1).
- The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received prenatal care according to Healthcare Effectiveness and Data Information Set (HEDIS) specifications for the measure (Measure 8-2).
- The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received postpartum care according to HEDIS specifications for the measure (Measure 8-3).
- The percentages of respondent's quick access to needed care (Measure 8-4).
- The percentage of respondent's ease of getting appointments with specialists (Measure 8-5).
- The percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit, by age group (Measure 8-6).

Results of Measure 8-1

HSAG employed a difference-in-differences model for Measure 8-1 (Medication Management for People with Asthma [MMA]) to estimate the effect of implementation of the PAP on the percentage of members 19–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75 percent of their treatment period (Table 4-21).

In the baseline period, a larger percentage of PAP members identified as having persistent asthma were dispensed appropriate medication and were compliant 75 percent of the time compared to members in the non-PAP comparison group. This difference is reversed in the evaluation period. However, after controlling for changes due to other causes over time, the results still support Hypothesis 8. During the baseline period, 46.67 percent of PAP members were dispensed appropriate medications and were compliant with the treatment, while 41.54 percent of non-PAP comparison group members were compliant with treatment. During the evaluation period, 42.93 percent of PAP members were dispensed appropriate medications and were compliant with the treatment while the figure for non-PAP comparison group members was 43.57 percent.

The change in the percentage of PAP members who were dispensed appropriate medications and were compliant with the treatment between the baseline and evaluation periods was -3.74 (42.93 – 46.67) percentage points in the percentage of PAP members who were dispensed appropriate medications and were compliant with the treatment. Non-PAP comparison group members experienced an increase of 2.03 percentage points (43.57 – 41.54) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 5.76 percentage points (-3.74 – 2.03 plus rounding error).

If Hypothesis 8 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 8-1. A statistical test of the hypothesis that the Measure 8-1 PAP impact is less than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 8-1 support Hypothesis 8.

Table 4-21: Medication Management for People with Asthma (MMA) (Measure 8-1)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	41.54% N=65	43.57% N=140	-5.76 (15.30)	64.67%
PAP	46.67% N=15	42.93% N=184		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 8-2

To estimate the effect of the PAP on the percentage of women who received prenatal care prior to a delivery of a live birth between November 6, 2015, and November 5, 2016 (the measurement year), HSAG had intended to conduct a difference-in-differences analysis, Measure 8-2 (Timeliness of Prenatal Care).

However, once eligibility and analysis criteria were applied to the number of live births during the specified period, the number of births in the PAP was too small for meaningful analysis.

There were 677 deliveries in the PAP encounter data. Of these, 126 met the baseline enrollment criteria for inclusion in the analysis, 382 met the 6-month continuous eligibility requirement for inclusion in the analysis, 69 met both the baseline and the 6-month continuous eligibility requirements, and only 57 met both the baseline

enrollment and 6-month continuous eligibility requirements, had fewer than 3 months of Medicaid MCO history (to reduce confounding of Medicaid MCO and PAP impacts), and were matched in the matching algorithm. This reduction suggests pregnant women in the PAP may be systematically different from other PAP members in that they have a shorter duration of enrollment. This may be driven, in part, by the newborn being eligible for non-PAP Medicaid, thereby carrying the woman into non-PAP Medicaid. However, additional research is necessary to confirm this hypothesis.

Results of Measure 8-3

To estimate the effect of the PAP on the percentage of women who received postpartum care after delivery of a live birth between November 6, 2015, and November 5, 2016 (the measurement year), HSAG had intended to conduct a difference-in-differences analysis, Measure 8-3 (Postpartum Care).

However, once eligibility and analysis criteria were applied to the number of live births during the specified period, the number of births in the PAP was too small for meaningful analysis. See the discussion in the Results of Measure 8-2 for additional details.

Results of Measure 8-4

To assess the extent to which the PAP affected the degree to which the members are able to get care as soon as needed, when members needed care right away, HSAG conducted an analysis of a question included in its administration of the 2017 CAHPS. A sample of both the PAP and non-PAP populations were asked “In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?”. Allowable responses were “never,” “sometimes,” “usually,” and “always” (Table 4-22).

Of PAP members, 83.87 percent report that they were usually or always able to receive care as soon as it was needed in the previous 6 months, when care was needed right away. This compares to a figure of 86.93 percent for non-PAP members.

If Hypothesis 8 is true, the percent of PAP members who answered “usually” or “always” to the survey question in Measure 8-4 (Patients’ Perception of Quick Access to Needed Care) should be greater than or equal to the percent of non-PAP members with similar answers. A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 8-4 support Hypothesis 8.

Table 4-22: In the Last 6 Months, When You Needed Care Right Away, How Often Did You Get Care as Soon as You Needed? (Measure 8-4)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	Never + Sometimes	Usually + Always			
Non-PAP	13.07% N=20	86.93% N=133	100% N=153	-0.666 (0.046)	74.72%
PAP	16.13% N=15	83.87% N=78	100% N=93		

Source: 2017 CAHPS

Results of Measure 8-5

To assess the impact of the PAP on members’ ability to get an appointment with a specialist as soon as needed, HSAG analyzed a question included in its administration of the 2017 CAHPS. A sample of the populations of both PAP and non-PAP members were asked “In the last 6 months, how often did you get an appointment to see a

specialist as soon as you needed?”. Allowable responses were “never,” “sometimes,” “usually,” and “always” (Table 4-23).

Of PAP members, 87.29 reported that they were usually or always able to get an appointment with a specialist as quickly as they needed in the previous 6 months. The percentage for non-PAP members was smaller at 78.44 percent.

If Hypothesis 8 is true, the percent of PAP members who answered “usually” or “always” to the survey question in Measure 8-5 (Patients’ Perception of Ease of Getting Appointments with Specialists) should be greater than or equal to the percent of non-PAP members with similar answers. A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 8-5 support Hypothesis 8.

Table 4-23: In the Last 6 Months, How Often Did You Get an Appointment to See a Specialist as Soon as You Needed? (Measure 8-5)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	Never + Sometimes	Usually + Always			
Non-PAP	21.56% N=36	78.44% N=131	100% N=167	1.919 (0.046)	2.75%
PAP	12.71% N=15	87.29% N=103	100% N=118		

Source: 2017 CAHPS

Results of Measure 8-6

HSAG employed a difference-in-differences model for Measure 8-6 (Adults’ Access to Ambulatory/Preventive Health Services) to estimate the effect of implementation of the PAP on the percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit (Table 4-24). For a more refined look at the results, the analysis was broken up into two age groups: 20–44 and 45–64 years of age.

Members 20–44 Years of Age

A smaller percentage of PAP members 20–44 years of age had an ambulatory or preventive care visit than did members in the non-PAP comparison group in both the baseline and evaluation periods. During the baseline period, 74.86 percent of PAP members had an ambulatory or preventive care visit, while 81.33 percent of non-PAP comparison group members had an ambulatory or preventive care visit. During the evaluation period, 71.66 percent of PAP members had an ambulatory or preventive care visit while 81.66 percent of non-PAP comparison group members had an ambulatory or preventive care visit.

The change in the percentage of PAP members had an ambulatory or preventive care visit between the baseline and evaluation periods was -3.20 (71.66 – 74.86) percentage points. Non-PAP comparison group members had an increase in ambulatory or preventive care visits of 0.33 percentage points (81.66 – 81.33) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 3.52 percentage points (-3.20 – 0.33 plus rounding error).

If Hypothesis 8 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 8-6. A statistical test of the hypothesis that the Measure 8-6 PAP impact for members 20–44 years old is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for members 20–44 years old for Measure 8-6 do not support Hypothesis 8.

Members 45–64 Years of Age

Similar to members in the 20–44 years of age group, a smaller percentage of PAP members 45–64 years of age had an ambulatory or preventive care visit than did members in the non-PAP comparison group in both the baseline and evaluation periods. During the baseline period, 82.25 percent of PAP members had an ambulatory or preventive care visit, while 88.28 percent of non-PAP comparison group members had an ambulatory or preventive care visit. However, during the evaluation period, the percentage of PAP members with ambulatory or preventive care visits decreased by 1.13 to 81.12 percent while the same rate for non-PAP comparison group members increased by 1.36 to 89.64 percent.

The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 2.49 percentage points (-1.13 – 1.36).

A statistical test of the hypothesis that the Measure 8-6 PAP impact for members 45–64 years old is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for members 45–64 years old for Measure 8-6 do not support Hypothesis 8.

Table 4-24: Adults’ Access to Ambulatory Preventive Health Services (Measure 8-6)

Age Category	Group	Time Period		PAP Impact (Standard Error)	Confidence Level
		Baseline	Evaluation		
20–44	Non-PAP	81.33% N=4,419	81.66% N=3,560	-3.52 (0.013)	99.63%
	PAP	74.86% N=4,041	71.66% N=4,083		
45–64	Non-PAP	88.28% N=2,142	89.64% N=1,863	-2.49 (0.015)	95.56%
	PAP	82.25% N=2,547	81.12% N=2,633		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Summary and Conclusions for Hypothesis 8

The majority of analyzed measures associated with Hypothesis 8 support the hypothesis (Table 4-25). The results of Measure 8-1 found a slight decrease in the appropriate medication management for people with asthma than what would have been expected in the absence of the PAP. However, the decrease was small enough that the statistical hypothesis that there was no change could not be rejected. Measures 8-2 and 8-3 were not analyzed due to sample sizes that were too small for reliable results. These measures are not considered in the determination if the hypothesis is supported by the results of the analyses. Measure 8-4 results showed PAP members reporting a slightly smaller percentage usually or always being able to get care as soon as needed, but statistical testing was unable to reject the hypothesis that there was no difference between the PAP and non-PAP responses. The results of Measure 8-5 showed that a greater percentage of PAP members were usually or always able to get specialist care as soon as needed than were non-PAP members. The results for Measure 8-6 were mixed in their support for Hypothesis 8. The PAP was found to be associated with a decrease in 20–44-year-old adults’ access to ambulatory preventive health services relative to what would have happened in the absence of the PAP. A similar result was found for adults 45–64 years old.

Based on these results, it appears that premium assistance beneficiaries did have equal or better access to care, including primary care and specialty physician networks and services.

Table 4-25: Hypothesis 8 Results

Measure ID	Measure Description	Supports Hypothesis 8
8-1	Medication Management for People with Asthma	Yes
8-2	Timeliness of Prenatal Care	N/A
8-3	Postpartum Care	N/A
8-4	In the Last 6 Months, When You Needed Care Right Away, How Often Did You Get Care as Soon as You Needed?	Yes
8-5	In the Last 6 Months, How Often Did You Get an Appointment to See a Specialist as Soon as You Needed?	Yes
8-6a	Adults' Access to Ambulatory Preventive Health Services—Members 20–44 Years Old	No
8-6b	Adults' Access to Ambulatory Preventive Health Services—Members 45–64 Years Old	No

Hypothesis 9⁴⁻³

Premium assistance beneficiaries will have equal or better access to preventive care services.

Eight measures were used to examine Hypothesis 9:

- The percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit, by age group (Measure 9-1).
- Flu vaccinations for adults ages 18–64: percentage of members 18–64 years of age who received an influenza vaccination between July 1 of the measurement year and the date on which the CAHPS 5.0 survey was completed (Measure 9-3).
- The percentage of patients 19–64 years of age with type 1 or type 2 diabetes who had an eye exam (retinal exam) performed (Measure 9-4).
- The percentage of patients 19–64 years of age with type 1 or type 2 diabetes who had an eye exam HbA1c test performed (Measure 9-5).
- The percentage of members 40 years of age and older with a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis (Measure 9-6).
- The percentage of women 21–64 years of age who were screened for cervical cancer every 3 year; and women 30–64 who had a cervical cancer screening with a cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (Measure 9-7).
- Number of members who report “usually” or always” getting an appointment for a check-up or routine care at a doctor’s office or clinic as soon as they needed (Measure 9-8).

⁴⁻³ As of result of changes to the evaluation plan, there is no Measure 9-2.

- The percentage of members 19–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year (Measure 9-9).

Results of Measure 9-1

HSAG employed a difference-in-differences model for Measure 9-1 (Adults' Access to Preventive Health Services) to estimate the effect of implementation of the PAP on the percentage of eligible members, age 20 years through 64 years, who had a preventive care visit (Table 4-26). For a more refined look at the results, the analysis was broken up into two age groups: 20–44 and 45–64 years of age. This measure is similar to Measure 8-6; however, this measure looks only at preventive care visits and does not include ambulatory care services or visits.

Members 20–44 Years of Age

A larger percentage of PAP members 20–44 years of age had a preventive care visit than did members in the non-PAP comparison group in the baseline period. The difference reversed during the evaluation period and after controlling for changes due to other causes over time, the results do not support Hypothesis 9. During the baseline period, 34.72 percent of PAP members had a preventive care visit, while 32.50 percent of non-PAP comparison group members had a preventive care visit. During the evaluation period, 31.89 percent of PAP members had a preventive care visit while 32.16 percent of non-PAP comparison group members had a preventive care visit.

The change in the percentage of PAP members had a preventive care visit was -2.83 (31.89 – 34.72) percentage points. Non-PAP comparison group members experienced a decrease in preventive care visits of 0.34 (32.16 – 32.50) percentage points during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 2.50 percentage points (-2.83 – (-0.34) plus rounding error).

If Hypothesis 9 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 9-1. A statistical test of the hypothesis that the Measure 9-1 PAP impact for members 20–44 years old is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for members 20–44 years old for Measure 9-1 do not support Hypothesis 9.

Members 45–64 Years of Age

A greater percentage of PAP members 45–64 years of age had a preventive care visit than did members in the non-PAP comparison group in both the baseline and evaluation periods, and the results after controlling for changes due to other causes over time do support Hypothesis 9. During the baseline period, 44.41 percent of PAP members had a preventive care visit, while 35.43 percent of non-PAP comparison group members had a preventive care visit. During the evaluation period, 43.33 percent of PAP members had a preventive care visit while 35.48 percent of non-PAP comparison group members had a preventive care visit.

The change in the percentage of PAP members had a preventive care visit was -1.08 (43.33 – 44.41) percentage points. Non-PAP comparison group members showed a small increase in preventive care visits of 0.05 (35.48 – 35.43) percentage points during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a decrease of 1.12 (-1.08 – (0.05) plus rounding error) percentage points.

A statistical test of the hypothesis that the Measure 9-1 PAP impact for members 45–64 years old is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for members 45–64 years old for Measure 9-1 support Hypothesis 9.

Table 4-26: Adults' Access to Preventive Health Services (Measure 9-1)

Age Category	Group	Time Period		PAP Impact (Standard Error)	Confidence Level
		Baseline	Evaluation		
20–44	Non-PAP	32.50% <i>N</i> =4,419	32.16% <i>N</i> =3,560	-2.50 (0.015)	95.38%
	PAP	34.72% <i>N</i> =4,041	31.89% <i>N</i> =4,083		
45–64	Non-PAP	35.43% <i>N</i> =2,142	35.48% <i>N</i> =1,863	-1.12 (0.020)	70.71%
	PAP	44.41% <i>N</i> =2,547	43.33% <i>N</i> =2,633		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 9-3

To assess the effect the PAP has had on flu vaccinations for adults, HSAG analyzed a question included in its administration of the 2017 CAHPS. A sample of both the PAP and non-PAP populations were asked “Have you had either a flu shot or flu spray in the nose since July 1, 2016?” (Table 4-27).

Fewer PAP members reported having had either a flu shot or spray since July 1, 2016 than non-PAP members with 38.89 percent of members reporting having had a flu vaccination compared to 46.15 percent of non-PAP members.

If Hypothesis 9 is true, the percent of PAP members who answered “Yes” to the survey question in Measure 9-3 (Annual Influenza Immunization) should be greater than or equal to the percent of non-PAP members who answered “Yes” to the same question. A statistical test of that hypothesis can be rejected at the 95 percent confidence level. Thus, the results for Measure 9-3 do not support Hypothesis 9, *prima facie*. It should be noted that these results indicate that PAP members were less likely to receive a flu vaccination than members not in the PAP. One reason for this may be that PAP and non-PAP respondents differ significantly in the acuity of other health needs that comparisons between the PAP and non-PAP populations are not entirely informative.

Table 4-27: Have You Had Either a Flu Shot or Flu Spray in the Nose Since July 1, 2016? (Measure 9-3)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	No	Yes			
Non-PAP	53.85% <i>N</i> =182	46.15% <i>N</i> =156	100% <i>N</i> =338	-1.798 (0.040)	96.39%
PAP	61.11% <i>N</i> =165	38.89% <i>N</i> =105	100% <i>N</i> =270		

Source: 2017 CAHPS

Results of Measure 9-4

HSAG employed a difference-in-differences model for Measure 9-4 (Comprehensive Diabetes Care—Eye Exam) to estimate the effect of the implementation of the PAP on the percentage of patients 19–64 years of age with type 1 or type 2 diabetes who had an eye exam (retinal exam) performed (Table 4-28).

PAP members with type 1 or type 2 diabetes had higher rates of eye exams than did the non-PAP comparison group in the baseline period (57.40 percent and 55.40 percent for PAP and non-PAP, respectively). In the evaluation period, a greater percentage of non-PAP comparison group members with type 1 or type 2 diabetes had an eye exam, with 49.54 percent of PAP members with an eye exam compared to 61.59 percent for non-PAP comparison group members.

The change in the percentage of PAP members with type 1 or type 2 diabetes receiving an eye exam between the baseline and the evaluation period was -7.86 (49.54 – 57.40) percentage points. Non-PAP comparison group members experienced an increase of 6.19 (61.59 – 55.40) percentage points during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 14.04 percentage points (-7.86 – 6.19 plus rounding error).

If Hypothesis 9 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 9-4. A statistical test of the hypothesis that the Measure 9-4 PAP impact is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for Measure 9-4 do not support Hypothesis 9.

Table 4-28: The Percentage of Patients 19 to 64 Years of Age with Type 1 or Type 2 Diabetes Who Had an Eye Exam (Retinal Exam) Performed (Measure 9-4)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	55.40% <i>N</i> =361	61.59% <i>N</i> =302	-14.04 (5.16)	99.67%
PAP	57.40% <i>N</i> =392	49.54% <i>N</i> =438		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 9-5

HSAG employed a difference-in-differences model for Measure 9-5 (Comprehensive Diabetes Care—HbA1c Testing) to estimate the effect of implementation of the PAP on the percentage of patients 19–64 years of age with type 1 or type 2 diabetes who had an HbA1c test performed (Table 4-29).

A larger percentage of PAP members with type 1 and type 2 diabetes had an HbA1c test than did similar members in the non-PAP comparison group in both the baseline and evaluation periods. During the baseline period, 82.91 percent of PAP members had an HbA1c test, while only 67.31 percent of non-PAP comparison group members had an HbA1c test. During the evaluation period, about 84.70 percent of PAP members had an HbA1c test while about 69.54 percent of non-PAP comparison group members had an HbA1c test.

The change in the percentage of PAP members with type 1 or type 2 diabetes having an HbA1c test performed between the baseline and evaluation periods was 1.79 (84.70 – 82.91) percentage points. The non-PAP comparison group members experienced an increase of 2.23 percentage points (69.54 – 67.31) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by

the change in the non-PAP comparison group, was a reduction of 0.43 percentage points (1.79 – 2.23 plus rounding error).

If Hypothesis 9 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 9-5. A statistical test of the hypothesis that the Measure 9-5 PAP impact is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 9-5 support Hypothesis 9.

Table 4-29: The Percentage of Patients 19 to 64 Years of Age with Type 1 or Type 2 Diabetes Who Had an HbA1c Test Performed (Measure 9-5)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	67.31% N=361	69.54% N=302	-0.43 (4.44)	53.85%
PAP	82.91% N=392	84.70% N=438		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 9-6

HSAG employed a difference-in-differences model for Measure 9-6 (Use of Spirometry Testing in the Assessment and Diagnosis of COPD) to estimate the effect of implementation of the PAP on the percentage of members 40 years of age and older with a diagnosis of COPD, who received appropriate spirometry testing to confirm the diagnosis or for the management of COPD (Table 4-30).

A larger percentage of the PAP members received spirometry testing to confirm or manage COPD than did members in the non-PAP comparison group in both the baseline and evaluation periods. However, after controlling for changes due to other causes over time, the results do not support Hypothesis 9. During the baseline period, 35.90 percent of PAP members received spirometry testing, while 13.50 percent of non-PAP comparison group members received spirometry testing. During the evaluation period, 28.09 percent of PAP members received spirometry testing while about 24.84 percent of non-PAP comparison group members received spirometry testing.

The change in the use of spirometry testing to confirm or manage COPD between the baseline and evaluation periods among PAP members was -7.81 (28.09 – 35.90) percentage points. Non-PAP comparison group members experienced an increase of 11.34 percentage points (24.84 – 13.50) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 19.15 percentage points (-7.81 – (11.34)).

If Hypothesis 9 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 9-6. A statistical test of the hypothesis that the Measure 9-6 PAP impact is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for Measure 9-6 do not support Hypothesis 9.

Table 4-30: The Percentage of Members 40 Years of Age and Older with a Diagnosis of COPD, Who Received Appropriate Spirometry Testing to Confirm the Diagnosis or For the Management of COPD (Measure 9-6)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	13.50% <i>N=163</i>	24.84% <i>N=153</i>	-19.15 (6.74)	99.77%
PAP	35.90% <i>N=156</i>	28.09% <i>N=178</i>		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 9-7

HSAG employed a difference-in-differences model for Measure 9-7 (Cervical Cancer Screening) to estimate the effect of the implementation of the PAP on the percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: women age 21–64 who had cervical cytology performed every 3 years, or women age 30–64 who had cervical cytology/HPV co-testing performed every 5 years. (Table 4-31).

A larger percentage of the appropriately aged female PAP members were screened for cervical cancer than were appropriately aged female members in the non-PAP comparison group in both the baseline and evaluation periods, and indeed, after controlling for changes due to other causes over time, the results still support Hypothesis 9. During the baseline period, 17.74 percent of PAP members were screened for cervical cancer, while only 11.11 percent of female non-PAP comparison group members were screened. During the evaluation period, the difference is a bit larger. About 18.72 percent of female PAP members were screened for cervical cancer while about 10.40 percent of non-PAP comparison group members were screened.

The change in cervical cancer screening rates for PAP between the baseline and evaluation periods was 0.98 (18.72 – 17.74) percentage points. Non-PAP comparison group members experienced a reduction of 0.71 percentage points (10.40 – 11.11) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was an increase of 1.70 percentage points (0.98 – (-0.71) plus rounding error).

If Hypothesis 9 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 9-7. A statistical test of the hypothesis that the Measure 9-7 PAP impact is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 9-7 support Hypothesis 9.

Table 4-31: The Percentage of Women 21–64 Years of Age Who Were Screened for Cervical Cancer (Measure 9-7)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	11.11% <i>N=3,348</i>	10.40% <i>N=2,751</i>	1.70 (1.26)	8.91%
PAP	17.74% <i>N=3,112</i>	18.72% <i>N=3,152</i>		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 9-8

To estimate the impact of the PAP on members' ability to get an appointment for a check-up or routine care at a doctor's office or clinic as soon as needed, HSAG analyzed a question included in the 2017 CAHPS. A sample of members from both the PAP and non-PAP population were asked "In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?". Allowable responses were "never," "sometimes," "usually," and "always" (Table 4-32).

Among PAP members, 78.57 percent indicated that they were usually or always able to schedule an appointment for a check-up or routine care at a doctor's office or clinic as soon as needed in the last 6 months. Among non-PAP members, 80.16 percent indicated this to be the case.

If Hypothesis 9 is true, the percent of PAP members who answered "usually" or "always" to the survey question in Measure 9-8 (Timeliness of Check-Up or Routine Care Appointments) should be greater than or equal to the percent of non-PAP members who with similar answers to the same question. A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 9-8 support Hypothesis 9.

Table 4-32: In the Last 6 Months, How Often Did You Get an Appointment for a Check-Up or Routine Care at a Doctor's Office or Clinic as Soon as You Needed? (Measure 9-8)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	Never + Sometimes	Usually + Always			
Non-PAP	19.84% N=51	80.16% N=206	100% N=257	-0.396 (0.040)	65.39%
PAP	21.43% N=36	78.57% N=132	100% N=168		

Source: 2017 CAHPS

Results of Measure 9-9

HSAG employed a difference-in-differences model for Measure 9-9 (Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications) to estimate the effect of implementation of the PAP on the percentage of members 19–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year (Table 4-33).

The percentage of PAP members 19–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year, was slightly greater than the percentage of similar members in the non-PAP comparison group in both the baseline and evaluation periods. During the baseline period, 70.77 percent of qualifying PAP members had a diabetes screening test, while only 61.97 percent of non-PAP comparison group members had a diabetes screening test. During the evaluation period, 76.56 percent of PAP members had a diabetes screening test while 72.22 percent of non-PAP comparison group members had a diabetes screening test.

The change in the percentage of PAP members who had a diabetes screening test between the baseline and evaluation periods was 5.79 (76.56 – 70.77) percentage points. Non-PAP comparison group members experienced increase of 10.25 percentage points (72.22 – 61.97) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 4.46 percentage points (5.79 – 10.25).

If Hypothesis 9 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 9-9. A statistical test of the hypothesis that the Measure 9-9 PAP impact is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 9-9 support Hypothesis 9.

Table 4-33: Percentage of Members 19–64 with Schizophrenia or Bipolar Disorder, Who Were Dispensed an Antipsychotic Medication and Had a Diabetes Screening Test During the Measurement Year (Measure 9-9)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	61.97% N=142	72.22% N=126	-4.46 (9.61)	67.84%
PAP	70.77% N=65	76.56% N=64		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Summary and Conclusions for Hypothesis 9

The majority of the measures associated with Hypothesis 9 support the conclusion that Premium assistance beneficiaries had equal or better access to preventive care services (Table 4-34).

The results for Measure 9-1 found that, for members 20–44 years old, there was a decrease in access to preventive health services and statistical testing rejected the hypothesis that there was no change in access compared to what would have been expected in the absence of the PAP. For members 45–64 years old; however, access to preventive health services was found to have increased very slightly, although statistical tests could not reject the hypothesis that there was no change.

Fewer PAP members reported receiving a flu vaccination than did non-PAP members in Measure 9-3; this difference was found to be statistically significant. As noted in the results for Measure 9-3, differences in the overall health status between PAP and non-PAP members may make a direct comparison between the populations problematic. Nevertheless, the results for Measure 9-3 do not support Hypothesis 9.

The analysis results of Measure 9-4 found the PAP was associated with a decrease beyond what would have been expected in the absence of the PAP in the percentage of patients with a diabetes diagnosis who had an eye exam. This decrease was found to be statistically significant and the results for Measure 9-4 do not support Hypothesis 9.

The analysis results were better for Measure 9-5, which found a slight decrease compared to what would have been expected in the absence of the PAP in the percentage of patients with a diagnosis of diabetes who had an HbA1c test. However, this decrease was statistically indistinguishable from zero, therefore, the results for Measure 9-5 support Hypothesis 9.

The results of the analysis of Measure 9-6 found a decrease beyond what would be expected in the absence of the PAP in the percentage of qualifying patients who received appropriate spirometry testing to diagnose or manage COPD. The decrease was found to be statistically different from zero, indicating that the results of Measure 9-6 do not support Hypothesis 9.

Analysis of Measure 9-7 found a slight increase above what would have been expected in the absence of the PAP in the percentage of qualifying women who were screened for cervical cancer. Although the value was statically indistinguishable from zero, the result supports Hypothesis 9.

Fewer PAP members reported that they were usually or always able to get an appointment for routine care or check-up than were non-PAP members, as reported in Measure 9-8. However, statistical testing was unable to reject the hypothesis that the difference was zero. Thus, the results of Measure 9-8 support Hypothesis 9.

Analysis of Measure 9-9 found a slight increase beyond what would have been expected in the absence of the PAP in the percentage of members with a qualifying mental health disorder and prescription who had a diabetes screening. Although the increase was small, the result supports Hypothesis 9.

Although few measures showed an improvement as the result of the PAP, most measures showed equal access. Therefore, the analytical evidence supports the hypothesis that premium assistance beneficiaries did have equal or better access to preventive care services.

Table 4-34: Hypothesis 9 Results

Measure ID	Measure Description	Supports Hypothesis 9
9-1a	Adults' Access to Preventive Health Services—Members 20–44 Years Old	No
9-1b	Adults' Access to Preventive Health Services—Members 45–64 Years Old	Yes
9-3	Have You Had Either a Flu Shot or Flu Spray in the Nose Since July 1, 2016?	No
9-4	Percentage of Patients 19 to 64 Years of Age with Type 1 or Type 2 Diabetes Who Had an Eye Exam (Retinal Exam) Performed	No
9-5	Percentage of Patients 19 to 64 Years of Age with Type 1 or Type 2 Diabetes Who Had an HbA1c Test Performed	Yes
9-6	Percentage of Members 40 Years of Age and Older with a Diagnosis of COPD, Who Received Appropriate Spirometry Testing to Confirm the Diagnosis or For the Management of COPD	No
9-7	Percentage of Women 21–64 Years of Age Who Were Screened for Cervical Cancer	Yes
9-8	In the Last 6 Months, How Often Did You Get an Appointment for a Check-Up or Routine Care at a Doctor's Office or Clinic as Soon as You Needed?	Yes
9-9	Percentage of Members 19–64 with Schizophrenia or Bipolar Disorder, Who Were Dispensed an Antipsychotic Medication and Had a Diabetes Screening Test	Yes

Hypothesis 10

Premium assistance beneficiaries will report equal or better satisfaction in the care provided.

Two measures were used to examine Hypothesis 10:

- The percentage of respondent's rating of overall health care (Measure 10-1).
- The percentage of respondent's rating of the health plan (Measure 10-2).

Results of Measure 10-1

To estimate the effect of the PAP on how members rated the quality of health care they received, HSAG analyzed a question included in the 2017 CAHPS. Samples of both PAP and non-PAP members were asked "Using any

number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?” (Table 4-35).

Among PAP members, 75.38 percent reported receiving high-level quality of health care with a response of 8 or greater. Non-PAP members reported slightly less satisfaction with the quality of the health care received with 74.52 percent of respondents reporting a score of 8 or greater.

If Hypothesis 10 is true, the percent of PAP members who rated their health care at an 8 or greater in the survey question used for Measure 10-1 (Patients’ Rating of Overall Health Care) should be greater than or equal to the percent of non-PAP members with similar answers to the same question. A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 10-1 support Hypothesis 10.

Table 4-35: What Number Would You Use to Rate All Your Health Care in the Last 6 Months? (Measure 10-1)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	0 - 7	8 + 9 + 10			
Non-PAP	25.48% N=67	74.52% N=196	100% N=263	0.210 (0.041)	41.69%
PAP	24.62% N=48	75.38% N=147	100% N=195		

Source: 2017 CAHPS

Results of Measure 10-2

To estimate the effect of the PAP on how members rate the quality of their health plan, HSAG analyzed a question included in the 2017 CAHPS. Samples of both PAP and non-PAP members were asked “Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?” (Table 4-36).

Among PAP members, 73.88 percent reported a high level of satisfaction with their health plan (with a response of 8 or greater). Non-PAP members reported slightly greater satisfaction with the quality of their health plans with 76.16 percent of respondents reporting a score of 8 or greater.

If Hypothesis 10 is true, the percent of PAP members who rated their health plan at an 8 or greater in the survey question used for Measure 10-2 (Patients’ Rating the Health Plan) should be greater than or equal to the percent of non-PAP members with similar answers to the same question. A statistical test of that hypothesis cannot be rejected at the 95 percent confidence level. Thus, the results for Measure 10-2 support Hypothesis 10.

Table 4-36: What Number Would You Use to Rate Your Health Plan? (Measure 10-2)

Group	Response		Group Total	z-Statistic (Standard Error)	Confidence Level
	0 - 7	8 + 9 + 10			
Non-PAP	23.84% N=82	76.16% N=262	100% N=344	-0.648 (0.035)	74.16%
PAP	26.12% N=70	73.88% N=198	100% N=268		

Source: 2017 CAHPS

Summary and Conclusions for Hypothesis 10

Both measures associated with Hypothesis 10 support the hypothesis (Table 4-37).

Slightly more PAP members would rate their health care at an 8 or better compared to non-PAP members, as reported in Measure 10-1. Although the difference is not statistically different from zero, the results support Hypothesis 10. The results of Measure 10-2 show slightly fewer PAP members would rate their health plan at an 8 or better compared to non-PAP members. However, statistical tests cannot reject the hypothesis that the PAP percentage is greater than or equal to the non-PAP percentage. Therefore, the results of Measure 10-2 support Hypothesis 10.

The analysis results for the measures associated with Hypothesis 10 suggest that premium assistance beneficiaries did report equal or better satisfaction in the care provided.

Table 4-37: Hypothesis 10 Results

Measure ID	Measure Description	Supports Hypothesis 10
10-1	What Number Would You Use to Rate All Your Health Care in the Last 6 Months?	Yes
10-2	What Number Would You Use to Rate Your Health Plan?	Yes

Hypothesis 11

Premium assistance beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.

Two measures were used to examine Hypothesis 11:

- Percentage of Members Aged 19 and 20 Who Had At Least One Comprehensive Well-Care Visit (Measure 11-1).
- The Percentage of Members Aged 19 and 20 Who Received At Least One Preventive Dental Visit (Measure 11-2).

Results of Measure 11-1

HSAG employed a difference-in-differences model for Measure 11-1 (EPSDT Screening—Well Care Visits) to estimate the effect of the implementation of the PAP on the percentage of members aged 19 and 20 who had at least one comprehensive well-care visit (Table 4-38).

During the baseline period, a greater percentage of PAP members had at least one comprehensive well-care visit than did members in the non-PAP comparison group. However, in the evaluation period this relationship reversed so that a smaller percentage of PAP members had at least one comprehensive well-care visit than did members in the non-PAP comparison group. During the baseline period, 29.01 percent of PAP members had at least one comprehensive well-care visit, while only 23.26 percent of non-PAP comparison group members had a well-care visit. During the evaluation period, only 25.18 percent of PAP members had at least one comprehensive well-care visit while 30.71 percent of non-PAP comparison group members had a well-care visit.

The change in the percentage of eligible PAP members who had a well-care visit between the baseline and evaluation periods was -3.83 (25.18 – 29.01) percentage points. Non-PAP comparison group members experienced an increase of 7.45 percentage points (30.71 – 23.26) during the same period. The estimated impact

of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 11.28 percentage points (-3.83 – 7.45).

If Hypothesis 11 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 11-1. A statistical test of the hypothesis that the PAP impact is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for Measure 11-1 do not support Hypothesis 11.

Table 4-38: Percentage of Members Aged 19 and 20 Who Had At Least One Comprehensive Well-Care Visit (Measure 11-1)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	23.26% N=215	30.71% N=127	-11.28 (5.66)	97.68%
PAP	29.01% N=886	25.18% N=409		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 11-2

HSAG employed a difference-in-differences model for Measure 11-2 (EPSDT Screening – Preventive Dental Visits) to estimate the effect of implementation of the PAP on the percentage of members aged 19 and 20 who received at least one preventive dental visit (Table 4-39).

A larger percentage of PAP members aged 19 and 20 received a preventive dental screening than did members in the non-PAP comparison group in the baseline period. However, this relationship reverses in the evaluation period. During the baseline period, 33.97 percent of PAP members aged 19 and 20 had a preventive dental screening, while only 27.44 percent of similar non-PAP comparison group members had a preventive dental screening. During the evaluation period, about 26.41 percent of PAP members aged 19 and 20 had a preventive dental screening, while about 29.92 percent of similar non-PAP comparison group members had a preventive dental screening.

The change in the percentage of PAP members who had a preventive dental visit between the baseline and evaluation periods was -7.56 (26.41 – 33.97). Non-PAP comparison group members experienced an increase of 2.48 percentage points (29.92 – 27.44) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 10.05 percentage points (-7.56 – 2.48 plus rounding error).

If Hypothesis 11 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 11-2. A statistical test of the hypothesis that the PAP impact is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for Measure 11-2 do not support Hypothesis 11.

Table 4-39: The Percentage of Members Aged 19 and 20 Who Received At Least One Preventive Dental Visit (Measure 11-2)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	27.44% N=215	29.92% N=127	-10.05 (5.75)	95.96%
PAP	33.97% N=886	26.41% N=409		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Summary and Conclusions for Hypothesis 11

Neither measure associated with Hypothesis 11 supports the hypothesis (Table 4-40).

Analysis of Measure 11-1 found a decrease beyond what would be expected in the absence of the PAP in the percentage of members 19 and 20 years old who had at least one comprehensive well-care visit. Statistical testing was able to reject the hypothesis that the impact of the PAP was greater than or equal to zero. Thus, the analysis results of Measure 11-1 do not support Hypothesis 11.

Analysis results for Measure 11-2 showed a decrease beyond what would be expected in the absence of the PAP in the percentage of members 19 and 20 years old who had a preventive dental exam. Statistical testing was able to reject the hypothesis that the impact was greater than or equal to zero, indicating that the results for this measure do not support Hypothesis 11.

The results of the measures associate with Hypothesis 11 suggest that premium assistance beneficiaries who are young adults eligible for EPSDT benefits did not have at least as satisfactory and appropriate access to EPSDT benefits. This result is not surprising given the fact that the PAP plans are geared to adult members and many plans may not be aware that EPSDT benefits extend beyond 18 years of age.

Table 4-40: Hypothesis 11 Results

Measure ID	Measure Description	Supports Hypothesis 11
11-1	Percentage of Members Aged 19 and 20 Who Had At Least One Comprehensive Well-Care Visit	No
11-2	Percentage of Members Aged 19 and 20 Who Received At Least One Preventive Dental Visit	No

Hypothesis 12

Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT).

Two measures were used to examine Hypothesis 12:

- The percentage of NEMT requests authorized, of those requested during the measure data period, for the eligible population (Measure 12-1).
- The percentage of NEMT requests authorized, of those requested during the measure data period, by type of medical service (i.e., hospital, medical provider, mental health provider, dentist, pharmacy, methadone treatment, other), for the eligible population (Measure 12-2).

Results of Measure 12-1

Measure 12-1 (NEMT Request Authorization Approval Rate) assessed the percentage of NEMT requests authorized in the PAP and non-PAP Medicaid programs. The data was derived from New Hampshire Medicaid Measure NEMT.13, which collects the non-emergent transportation request authorization approval rate by mode of transportation quarterly. The authorization rate for the PAP plans was 99.88 percent; that of the MMC plans combined was 99.83 percent.

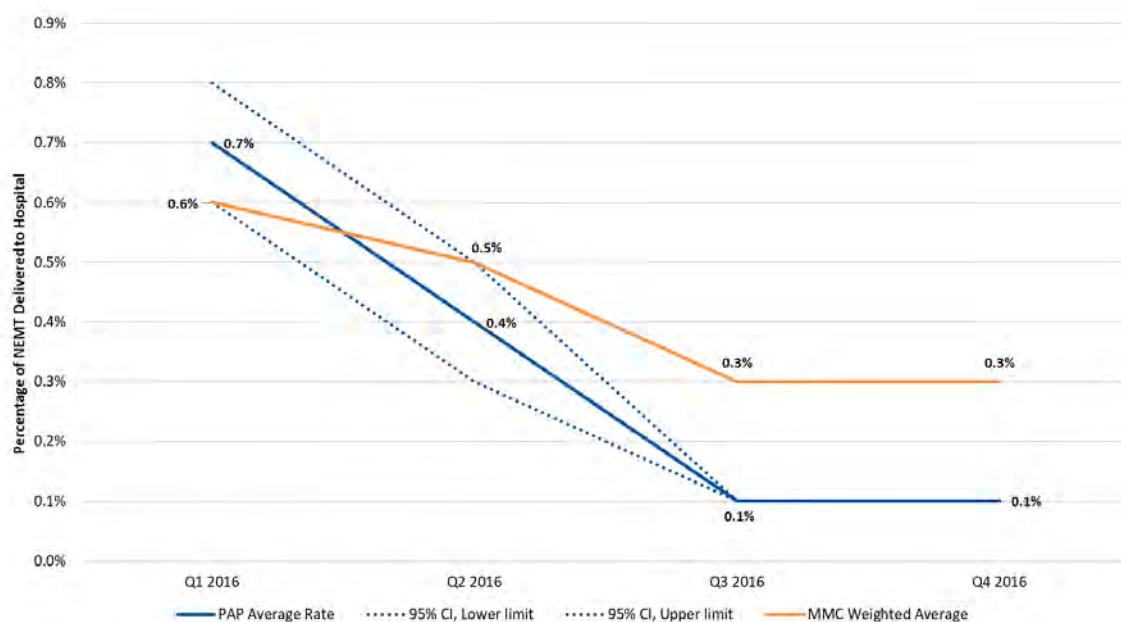
Results of Measure 12-2

Measure 12-2 (NEMT Requests Delivered by Type of Service) considered the requests for NEMT actually delivered by the type of medical service involved. The data were derived from New Hampshire Medicaid Measure NEMT.15, which looks at all requests for NEMT that were delivered by each plan by the type of provider destination.

For both PAP and MMC plans, transportation for methadone treatment constituted the majority of NEMT delivered, ranging from 65 percent to 88 percent. Transportation to medical providers and mental health providers were the second and third most frequent services for which members received transportation. The remaining categories of medical service each accounted for at or less than 1 percent of delivered NEMT. The percentages of NEMT provided to each type of provider is presented in Figure 4-1 through Figure 4-7. The figures display the average PAP rate, together with the 95 percent Confidence Intervals surrounding the rate, as well as the weighted average percentage combining the two MMC plans' averages.

The percentage of non-emergency trips transporting members to the hospital were relatively small, at less than 1 percent of overall transportation delivered for PAP and non-PAP plans, as shown in Figure 4-1. The MMC weighted average falls within, or very close to the 95 percent confidence intervals for the PAP plans, making it impossible to reject the null hypothesis that the rates are a functional equivalent for the first two quarters.

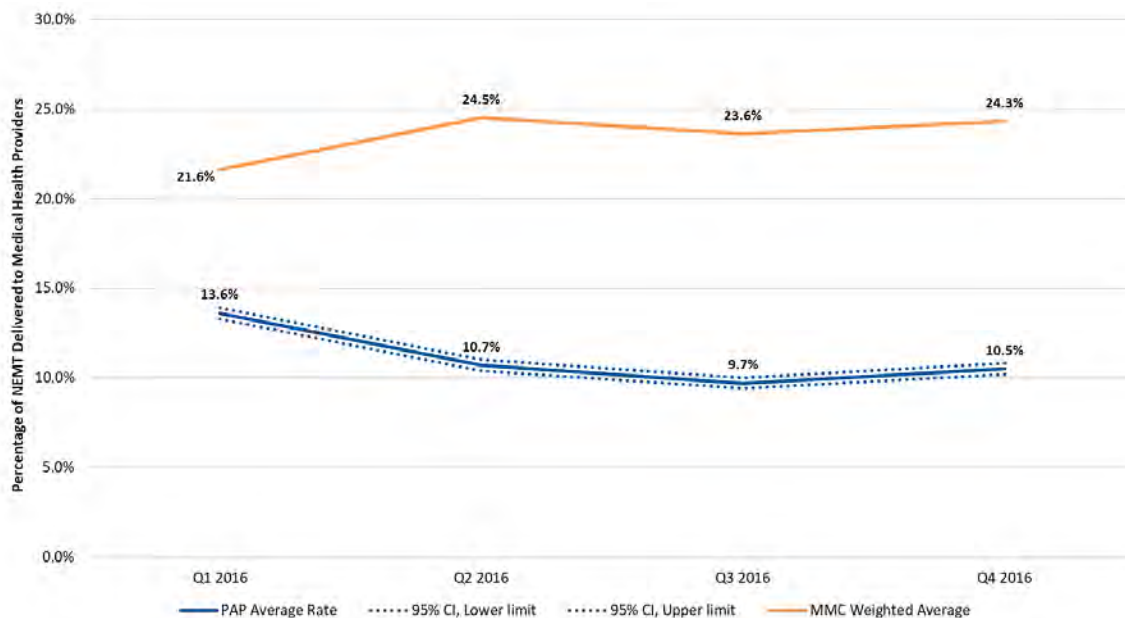
Figure 4-1: Transportation to Hospital



The percentage of non-emergency trips transporting members to visits with medical providers was much greater for PAP and MMC plans. The MMC weighted average rate for all four quarters provided were much higher than

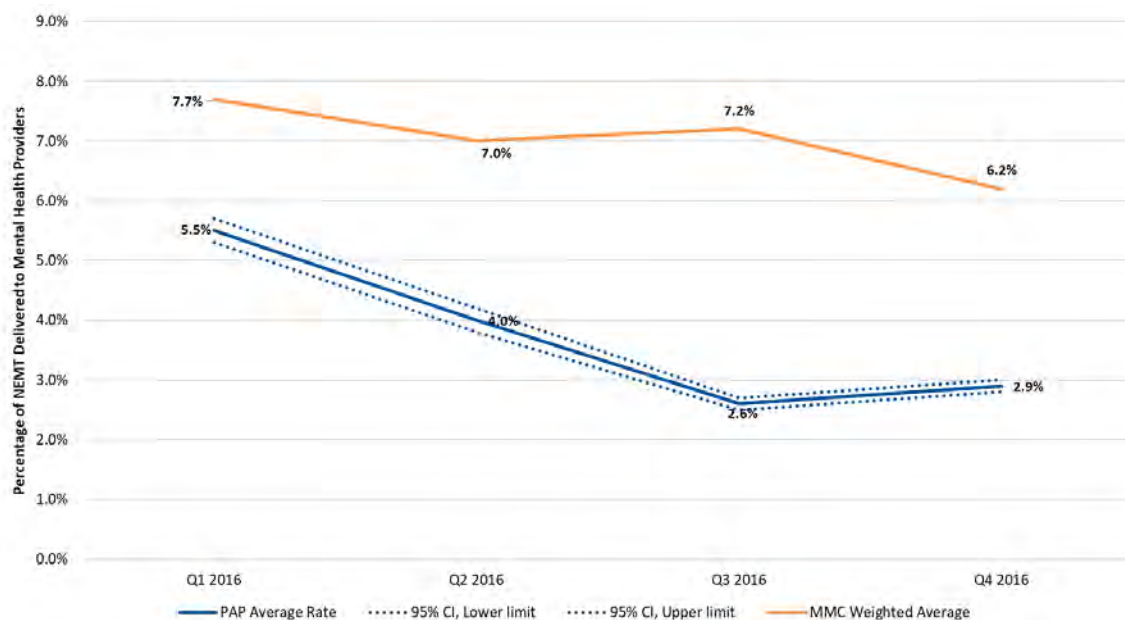
the entire 95 percent confidence interval surrounding the average PAP rates, a finding that would be consistent with the interpretation that the MMC members used a significantly greater percentage of NEMT for visits to medical providers than did PAP members. The results are presented in Figure 4-2.

Figure 4-2: Transportation to Medical Providers



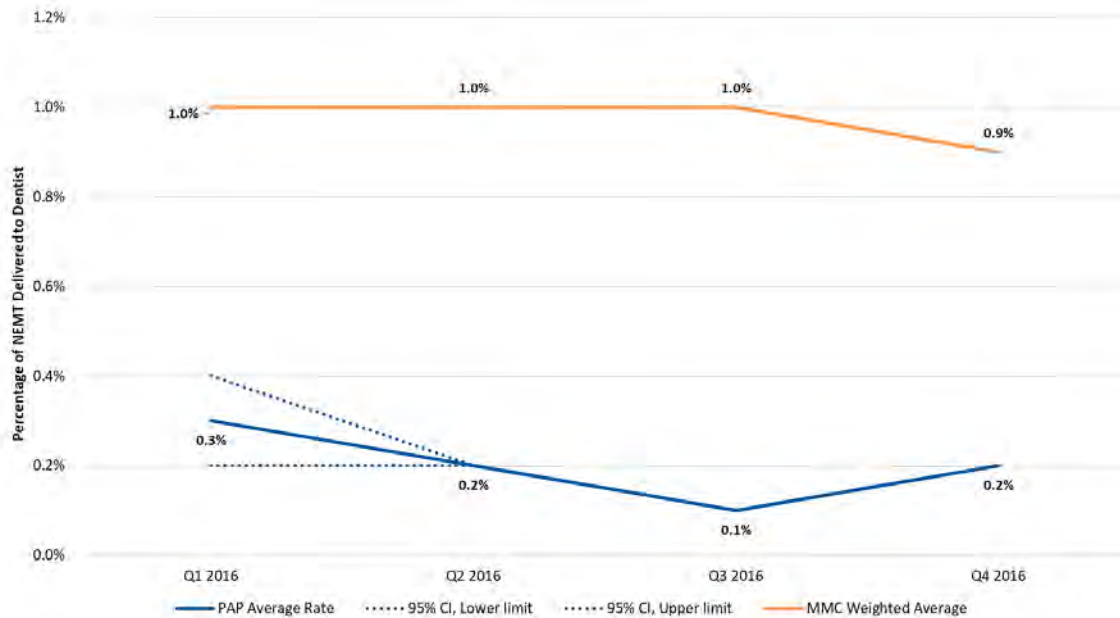
The share of NEMT delivered that was used to travel to see mental health providers was smaller than that used for other medical providers for all plans as shown in Figure 4-3. The MMC weighted average rate was significantly greater than the PAP rate, with rates that fell outside the 95 percent confidence intervals.

Figure 4-3: Transportation to Mental Health Providers



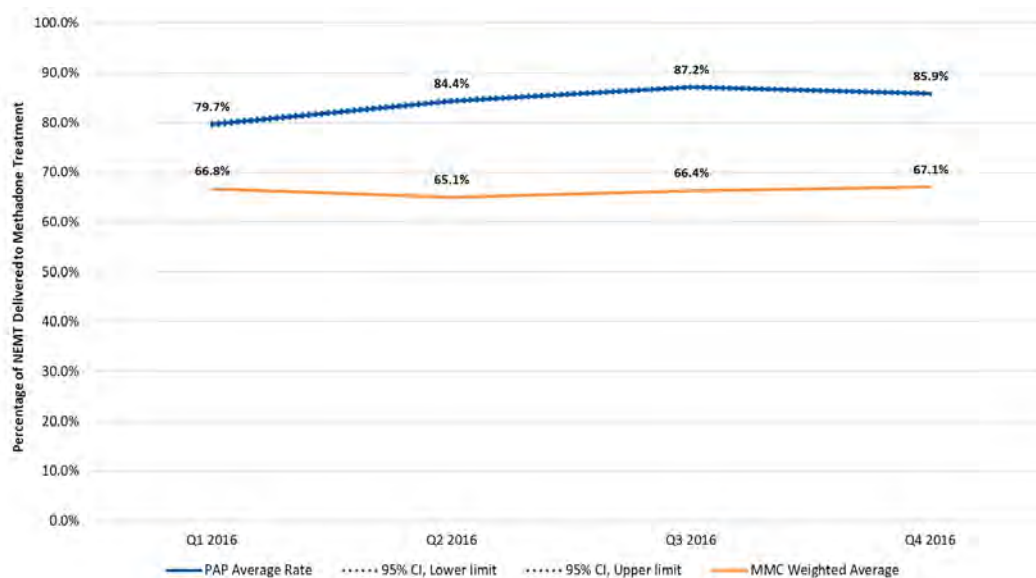
The percentage of NEMT used to travel to the dentist was around or below 1 percent for both PAP and MMC plans, as shown in Figure 4-4. Again, the MMC weighted average rate was higher than the 95 percent confidence intervals for the PAP plans, indicating higher usage of NEMT for dental visits by MMC members.

Figure 4-4: Percentage of NEMT Delivered to Dentist



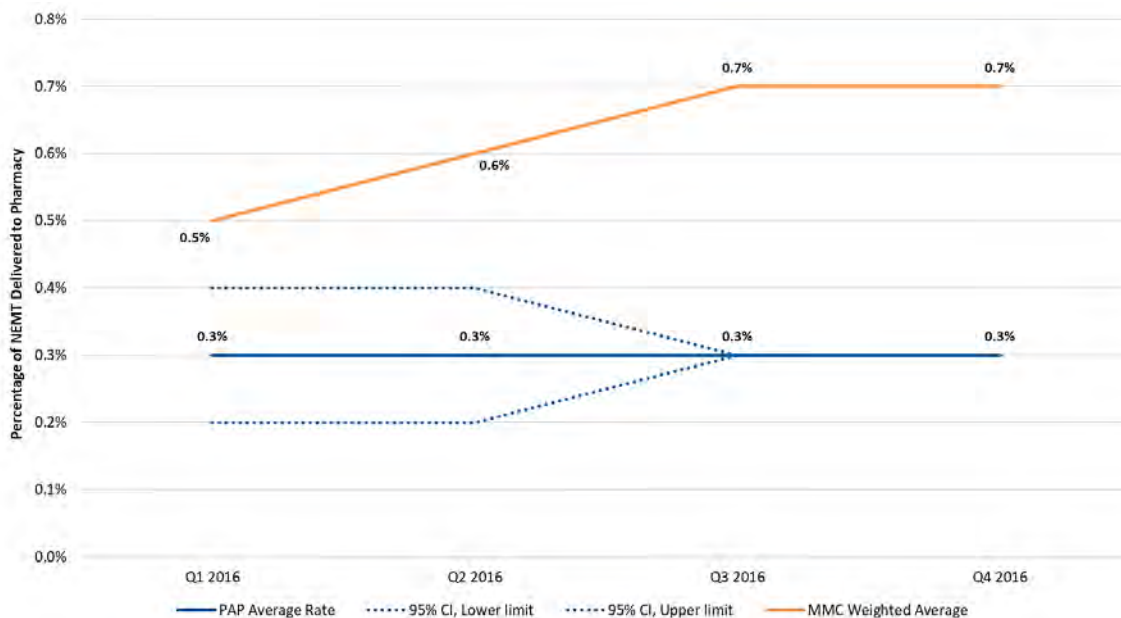
As stated previously, the largest share of NEMT transportation for both PAP and MMC plans was for methadone treatment, as shown in Figure 4-5. The entire 95 percent confidence interval for the PAP plans was above the average rates for the MMCs for all quarters with results, a result that is likely significant. This is the only type of provider for which PAP members received more NEMT than MMC members.

Figure 4-5: Transportation for Methadone Treatment



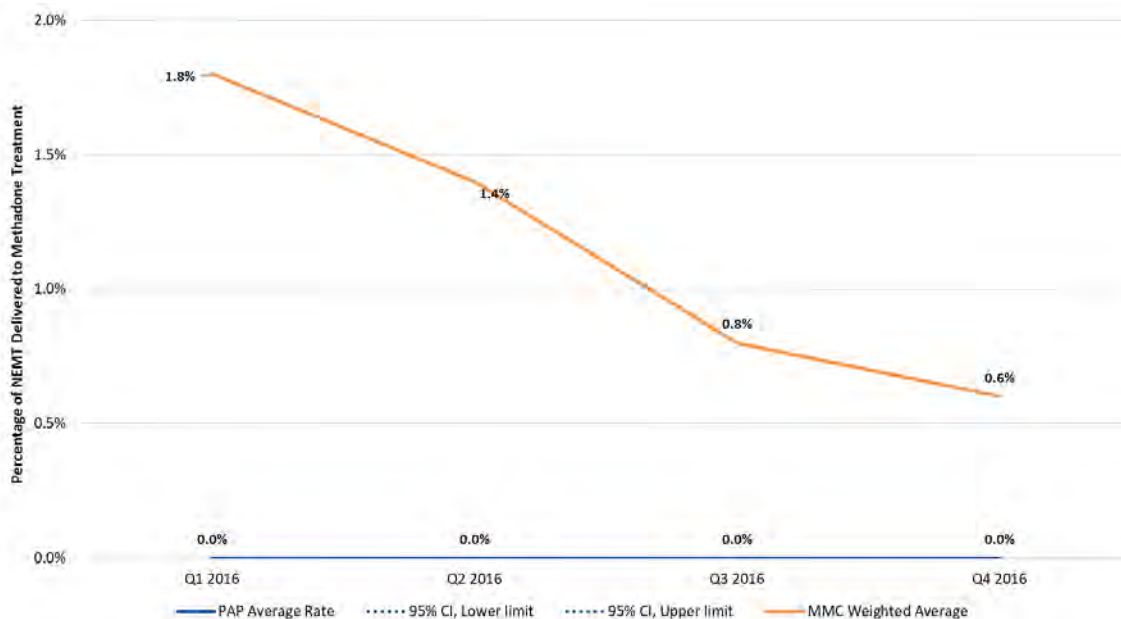
Less than 1 percent of NEMT was delivered to provide transportation to a pharmacy, and the percentage of requests by MMC members exceeded the 95 percent confidence interval for PAP members as shown in Figure 4-6.

Figure 4-6: Transportation to Pharmacy



There was also very little use of NEMT for transportation to “other” providers, as shown in Figure 4-7, with the weighted average for MMC members exceeding the 95 percent confidence interval range for PAP members.

Figure 4-7: Transportation for Other Providers



Summary and Conclusions for Hypothesis 12

Both PAP plans and MMC plans provided for excellent NEMT to members, authorizing more than 99 percent of all requests in 2016. Most NEMT was used for methadone treatment, with substantial shares also used for transportation to individual medical and mental health providers. Visual inspection of the measure results demonstrated that NEMT was used significantly more frequently by PAP members to travel to obtain methadone treatment, combined with significantly lower percentages for travel to most other types of services when compared to MMC members. The only exception was for non-emergency travel to the hospital, for which the percentages used by PAP and MMC members were indistinguishable (Table 4-41).

Table 4-41: Hypothesis 12 Results

Measure ID	Measure Description	Supports Hypothesis 12
12-1	Percentage of NEMT requests authorized, of those requested during the measure data period, for the eligible population	Yes
12-2	Percentage of NEMT requests authorized, of those requested during the measure data period, by type of medical service (i.e., hospital, medical provider, mental health provider, dentist, pharmacy, methadone treatment, other), for the eligible population	Yes

Hypothesis 13

Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.

Four measures were used to examine Hypothesis 13:

- The percentage of discharges for members 19 years through 64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge (Measure 13-1).
- The percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) abuse or dependence who (1) received initiation of AOD treatment within 14 days of the diagnosis, and (2) initiated treatment and had two or more additional AOD services or medication assisted treatment (MAT) within 34 days of initiation (Measure 13-2).
- The number and percentage of members receiving mental health outpatient services during the measurement year (Measure 13-3).
- The number and percentage of members with and AOD claim who received chemical dependency outpatient services during the measurement year (Measure 13-4).

Results of Measure 13-1

HSAG employed a difference-in-differences model for Measure 13-1 (Follow-Up After Hospitalization for Mental Illness [7-Day Follow-Up]) to estimate the effect of the implementation of the PAP on the percentage of discharges for members 19 years through 64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge (Table 4-42).

A smaller percentage of the PAP members had a mental health follow-up after a mental health related inpatient discharge than did members in the non-PAP comparison group in both the baseline and evaluation periods; however, after controlling for changes due to other causes over time, the results support Hypothesis 13. During

the baseline period, 36.67 percent of PAP members received mental health follow-up treatment, while 60.78 percent of non-PAP comparison group members received a mental health hospitalization follow-up. During the evaluation period, 29.09 percent of PAP members received follow-up treatment while about 60.00 percent of non-PAP comparison group members received follow-up mental health treatment.

The change in the percentage of PAP members receiving mental health follow-up treatment between the baseline and evaluation periods was -7.58 (29.09 – 36.67) percentage points. Non-PAP comparison group members experienced a reduction of 0.78 percentage points (60.00 – 60.78) during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a decrease of 6.79 percentage points (-7.58 – (-0.78) plus rounding error).

If Hypothesis 13 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 13-1. A statistical test of the hypothesis that the PAP impact is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 13-1 support Hypothesis 13.

Table 4-42: Follow-Up After Hospitalization for Mental Illness (Measure 13-1)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	60.78% N=51	60.00% N=60	-6.79 (14.20)	68.35%
PAP	36.67% N=30	29.09% N=55		

Source: PAP encounter data, EDI transaction encounters, MMIS FFS claims data, and hospital discharge data.

Results of Measure 13-2

HSAG employed a difference-in-differences model for Measure 13-2 (Initiation and Engagement of AOD Dependence Treatment [IET]) to estimate the effect of the implementation of the PAP on the percentage of members with a new episode of AOD abuse or dependence who (1) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or MAT within 14 days of the diagnosis; and (2) initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

Initiation of Treatment

PAP members had slightly lower rates of initiation of AOD treatment in the baseline period than the non-PAP comparison group, but higher rates of AOD treatment in the evaluation period (Table 4-43). In the baseline period, 34.00 percent of PAP members with an AOD diagnosis initiated treatment while 34.84 percent of non-PAP comparison group members initiated treatment. In the evaluation period, both groups declined, but the relationship between PAP and non-PAP was flipped—32.62 percent of PAP members with a diagnosis of AOD initiated treatment, while only 28.96 percent of the non-PAP comparison group initiated treatment.

The change in the percentage of PAP members who initiated treatment was -1.38 (32.62 – 34.00) percentage points between the baseline and evaluation period. Non-PAP comparison group members experienced a reduction of 5.88 (28.96 – 34.84) percentage points. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was an increase of 4.50 percentage points (-1.38 – (-5.88)).

If Hypothesis 13 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Initiation of Treatment for Measure 13-2. A statistical test of the hypothesis that the PAP impact is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Initiation of Treatment in Measure 13-2 support Hypothesis 13. It should be noted that New Hampshire added a substance use disorder (SUD) benefit for non-PAP members starting July 1, 2016. The implementation of this new program benefit may have had the effect of increasing the non-PAP rates and exacerbating the impact of the decline in the rates for the PAP population by comparison.

Engagement of Treatment

PAP members had higher rates of engagement of AOD treatment than the non-PAP comparison group in both the baseline and evaluation period. In the baseline period, 18.00 percent of PAP members who initiated AOD treatment met the criteria for engagement of treatment in the following 34 days. This figure was 15.48 percent for the non-PAP comparison group. Both groups declined in the evaluation period, where 13.59 percent of PAP members and 10.98 percent of non-PAP comparison group members engaged in AOD treatment after initiation.

The change in the percentage of PAP members who engaged in AOD treatment was -4.41 (13.59 – 18.00) percentage points. Non-PAP comparison group members experienced a reduction of 4.50 (10.98 – 15.48) percentage points. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was an increase of 0.10 percentage points (-4.41 – (-4.50) plus rounding error).

If Hypothesis 13 is true, implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Engagement of Treatment for Measure 13-2. A statistical test of the hypothesis that the PAP impact is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results of Engagement of Treatment in Measure 13-2 support Hypothesis 13. Similar to the Initiation of Treatment measure, the implementation of a SUD benefit for non-PAP members on July 1, 2016 may have exacerbated the decrease in the PAP rates by comparison.

**Table 4-43: Initiation and Engagement of AOD Abuse or Dependence Treatment
(Measure 13-2)**

Measure Indicator	Group	Time Period		PAP Impact (Standard Error)	Confidence Level
		Baseline	Evaluation		
Initiation	Non-PAP	34.84% <i>N</i> =155	28.96% <i>N</i> =328	4.50 (0.063)	23.90%
	PAP	34.00% <i>N</i> =150	32.62% <i>N</i> =515		
Engagement	Non-PAP	15.48% <i>N</i> =155	10.98% <i>N</i> =328	0.10 (0.049)	49.17%
	PAP	18.00% <i>N</i> =150	13.59% <i>N</i> =515		

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 13-3

HSAG employed a difference-in-differences model for Measure 13-3 (Mental Health Utilization) to estimate the effect of implementation of the PAP on the number and percentage of members receiving mental health outpatient services during the measurement year (Table 4-44).

A smaller percentage of PAP members utilized mental health outpatient services than did the non-PAP comparison group in both the baseline and evaluation period. During the baseline period, 14.29 percent of PAP members utilized mental health services, while 22.50 percent of non-PAP members utilized mental health services. During the evaluation period, this percentage declined for PAP members to 12.51 percent, while it also decreased for non-PAP comparison group members to 20.73 percent.

The change in the percentage of PAP members utilizing mental health outpatient services between the baseline and evaluation period was -1.78 (12.51 – 14.29) percentage points. Non-PAP comparison group members experienced a nearly identical decrease of 1.77 (20.73 – 22.50) percentage points during the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of only 0.01 percentage points (-1.78 – 1.77).

If Hypothesis 13 is true, the implementation of the PAP controlling for changes due to other causes over time should be associated with an increase of no change in Measure 13-3. A statistical test of the hypothesis that the PAP impact is greater than or equal to zero cannot be rejected at the 95 percent confidence level. Therefore, the results for Measure 13-3 support Hypothesis 13.

Table 4-44: Mental Health Utilization (Measure 13-3)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	22.50% N=97,379	20.73% N=78,145	-0.01 (0.26)	51.03%
PAP	14.29% N=83,573	12.51% N=97,082		

Note: Reported sample sizes are member months.

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Results of Measure 13-4

HSAG employed a difference-in-differences model for Measure 13-4 (Chemical Dependency Outpatient Services Utilization) to estimate the number and percentage of members with an AOD claim who received chemical dependency outpatient services during the measurement year (Table 4-45). A slightly smaller percentage of PAP members utilized chemical dependency outpatient services during both the baseline and evaluation periods. In the baseline period, 6.82 percent of PAP members utilized chemical dependency outpatient services while 7.02 percent of non-PAP comparison group members did so. In the evaluation period, the percentage of PAP members utilizing chemical dependency outpatient services increased slightly to 7.22 percent, the non-PAP comparison group increased by a greater proportion to 7.82 percent.

The change in the percentage of PAP members utilizing chemical dependency outpatient services between the baseline and evaluation period was 0.40 (7.22 – 6.82) percentage points. Non-PAP comparison group members experienced an increase of 0.80 (7.82 – 7.02) percentage points over the same period. The estimated impact of the PAP, controlling for changes due to other causes over time as represented by the change in the non-PAP comparison group, was a reduction of 0.39 percentage points (0.40 – 0.80 plus rounding error).

If Hypothesis 13 is true, the implementation of the PAP controlling for changes due to other causes over time should be associated with an increase or no change in Measure 13-3. A statistical test of the hypothesis that the PAP impact is greater than or equal to zero can be rejected at the 95 percent confidence level. Therefore, the results for Measure 13-4 do not support Hypothesis 13.

Table 4-45: Chemical Dependency Utilization (Measure 13-4)

Group	Time Period		PAP Impact (Standard Error)	Confidence Level
	Baseline	Evaluation		
Non-PAP	7.02% N=97,379	7.82% N=78,145	-0.39 (0.18)	98.60%
PAP	6.82% N=83,573	7.22% N=97,082		

Note: Reported sample sizes are member months.

Source: PAP encounter data, EDI transaction encounters, and MMIS FFS claims data.

Summary and Conclusions for Hypothesis 13

Of the measures associated with Hypothesis 13, 3 out of 4 support the hypothesis that premium assistance beneficiaries will have equal or better access to care, including behavioral health services (Table 4-46). Measure 13-1, Follow-Up After Hospitalization for Mental Illness, shows that PAP members had a much lower rate of follow-up than the non-PAP comparison group in both time periods, but the change in rates after controlling for the change beyond what would be expected in the absence of the PAP was not statistically different from zero, thereby satisfying the hypothesis that PAP members had equal or better access to care. The results for Measure 13-2a showed a decrease in rates beyond what would be expected in the absence of PAP in the percentage of members who initiated AOD treatment. Statistical testing, however, was unable to reject the hypothesis that the impact was greater than or equal to zero, indicating the results for this measure do support Hypothesis 13. Similarly, results for Measure 13-2b showed a decrease in rates beyond what would be expected in the absence of PAP in the percentage of members who engaged in AOD treatment, but statistical testing was not able to reject the hypothesis that the impact was greater than or equal to zero. This finding further supports Hypothesis 13.

The results for Measure 13-3 showed that the utilization of mental health outpatient services did not materially change beyond what would be expected in the absence of the PAP. Statistical testing did not reject the hypothesis that the impact was greater than or equal to zero, indicating that this measure also supports Hypothesis 13.

The results for Measure 13-4 showed a decrease beyond what would be expected in the absence of the PAP in the percentage of members utilizing chemical dependency services. Statistical testing rejected the hypothesis that the impact was greater than or equal to zero, indicating that the results for this measure do not support Hypothesis 13. It should be noted that because the level of analysis was the member month, the number of observations used in the analysis lead to a decrease in the standard errors of the estimate; which then lead to an increase in the confidence level that rejected the hypothesis that the impact of PAP was greater than or equal to zero.

Table 4-46: Hypothesis 13 Results

Measure ID	Measure Description	Supports Hypothesis 13
13-1	Follow-Up After Hospitalization for Mental Illness	Yes
13-2a	Initiation of AOD Abuse or Dependence Treatment	Yes
13-2b	Engagement of AOD Abuse or Dependence Treatment	Yes

Measure ID	Measure Description	Supports Hypothesis 13
13-3	Mental Health Outpatient Services Utilization	Yes
13-4	Chemical Dependency Outpatient Services Utilization	No

Summary and Conclusion for Waiver Goal: Uniform Provider Access

Hypotheses 8 through 13 are related to the Uniform Provider Access waiver goal. Four of the six hypotheses are supported by the measures associated with each hypothesis.

Three of the four measures calculated for Hypothesis 8 support the hypothesis. Only the analysis of Adults' Access to Ambulatory Preventive Health Services did not support the hypothesis. Hypothesis 9 was unambiguously supported by 4 of the 8 associated measures with one measure providing mixed support. Hypothesis 10 was supported by both measures associated with it. Hypothesis 11 was not supported by either measure associated with it; this is likely due to health plans focusing on adult services and an unfamiliarity with EPSDT eligibility and services. Hypothesis 12 was supported by the available data. The results for Hypothesis 13 were supported by 3 of its 4 measures.

Based on these results, it appears that PAP members largely had comparable access to primary, specialty, and behavioral health care services to what had been provided under the Bridge program. Since the evaluation did not include access to utilization data for the general population, specifically, non-Medicaid members, it was not possible to evaluate the access to care for PAP members compared to the general population.

Waiver Goal: Cost Neutrality

The premium assistance program will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.

This section of the report documents the analysis and review of specific measures identified by the DHHS to determine the cost neutrality aspect of the PAP.

DHHS believed that the premium assistance approach would increase QHP enrollment and result in greater economies of scale and competition among QHPs. This, in turn, could result in coverage that achieves cost reductions in comparison to the continuation of the previous New Hampshire Medicaid expansion program (i.e., the Bridge program).

Please note that the term “cost neutrality” used in this report does not refer to the formal Budget Neutrality test required under the Section 1115 Waiver Demonstration program.

The CMS approved budget neutrality target for 2016 is \$701.53 per member per month (PMPM). The actual PAP cost under both approaches described in the rest of this report is below the \$701.53 PMPM target.

The cost neutrality portion of the evaluation examines costs for three components: total cost, medical cost, and administrative cost. The total cost is equal to the sum of the medical and administrative cost components.⁴⁻⁴

⁴⁻⁴ Details of the development of the cost estimates for cost neutrality can be found in Appendix D.

Hypothesis 14

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

The hypothesis essentially states that the PAP will be cost neutral with respect to the continuation of the previous New Hampshire Medicaid expansion program (i.e., the Bridge program). To validate this research hypothesis, Milliman examined the relative costs in a comparative format between the new beneficiary program (i.e., the study group) and the continuation of the Bridge program (i.e., the comparison group). For each of the measures, the comparison group comprises the newly eligible adult members of the Bridge program, which was in effect from September 2014 – December 2015. The Bridge program ended on January 1, 2016, at which time most members enrolled in PAP coverage and a limited number remained in the New Hampshire Health Protection Program (NHHPP) as medically frail or transitional members. The comparison group excludes the medically frail members who were not eligible to enroll in PAP coverage.

The estimated costs of a hypothetically extended Bridge program were based on the CY 2015 per capita monthly paid cost for QHP eligible enrollees only and for all covered benefits. The CY 2015 costs were adjusted to account for claims incurred but not reported, utilization and unit cost trends between the base experience period and the projection period and changes in mental health services funding mandated by the Community Mental Health Agreement (CMHA).⁴⁻⁵

Three measures were used to examine Hypothesis 14:

- Annual total costs divided by total number of member months, calculated separately for the study and comparison groups. Calculated as the sum of the medical cost component (Measure 7-2) and the administrative cost component (Measure 3-4) (Measure 14-1).
- Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued (Measure 14-2).
- Annual administrative costs divided by total number of member months, calculated separately for the study and comparison groups (Measure 14-3).

Results of Measure 14-1

Measure 14-1 (Total Costs by Group) compares the total annual total costs PMPM between the PAP and the hypothetical Bridge program capitation rate. Measure 14-1 is calculated as the sum of the medical cost component (Measure 14-2) and the administrative cost component (Measure 14-3).

Milliman used a cost neutrality factor to confirm the hypothesis. The cost neutrality factor is defined as the ratio of the total cost PMPM for the PAP to the total cost for the hypothetical Bridge program capitation rate. A ratio over 1.000 signifies that the PAP may not be cost neutral, refuting the hypothesis. Similarly, a ratio below 1.000 signifies that the PAP appears to be cost neutral, validating the hypothesis. It is important to note that other factors not measured here, such as quality and health outcomes, could impact the determination whether or not the PAP is cost effective from a value-based purchasing perspective.

Milliman included results for two approaches to compare the relative costs of the program. Please refer to the sections below on Measures 14-2 and 14-3 for a more detailed description of the methodology used to develop the medical cost and administrative components used in this comparison.

⁴⁻⁵ Details of the development of the cost estimates for this comparison group can be found in Appendix D.

Approach #1 Results

For this approach, Milliman compared the hypothetical Bridge program capitation rate to the average PAP carrier premiums, CSR payment, deductible funding, and the cost of wraparound services for the PAP population.

Table 4-47 below shows a summary of the comparison.

Table 4-47: Comparison of Total Cost PMPM – Approach #1

Cost Components	PAP Actual Costs	Hypothetical Bridge Program Capitation Rate
Medical Cost	\$487.14	\$451.35
Administrative Cost, Margin, Taxes, and Fees	\$92.14	\$65.11
Total Annual Cost PMPM	\$579.28	\$516.46
Cost Neutrality Factor	1.122	

The total cost paid by DHHS for the PAP population is about 12 percent higher than the estimated cost of a comparable population enrolled in the Bridge program. This result suggests that the PAP may not be cost neutral under this approach. As shown in Table 4-47, the cost difference is due to both higher medical and administrative expenses under the PAP than the Bridge program. The differences in administrative expenses are discussed in more detail in Measure 14-3.

Approach #2 Results

For this approach, Milliman compared the hypothetical Bridge program capitation rate to the carriers' actual medical cost of covering the PAP population in the exchange (which already reflects reduced cost sharing and deductible funding) and added the cost of wraparound services.

Table 4-48 below shows a summary of the comparison.

Table 4-48: Comparison of Total Cost PMPM – Approach #2

Cost Components	PAP Experience Based Cost	Hypothetical Bridge Program Capitation Rate
Medical Cost	\$523.81	\$451.35
Administrative Cost, Margin, Taxes, and Fees	99.08	65.11
Total Annual Cost PMPM	\$622.89	\$516.46
Cost Neutrality Factor	1.206	

The total cost for the PAP population, based on actual medical claims paid by the carriers, is about 21 percent higher than a comparable population enrolled in the Bridge program. This result suggests that the PAP may not be cost neutral under this approach. However, this comparison does not represent a true measure of cost neutrality since actual PAP medical claims do not represent actual DHHS expenses. Approach #1 more accurately measures DHHS program expenses.

Results of Measure 14-2

Measure 14-2 (Medical Costs by Group) compares the medical costs PMPM between the PAP program and the hypothetical Bridge program capitation rate.

Milliman included results for two approaches to compare the relative costs of the program and used a cost neutrality factor to confirm the hypothesis.

Approach #1 Results

For this approach, Milliman compared the hypothetical Bridge program capitation rate to the average PAP carrier premiums, CSR payment, deductible funding, and the cost of wraparound services for the PAP population.

Table 4-49 below shows a summary of the comparison.

Table 4-49: Comparison of Medical Cost PMPM—Approach #1

Cost Components	PAP Medical Cost	Hypothetical Bridge Program Medical Cost
Medical Cost	\$487.14	\$451.35
Cost Neutrality Factor	1.079	

The medical cost component of the PAP population is 7.9 percent higher than the estimated medical cost component of the hypothetical Bridge program capitation rate.

Approach #2 Results

For this approach, Milliman compared the hypothetical Bridge program capitation rate to the actual medical claims experience for the PAP population (which already reflects reduced cost sharing and deductible funding) and added the cost of wraparound services.

Table 4-50 below shows a summary of the comparison.

Table 4-50: Comparison of Medical Cost PMPM—Approach #2

Cost Components	PAP Experience Based Medical Cost	Hypothetical Bridge Program Medical Cost
Medical Cost	\$523.81	\$451.35
Cost Neutrality Factor	1.161	

The information in the table above shows that the actual medical cost of the PAP population is about 16 percent higher than the estimated medical cost component for the hypothetical Bridge program capitation rate. Milliman expects that some of this discrepancy is due to provider reimbursement differences. It is common for insurance carriers to pay providers at rates higher than Medicaid and Medicare reimbursement levels. Since the NHHPP Bridge program fee schedule was loosely based on prevailing Medicare fees, there could still be a significant difference in reimbursement level between the two delivery systems.

As stated above, this comparison does not represent a true measure of cost neutrality since the actual PAP medical costs do not represent actual DHHS expenses.

Results of Measure 14-3

Measure 14-3 (Members' Administrative Cost) compares the administrative costs PMPM between the PAP program and the hypothetical Bridge program capitation rate.

The administrative costs in the PAP rate filings are significantly higher than the administrative costs from the hypothetical CY 2016 Bridge program due to additional profit and fees that are not attributable to the Bridge program.

The administrative costs in the PAP rate filings are significantly higher than the administrative cost from the hypothetical CY 2016 Bridge program due to additional profit and fees that are not attributable to the Bridge program.

Table 4-51 below compares the administrative costs for the study and comparison groups on a PMPM and percent of premium basis. The administrative costs in the PAP rate filings are significantly higher than the administrative cost from the hypothetical CY 2016 Bridge program due to additional profit and fees that are not attributable to the Bridge program.

Table 4-51: Comparison of Administrative Costs PMPM

	PMPM	Percent of Total Program Costs
Average PAP Administrative Expenses from Rate Filings	\$99.08	15.9%
Estimated Bridge Program Administrative Expenses	\$65.11	12.6%

The administrative expense allowance included in the PAP premium is significantly higher than the allowance included in the hypothetical Bridge program capitation rates. As discussed above, this difference is a significant driver behind the total costs being higher in the PAP.

Table 4-52 below shows a comparison of the various administrative expense components.

Table 4-52: Summary of CY 2016 Administrative Expenses from Rate Filings as a Percent of Total Program Cost

Administrative Cost Components	Premium Assistance Program	Hypothetical Bridge Program
General Administrative Expenses	7.6%	7.1%
Profit and Risk Margin	1.8%	1.9%
Taxes and Fees	6.5%	3.5%
Total	15.9%	12.6%

The greatest difference in administrative expenses is due to taxes and fees. Unfortunately, most rate filings did not include enough information to quantify each of the fees individually.

Summary and Conclusions for Hypothesis 14

Based on the above information and the two approaches used in this analysis, the hypothesis that the cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid has been refuted. The difference between the provider reimbursement levels and administrative costs in the PAP rate and the hypothetical CY 2016 Bridge program rate appear to be the largest drivers of this conclusion.

Table 4-53 shows a summary of the various cost neutrality measures.

Table 4-53: Summary of Cost Neutrality Measures

Cost Components	PAP	Hypothetical Bridge Program Capitation Rate	Cost Neutrality Factor
Approach #1			
Medical Cost	\$487.14	\$451.35	1.079
Administrative Cost, Margin, Taxes, and Fees	\$92.14	\$65.11	1.415
Total Annual Cost PMPM	\$579.28	\$516.46	1.122
Approach #2			
Medical Cost	\$523.81	\$451.35	1.161
Administrative Cost, Margin, Taxes, and Fees	\$99.08	\$65.11	1.522
Total Annual Cost PMPM	\$622.89	\$516.46	1.206

Summary and Conclusion for Waiver Goal: Cost Neutrality

Based on this analysis, it appears that the PAP is not cost neutral to the state. Based on the analysis in this report, the program could have saved up to \$62.82 PMPM or roughly \$30.3 million in CY 2016 if the Medicaid expansion had remained in the Bridge program at the hypothetical Bridge program rates calculated in this report. This estimate includes both the federal and state share of the expenditures. Note that the hypothetical Bridge program rates calculated in this report are based on CY 2015 encounter data that would not have been available to set rates for CY 2016, therefore the actual rates would have been different than the hypothetical rates.

The difference in costs can be attributed to higher reimbursement level on the Marketplace as well as significantly higher administrative costs for PAP carriers.

Please note that the term “cost neutrality” used in this report does not refer to the formal Budget Neutrality test required under the Section 1115 Waiver Demonstration program.

The CMS approved budget neutrality target for 2016 is \$701.53 per member per month (PMPM). The actual PAP cost under both approaches described in the rest of this report is below the \$701.53 PMPM target.

Self-Declared Medically Frail

People who are eligible for the PAP can opt of the PAP by declaring themselves to be medically frail. These people are then enrolled in a non-PAP Medicaid MCO. Because this is nevertheless a Medicaid expansion population, it is important to understand the differences between the self-declared medically frail (SDMF) population and the non-self-declared medically frail population (i.e., the PAP population). As illustrated in Figure 4-8 and Table 4-54, throughout 2016, the number of New Hampshire Medicaid expansion members self-declaring as medically frail steadily increased from 4,208 in January 2016 to 6,204 by December 2016. Those enrolled in the PAP also increased throughout 2016, but the SDMF group grew as a percentage of the PAP population throughout that time.

Figure 4-8: Self-Declared Medically Frail and PAP Enrollment in 2016

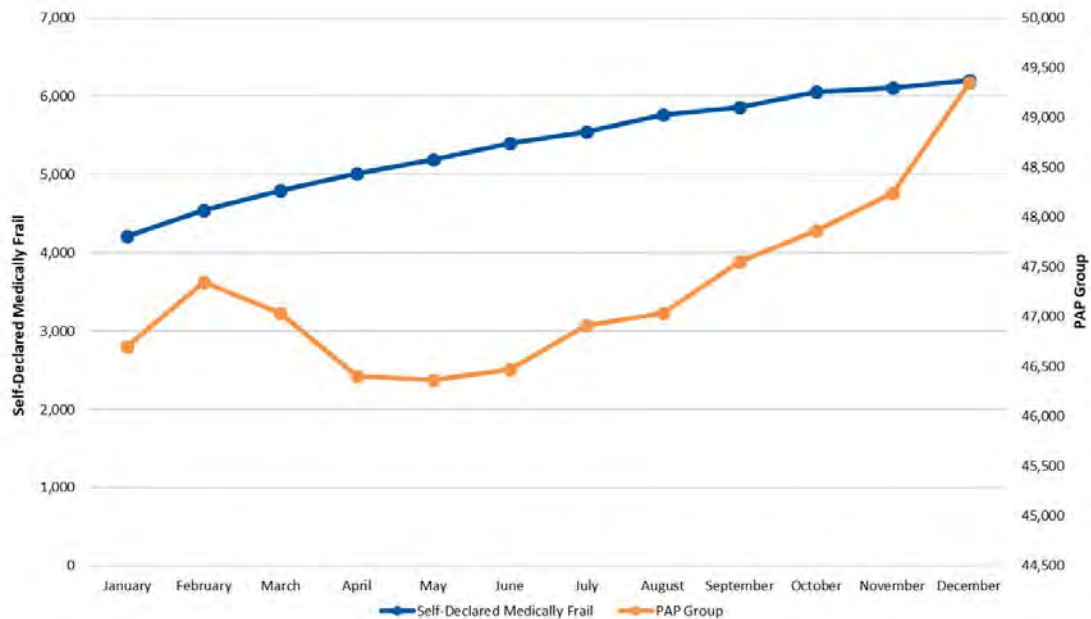


Table 4-54: Enrollment of Self-Declared Medically Frail in 2016

Month	SDMF Count	PAP Count	Percent of PAP Enrollment
January	4,208	46,701	9.01%
February	4,543	47,353	9.59%
March	4,797	47,035	10.20%
April	5,011	46,410	10.80%
May	5,191	46,370	11.19%
June	5,404	46,471	11.63%
July	5,551	46,918	11.83%
August	5,769	47,039	12.26%
September	5,864	47,555	12.33%
October	6,055	47,866	12.65%
November	6,106	48,243	12.66%
December	6,204	49,351	12.57%

In terms of member demographic composition, as shown in Table 4-55, those self-declaring as medically frail were generally older by an average of nearly 4 years, and more likely to be male (48.17 percent female for the SDMF group compared to 54.08 percent female for the PAP group). Additionally, there were small but statistically significant differences found in county of residence and race. For example, 4.87 percent of PAP members resided in Carroll county, while only 4.26 percent of the SDMF members resided in Carroll county. While this difference is statistically significant, the difference of 0.61 percentage points may not be meaningful.

Table 4-55: Comparison of Self-Declared Medically Frail to Non-Self-Declared Medically Frail Group Demographics

Attribute	PAP Group	Medically Frail	Significantly Different
Age	36.89	40.52	*
Female	54.08%	48.17%	*
Ethnicity: Hispanic	4.37%	3.14%	*
County: Belknap	6.13%	5.71%	
County: Carroll	4.87%	4.26%	*
County: Cheshire	6.37%	4.57%	*
County: Coos	3.91%	2.63%	*
County: Grafton	6.72%	5.23%	*
County: Hillsborough	30.25%	34.16%	*
County: Merrimack	11.28%	12.15%	*
County: Rockingham	15.01%	15.86%	*
County: Strafford	9.45%	10.21%	*
County: Sullivan	4.08%	3.23%	*
County: Unknown	1.93%	2.01%	
Race: African American	2.36%	2.85%	*
Race: American Indian	0.49%	0.66%	*
Race: Multiple	1.10%	1.18%	
Race: Other	1.73%	1.65%	
Race: Native Hawaiian	0.08%	0.09%	
Race: Asian	1.70%	1.62%	
Race: White	83.75%	84.93%	*
Race: None	8.78%	7.02%	*

In contrast to the comparison of demographics, when evaluating the prevalence of health conditions, the differences between the two groups are much more striking.⁴⁻⁶ Table 4-56 below shows a comparison of the prevalence of health conditions between the SDMF group and the PAP group. The SDMF group had a significantly higher prevalence across all health conditions. These differences are both statistically significant as well as clinically meaningful. For example, the prevalence of mental health disorders and substance abuse were over two times that of the PAP—27.41 percent of the PAP group had a primary diagnosis related to mental health disorders, while over half (56.89 percent) of the SDMF group was diagnosed with a mental health disorder. For substance abuse, 13.62 percent of the PAP group had a primary diagnosis for substance abuse, while 33.80 percent of the SDMF group had such a diagnosis.

⁴⁻⁶ Health conditions were identified using all available data during and before the evaluation period. Because it is possible for one group to show a higher prevalence than the other in the event one group has more enrollment, HSAG also evaluated health conditions using only claims during 2016. The results of this did not change the conclusions presented above. By incorporating additional claims, a more accurate summary of member composition is given.

Large differences were found across the remaining health conditions—COPD among the SDMF group was over double that of the PAP, at 11.92 percent compared to 5.24 percent. Similarly, the prevalence for both diabetes and hypertension among the SDMF group was approximately double that of the PAP. While having a low prevalence, the SDMF population was more than *four times* as likely as the PAP population to have had a stroke or congestive heart failure at 0.47 percent compared to 2.03 percent for stroke, and 0.53 percent compared to 2.36 percent for congestive heart failure.

Table 4-56: Comparison of Self-Declared Medically Frail to Non-Self-Declared Medically Frail Group Health Conditions

Attribute	PAP Group	Medically Frail	Significantly Different
Asthma	5.42%	9.16%	*
COPD	5.24%	11.92%	*
Cancer	6.12%	11.24%	*
Congestive Heart Failure	0.53%	2.36%	*
Coronary Artery Disease	1.11%	3.38%	*
Diabetes	6.13%	13.41%	*
Hypertension	7.75%	15.41%	*
Mental Health Disorders	27.41%	56.89%	*
Other Cardiac Conditions	7.47%	16.90%	*
Other Respiratory Conditions	19.07%	34.72%	*
Pregnancy	12.01%	6.78%	*
Stroke	0.47%	2.03%	*
Substance Abuse	13.62%	33.80%	*
N=	62,842	8,973	

While, the member composition in terms of demographics is not particularly significant, other than the SDMF generally being older by an average of 4 years and more likely to be male, it is clear there are significant differences between the SDMF and PAP groups across chronic health conditions with the SDMF generally experiencing greater prevalence of serious health conditions.

Discussion of Cost-Effectiveness

The PAP was found to be cost effective in the sense defined by the Cost-Effective Coverage waiver goal (see above). However, there remains the broader question of cost-effectiveness of the program in the more general sense of the term.

Based on the analysis conducted by Milliman, it appears that the PAP is not cost neutral to the state. Estimates suggest that DHHS could have saved up to \$62.82 PMPM or roughly \$30.3 million in CY 2016 if the Medicaid expansion had remained in the Bridge program, including both the federal and state share of the expenditures.

Medical costs were about 8 percent higher than a hypothetical continuation of the Bridge program. The largest driver of the difference in costs stems from administrative costs that were approximately 42 percent higher than a hypothetical continuation of the Bridge program for carriers in the Marketplace.

The results of the health care processes and outcomes suggest that the PAP generally provides care equally as good as that provided under the Bridge program, controlling for changes caused by other factors. However, the program is more costly than hypothetical continuation of the Bridge program. While there are advantages to

having members obtain coverage through the Marketplace, it is not clear that the advantages outweigh the increased costs.

Discussion of Implementation Success, Challenges, and Lessons Learned

The analysis identified several successes of the PAP. There is evidence of continuity of same-plan eligibility leading to increased continuity and coordination of care. The care provided under the PAP is, in general, at least as good as that provided under the Bridge program. PAP members rated the quality of the health care they have received higher than do non-PAP Medicaid members.

There are, however, challenges that have been identified through the analysis as well. Lack of plan experience or focus on children's EPSDT services means that eligible members are not receiving the EPSDT preventive services they should. This could be improved by additional information and training for the PAP plans as well as members eligible for EPSDT. It appears that plans may be struggling to manage the increased rates of mental health and chemical dependency issues among the Medicaid expansion population, which resulted in lower utilization of mental health and chemical dependency services. This could be improved by additional information and training for the PAP plans.

There may also be structural elements of the PAP that are blunting the price benefits of the competitive market. Since the state is willing to pay the premium posted on the Marketplace for PAP coverage, there is no incentive for PAP members to choose less expensive plans. In fact, is it likely that higher premiums are treated as signals of higher quality by members, which will attract more members to the higher premium plans.

5. Policy Implications

Health Services Advisory Group, Inc. (HSAG) and its subcontractor, Milliman, conducted analyses of 43 total measures, each related to 1 of the 14 hypotheses. Each of the 14 hypotheses are related to one waiver goal. The following provides an interpretation of findings, impacts on health policy, and opportunities for other State Medicaid demonstrations.

Interpretation of Results

A waiver goal is considered to have been met if a majority of the related hypotheses are supported by the analysis. A hypothesis is “supported by the analysis” if a majority of the measures associated with that hypothesis produce results that are consistent with the hypothesis. If the number of measures that support a hypothesis and those that do not support the hypothesis are equal, the support for the hypothesis based on the analysis is considered “mixed.” A hypothesis with multiple parts is “partially” supported if the analyses support the hypothesis in part, but not in its entirety. Table 5-1 provides a performance summary of the Premium Assistance Program (PAP) by measure, hypothesis, and waiver goal.

Table 5-1: Summary of Measure Support for PAP Hypotheses and Waiver Goals

Measure ID	Measure Description	Measure Supports Hypothesis	Hypothesis Supported by Analysis	Waiver Goal Met
Continuity of Coverage Waiver Goal: For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.				Yes
Hypothesis 1—Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage than non-PAP members enrolled in Medicaid.			Yes	
1-1	Average Number of Gaps in Medicaid Coverage per 100 Members	Yes		
1-2	Percentage of Eligible Members with Gaps in Medicaid Coverage	Yes		
1-3	In the Last 12 Months, Were You Without Health Insurance at Any Time?	Yes		
Hypothesis 2—Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.			Yes	
2-1	Percentage of Members with Continuous Access to the Same Health Plan	No		
2-2	In the Last Six Months, Did You Switch to a Different Health Care Plan?	Yes		
2-4	Continuous Care During Marketplace Transition	Yes		
Plan Variety Waiver Goal: The Demonstration could also encourage Medicaid Care Management (MCM) carriers to offer Qualified Health Plans (QHPs) in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid Managed Care (MMC) contracts.				Partially
Hypothesis 3—Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.			Yes	
3-1	Average Number of Gaps in Enrollment in Any Managed Care Organization (MCO) or PAP QHP per 100 Enrollee Years	Yes		
3-2	Percentage of Eligible Members with Continuous Access to Any Medicaid MCO or PAP Health Plan	No		

Measure ID	Measure Description	Measure Supports Hypothesis	Hypothesis Supported by Analysis	Waiver Goal Met
3-3	In the Last 6 Months, How Often Did Your Personal Doctor Seem Informed and Up-To-Date About the Care You Got from These [Other] Doctors or Other Health Providers?	Yes		
3-4a	To What Extent Did Members Changing Plans Increase Your Administrative Costs?	No		
3-4b	To What Extent Did Implementation of PAP Reduce the Number or Percentage of Members Changing Plans?	Yes		
Hypothesis 4—The Demonstration leads to an increase in plan variety by encouraging MMC carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek MMC contracts.			Partially	
4-1	Desk audit for the number of Medicaid Managed Care carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter for which dual participation could be an option	Yes		
4-2	Desk audit for the number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO Plans at the start of the waiver and annually thereafter	No		
Cost-Effective Coverage Waiver Goal: The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.				Yes
Hypothesis 5—Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.			Yes	
5-1a	Ambulatory Care: Emergency Department (ED) Visits Potentially Treatable in Primary Care – Members 19–44 Years Old	Yes		
5-1b	Ambulatory Care: ED Visits Potentially Treatable in Primary Care – Members 45–64 Years Old	Yes		
Hypothesis 6—Premium assistance beneficiaries will have equal or lower rates of potentially preventable ED and hospital admissions.			Yes	
6-1	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	Yes		
6-2	ED Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	Yes		
Hypothesis 7—Implementation of the program will result in more Medicaid plans deciding to enter the New Hampshire health insurance marketplace.			Yes	
7-1	Whether implementation of the PAP influenced their decision to enter the New Hampshire Marketplace	Yes		
Uniform Provider Access Waiver Goal: The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.				Yes
Hypothesis 8—Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.			Yes	
8-1	Medication Management for People with Asthma	Yes		
8-2	Timeliness of Prenatal Care	N/A		

Measure ID	Measure Description	Measure Supports Hypothesis	Hypothesis Supported by Analysis	Waiver Goal Met
8-3	Postpartum Care	N/A		
8-4	In the Last 6 Months, When You Needed Care Right Away, How Often Did You Get Care as Soon as You Needed?	Yes		
8-5	In the Last 6 Months, How Often Did You Get an Appointment to See a Specialist as Soon as You Needed?	Yes		
8-6a	Adults' Access to Ambulatory Preventive Health Services—Members 20–44 Years Old	No		
8-6b	Adults' Access to Ambulatory Preventive Health Services—Members 45–64 Years Old	No		
Hypothesis 9—Premium assistance beneficiaries will have equal or better access to preventive care services.			Yes	
9-1a	Adults' Access to Preventive Health Services—Members 20–44 Years Old	No		
9-1b	Adults' Access to Preventive Health Services—Members 45–64 Years Old	Yes		
9-3	Have You Had Either a Flu Shot or Flu Spray in the Nose Since July 1, 2016?	No		
9-4	Percentage of Patients 19 to 64 Years of Age with Type 1 or Type 2 Diabetes Who Had an Eye Exam (Retinal Exam) Performed	No		
9-5	Percentage of Patients 19 to 64 Years of Age with Type 1 or Type 2 Diabetes Who Had an HbA1c Test Performed	Yes		
9-6	Percentage of Members 40 Years of Age and Older with a Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Who Received Appropriate Spirometry Testing to Confirm the Diagnosis or For the Management of COPD	No		
9-7	Percentage of Women 21–64 Years of Age Who Were Screened for Cervical Cancer	Yes		
9-8	In the Last 6 Months, How Often Did You Get an Appointment for a Check-Up or Routine Care at a Doctor's Office or Clinic as Soon as You Needed?	Yes		
9-9	Percentage of Members 19–64 with Schizophrenia or Bipolar Disorder, Who Were Dispensed an Antipsychotic Medication and Had a Diabetes Screening Test	Yes		
Hypothesis 10—Premium assistance beneficiaries will report equal or better satisfaction in the care provided.			Yes	
10-1	What Number Would You Use to Rate All Your Health Care in the Last 6 Months?	Yes		
10-2	What Number Would You Use to Rate Your Health Plan?	Yes		
Hypothesis 11—Premium assistance beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.			No	
11-1	Percentage of Members Aged 19 and 20 Who Had At Least One Comprehensive Well-Care Visit	No		

Measure ID	Measure Description	Measure Supports Hypothesis	Hypothesis Supported by Analysis	Waiver Goal Met
11-2	Percentage of Members Aged 19 and 20 Who Received At Least One Preventive Dental Visit	No		
Hypothesis 12—Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT).			Yes	
12-1	Percentage of NEMT requests authorized, of those requested during the measure data period, for the eligible population	Yes		
12-2	Percentage of NEMT requests authorized, of those requested during the measure data period, by type of medical service (i.e., hospital, medical provider, mental health provider, dentist, pharmacy, methadone treatment, other), for the eligible population	Yes		
Hypothesis 13—Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.			Yes	
13-1	Follow-Up After Hospitalization for Mental Illness	Yes		
13-2a	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	Yes		
13-2b	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Yes		
13-3	Mental Health Outpatient Services Utilization	Yes		
13-4	Chemical Dependency Outpatient Services Utilization	No		
Cost Neutrality Waiver Goal: The premium assistance program will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.				No
Hypothesis 14—Premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with Special Terms and Conditions (STC) #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by the Centers for Medicare & Medicaid Services (CMS).			No	
14-1	Total Costs by Group	No		
14-2	Medical Costs by Group	No		
14-3	Members' Administrative Cost	No		

Some themes emerge from the measures in which the PAP performed worse than a hypothetical extended Bridge program. At first glance, it seems counterintuitive that the PAP would not at least meet the same level of performance in Measures 2-1 and 3-2. However, when members were in the Bridge program, care and plan enrollment was more “churn-proof” since Medicaid expansion members were enrolled in a Medicaid MCO and received the same care from the same plan as non-expansion Medicaid members. Under these conditions, changes in an individual’s program eligibility that would otherwise lead to members churning between the expansion Medicaid and non-expansion Medicaid programs would generally not impact the member since the same plan, provider networks, and services would be retained.

Several of the measures that performed worse than the Bridge program suggest that PAP plans may be struggling with some of the higher needs associated with the Medicaid expansion population compared to the general population that they have historically managed. One example of this is the performance of the EPSDT measures (Measures 11-1 and 11-2). These results likely stem from plans being focused on providing and managing care to adults and not being aware of EPSDT requirements, eligibility, or services. Another example is in the results of

the chemical dependency measure in Hypothesis 13. The results for Measure 13-4 suggest that plans are struggling to accommodate the higher rates of chemical dependency among the Medicaid expansion population compared to the populations that they normally manage. However, the results for Measure 13-2 provide evidence that they are making progress.

The results of the analysis show that the PAP met most of the waiver goals set for it during calendar year (CY) 2016. Implementation of the PAP did not appear to encourage any QHP carriers in the New Hampshire health insurance marketplace (the Marketplace) to seek new Medicaid contracts during its first year of implementation. The PAP also did not meet the Cost Neutrality waiver goal when compared to a hypothetically extended Bridge program.⁵⁻¹ Estimates suggest that Department of Health and Human Services (DHHS) could have saved up to \$62.82 per member per month (PMPM), or roughly \$30.3 million in CY 2016, if the Medicaid expansion had remained in the Bridge program, including both the federal and state share of the expenditures.

Medical costs were about 8 percent higher than a hypothetical continuation of the Bridge program. The largest driver of the difference in costs stems from administrative costs that were approximately 42 percent higher than a hypothetical continuation of the Bridge program for carriers in the Marketplace.

Implications for State and Federal Health Policy

The analysis of the New Hampshire PAP has demonstrated that the public marketplace approach can achieve health outcomes at least as good as traditional MMC; however, the analysis has not validated that the same quality of care can be achieved at an equal or lower cost.

It should be noted, however, that the cost neutrality issue does not necessarily negate the public marketplace approach. The cost containment mechanism that is expected to be in place through the public marketplace is based on the idea of competition between plans keeping prices down. However, the underlying assumption is that carriers in the public marketplace will compete based on lower prices. In the case of the PAP population, since the state is paying 100 percent of the premium for qualifying plans, members have no incentive to select lower-priced plans. PAP members “shopping” for a health plan may interpret higher premiums as a signal of more services and higher quality care.

This does not mean that the public marketplace cannot be a viable and cost-effective option for providing health care coverage and services to expansion populations. Mechanisms may be designed to effectively implement additional price containment for similar premium assistance programs for Medicaid expansion populations. As a result, attention to financial incentives inherent in the structure of the program and public marketplace need to be considered in designing reimbursement mechanisms.

Potential for Successful Demonstration Strategies to be Replicated in Other State Medicaid Programs

While every Medicaid program is unique, the New Hampshire PAP established that there are components of the Demonstration that could be replicated in other Medicaid programs. By successfully encouraging Medicaid MCOs to enter the Marketplace, PAP members were provided continuity of health care plan carrier coverage which can, therefore, lead to increased continuity of care.

⁵⁻¹ The term “cost neutrality” used herein does not refer to the formal Budget Neutrality test required under the Section 1115 Waiver Demonstration program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved. See the Cost Neutrality section in Findings and Conclusions.

The PAP has demonstrated it is possible to provide health care of equal quality, as measured by both process and outcome measures, as care delivered by strictly Medicaid MCOs. In order to increase the probability of success of similar approaches to providing care to Medicaid expansion populations in other State Medicaid programs, States should consider implementing the following strategies:

- Encourage Medicaid plans to participate in the public marketplace to ensure continuity and coordination of care among a population subject to significant levels of churn.
- Ensure plans have experience with, and are cognizant of, the unique needs of the Medicaid expansion population. In the absence of plan experience, provide the plans with de-identified unpriced claim and encounter data prior to the first PAP enrollment to help plans develop premiums as well as understand needs that may be unique to the Medicaid population.
- Provide additional education to plans with limited experience serving Medicaid members eligible for additional required services, particularly for programs with limited enrollment and more intense service requirements, such as EPSDT.
- Develop a premium payment mechanism that incorporates appropriate financial incentives that are aligned with program goals such as provision of quality care and cost neutrality. One strategy may involve hidden premium pricing for PAP members so that pricing cannot be used as a signal of quality.
- Ensure that members have access to care quality information by providing members with plan performance information prior to the selection of a plan.

Through the implementation of these strategies would not guarantee a successful program, they may assist a State Medicaid program to replicate the best elements and avoid the challenges associated with the New Hampshire PAP experience.

6. Interactions with Other State Initiatives

As mentioned in the study limitations above, the Premium Assistance Program (PAP) took place in a period of overall change in health care, especially for the individuals impacted by the expansion of Medicaid coverage. The PAP initiative was one in a group of interventions the State of New Hampshire undertook to improve health care for its residents, as discussed in this section.

Discussion of This Demonstration Within an Overall Medicaid Context and Long-Term Planning

New Hampshire was one of several states that applied for and were granted waivers from the Centers for Medicare & Medicaid Services (CMS) to design a unique approach to the expansion of Medicaid to a new population—adults with incomes up to 133 percent of Federal Poverty Level (FPL). This population was different from the population eligible for Medicaid as determined by eligibility for Social Security disability prior to the expansion. It was expected that this coverage would not be long-term, but would change as the economy improved and more people were able to earn more than the minimum eligibility threshold.

Interrelations of the Demonstration With Other Aspects of the State's Medicaid Program

When New Hampshire accepted the federal government's offer to expand Medicaid eligibility to adults up to 133 percent of FPL beginning in December 2013, the population was enrolled in Medicaid Managed Care (MMC). With the PAP, many of these adults, especially those who were not disabled, moved into the New Hampshire health insurance marketplace (the Marketplace) beginning in January 2015. Qualified Health Plans (QHPs) and the Actuary who evaluated the PAP for New Hampshire discovered that the PAP population was actuarially distinct from the general commercial population. This resulted in higher than expected costs for some of the QHPs (those without prior experience with the population), and was a factor in the exit of one insurer (Minuteman) from the PAP.

Interactions with Other Medicaid Waivers, the State Innovation Model (SIM) Award, and Other Federal Awards Affecting Service Delivery, Health Outcomes, and the Cost of Care Under Medicaid

The population covered under the PAP is made up primarily of adults who are of working age and healthy enough to work, excluding individuals who are on disability (dually eligible for Medicare and Medicaid) or who declare themselves to be medically frail. This population gained coverage due to the Affordable Care Act's (ACA's) Medicaid expansion, and New Hampshire's decision to participate in the Medicaid expansion was predicated on implementation of the PAP. If not for the PAP, there would be no Medicaid expansion in New Hampshire and these adults would likely remain uninsured.

The PAP will expire at the end of 2018, unless the New Hampshire legislature reapproves the program.⁶⁻¹ Its successes and failures have been the subject of a series of hearings in the New Hampshire legislature and are not the subject of this Interim Evaluation Report.

Other Medicaid Waivers

There are several other Medicaid waivers operative in New Hampshire, as listed in Table 6-1. The population for the PAP is demographically and programmatically distinct from the children and disabled populations generally covered in these other waiver programs, so interrelations between the programs are limited.

Table 6-1: New Hampshire Medicaid Waivers

Waiver	Program Description	Interaction with PAP Population
New Hampshire Developmental Disabilities Waiver	Provides community participation services for individuals with autism, developmental disability, or intellectual disability (ID) of any age.	Excluded from PAP because of age and/or dual eligibility.
New Hampshire Acquired Brain Disorder Services Waiver	Provides community participation and support services for adults age 22 and over who have suffered brain injury.	Excluded from PAP because of dual eligibility.
New Hampshire In Home Supports for Children with Development Disabilities	Provides personal care, family support and coordination for individuals aged 0-21 with autism, ID, or developmental disabilities.	Excluded from PAP because of age and/or dual eligibility.
New Hampshire Choices for Independence	Provides adult medical day services, residential care, and adult in-home services for aged individuals 65 years and older, and for adults with disabilities aged 18-64 years.	Excluded from PAP because of dual eligibility.
New Hampshire Building Capacity for Transformation	Beginning in 2018, reforms the State's behavioral health care system by creating a Delivery System Reform Incentive Payment (DSRIP) program that provides integrated behavioral health services through a statewide network of regionally-based Integrated Delivery Networks.	Medicaid members eligible for this program are specifically excluded from the PAP waiver program and will receive Medicaid benefits through their QHPs. However, the two programs may potentially influence each other in the future, especially if the PAP is reauthorized.
Mandatory Managed Care for State Plan Services for Currently Voluntary Populations	Mandates enrollment in MMC plans for individuals with voluntary enrollment in Medicaid, (e.g., children in foster care, members of Federally recognized Indian tribes, dual eligible).	This waiver mandates enrollment into capitated managed care (MMC plans) for some voluntary Medicaid enrollees who were formerly permitted to elect fee-for-service (FFS) Medicaid.

Source: State Waivers List, Medicaid.gov. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=35353>. Accessed on December 6, 2017.

The waiver program that will have the most interaction with PAP is Building Capacity for Transformation, approved by CMS in early 2016. The waiver plan includes the DSRIP, designed to serve Medicaid members with behavioral health needs by developing regional care delivery systems integrating their behavioral health care with their other health needs, from primary care to care coordination across transitions in care. The DSRIP includes seven regional integrated networks, with each pursuing a variety of projects. The overall focus is coordinating the State's community-based social service organizations, hospitals, county facilities, physical health providers, and

⁶⁻¹ There are current hearings.

behavioral health providers (mental health and substance abuse) to build behavioral health capacity, promote integration, facilitate smooth transitions in care, and prepare for alternative payment models (APMs).⁶⁻²

The DSRIP has created a roadmap for its approach to APM, which will ramp up over 2018. The carriers who provide insurance to PAP members are certainly stakeholders in the complex program task of preparing for the APMs anticipated under Medicaid Access and CHIP Reauthorization Act (MACRA), but are not directly impacted in the material payment reform efforts that drive the CMS program.⁶⁻³

Although PAP members are not among the severe or chronically mentally ill who are disabled from working due to behavioral health needs, as many as 25 percent of PAP members have behavioral health needs. There will undoubtedly be some programmatic overlap despite the specific exclusion of PAP members from the DSRIP demonstration; some PAP members will receive care from members of the integrated care delivery networks. However, the integrated care delivery networks developed under the DSRIP will not be fully operational until the end of 2017, and PAP is scheduled to expire at the end of 2018, limiting the potential for programmatic overlap.

⁶⁻² Building Capacity for Transformation: New Hampshire's DSRIP Waiver Program, May 2016. Available at <https://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrp-overview-052016.pdf>. Accessed on December 6, 2017.

⁶⁻³ New Hampshire's Building Capacity for Transformation Section 1115(a) Medicaid Research and Demonstration Waiver DSRIP Alternative Payment Models Roadmap for Year 2 (CY 2017) and Year 3 (CY 2018) Available for download from <https://www.dhhs.nh.gov/section-1115-waiver/>. Accessed on December 6, 2017.



State of New Hampshire
Department of Health and Human Services

Premium Assistance Program (PAP)

Evaluation Plan Implementation

Interim Evaluation Report, Appendices

March 2018



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A. Methodologies

The methods and approaches described in Appendix A are based on the most recently available information about the data sources used in the evaluation of the Premium Assistance Program (PAP). Health Services Advisory Group, Inc. (HSAG) conducted several analyses involving the following methodologies:

- Defining evaluation periods
- Measure selection
- Identification of study populations
- Measure calculation
- Estimating the impact

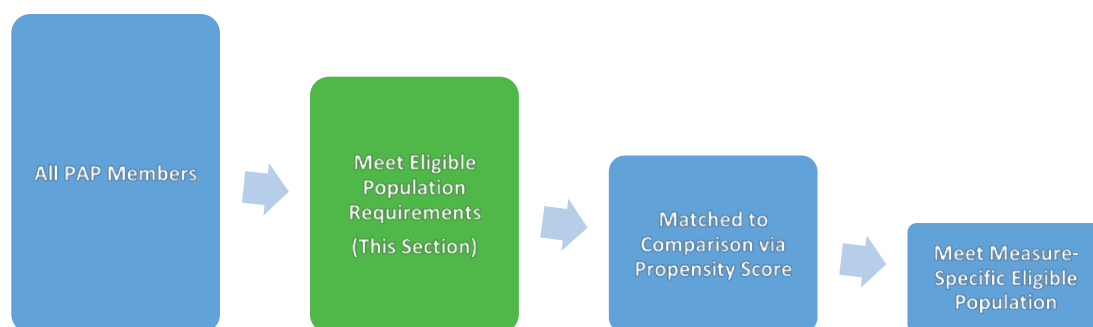
Some methods and approaches may require adjustment for the final evaluation report, if additional information about the data sources indicate the method(s) are not appropriate as described.

Health Outcomes

To evaluate the health-related outcomes (i.e., non-financial or web research-based) two eligible populations were identified.^{A-1} The eligible populations defined in this section were used as a starting point in the evaluation of all health-related outcomes. The eligible treatment group defined below was subject to a number of further limitations globally and for each measure. In particular, a member meeting the eligible treatment group criteria may have later been removed from the study if not matched with an eligible comparison group member, or the member may have been removed from a particular measure if the measure's specific eligible population criteria were not met (such as demonstrating continuous enrollment for the evaluation year after allowing for one gap in coverage of up to 45 days).

Figure A-1 outlines the member selection process for the PAP population (i.e., treatment group). Identification of the final comparison group followed similar steps.

Figure A-1: Member Selection Process for the PAP Population



^{A-1} Financial outcomes were evaluated using a separate methodology included in Appendix D.

Treatment Group

The treatment group (i.e., the Bridge/PAP population) for the health outcomes measures was composed of members who are in New Hampshire Health Protection Program (NHHPP) who are not medically frail. These members were either:

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

Brief periods of enrollment in the PAP, or mixed enrollment in PAP and a non-PAP Managed Care Organization (MCO), are less likely to generate substantial or sustained improvements in outcomes than longer enrollments. Therefore, members must exhibit a continuous enrollment of 6 months or longer in the PAP and no more than 2 months in an MCO during the evaluation period to be included in the analysis as program participants. Some measures used in this evaluation require additional enrollment criteria. The measure specifications describe these requirements and the type of enrollment necessary (e.g., PAP, Medicaid). Health outcomes for the treatment group were evaluated only during the time the member was enrolled in the PAP. If the member transitioned in or out of the PAP (either leaving Medicaid entirely or transitioning to/from an MCO), but still met the 6 months continuous enrollment requirements, only claims during their time in the PAP were used to evaluate outcomes.^{A-2} To adequately identify health conditions and outcomes at baseline, members must also have had sufficient enrollment throughout the baseline period. Eligible treatment group members must have had continuous enrollment during calendar year (CY) 2015 with no more than one gap of up to 45 days.

Comparison Group

The comparison group for the health outcomes analysis is composed of adult MCO members who were never enrolled in the Bridge or PAP programs and were continuously enrolled in a single MCO for 6 months or more during the evaluation period.

To adequately identify health conditions and outcomes at baseline, members must also demonstrate sufficient enrollment throughout the baseline period. Eligible comparison group members must have continuous enrollment during CY 2015 with no more than one gap of up to 45 days.

Exclusions

Given that the PAP excludes certain groups of enrollees, it is necessary to exclude these same groups from the eligible comparison group. This includes dual enrollees, members younger than 19 and older than 65, and members who self-identify as medically frail.

^{A-2} To the extent an outcome measure requires historical claims data (e.g., year prior to the evaluation period) for purposes such as identification of members with relevant chronic conditions, all claims were used to assess the historical claims.

Propensity Scoring Matching

For purposes of determining the expected rates for the treatment group, a non-Bridge/PAP population with characteristics similar to the Bridge/PAP population was identified. Propensity score-based matching is a common methodology used to select a comparison group that is statistically similar to a treatment group. The following describes the methodology for generating propensity scores and using those scores to match members in the treatment group (i.e., the Bridge/PAP population) with members in the comparison group (i.e., the non-Bridge/non-PAP population).

Covariate Identification

Demographic and health condition covariates were identified for each member. The following provides a description of each of the covariates and the methods that were used to identify the covariates. All covariates were identified during the baseline period, and were expected to be related to the likelihood of a member being enrolled in the PAP. Table A-1 provides a list of the demographic covariates and the methods that were used to identify each covariate.

Table A-1: Demographic and Utilization Covariates

Covariates	Identification Method
Age	
Age	Member's date of birth was used to identify the member's age at the end of the baseline period.
Gender	
Male Female	Member's gender in the demographic file.
Geography	
County	County codes in demographic data.
Race	
White African American American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander Asian Other Multiple	Members flagged as "W" were classified as White. Members flagged as "A" were classified as African American. Members flagged as "I" were classified as American Indian/Alaskan Native. Members flagged as "P" were classified as Native Hawaiian/Other Pacific Islander. Members flagged as "S" were classified as Asian. Members flagged as "O" were classified as Other. Members with more than one race code were classified as Multiple.
Ethnicity	
Hispanic Non-Hispanic	Members with ethnicity of "1" were classified as Hispanic. Members with ethnicity of "0" were classified as non-Hispanic.
Enrollment	
Number of months a member was enrolled in PAP/Medicaid	Eligibility/Enrollment files were used to determine the number of months a member was enrolled in PAP or Medicaid.

The list below provides the health condition covariates that were incorporated into the propensity scoring methodology.^{A-3} Encounter and fee-for-service (FFS) data were used to identify members who had a primary diagnosis for any of the health conditions listed below. Each health condition was represented separately as an indicator variable. For example, a member diagnosed with both asthma and hypertension would have two health condition flags, one for asthma and another for hypertension.

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Cancer
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- Hypertension
- Mental Health Disorders
- Other Cardiac Conditions
- Other Respiratory Conditions
- Pregnancy
- Stroke
- Substance Abuse

Propensity Score Matching

Propensity scores were derived to match individuals in the Bridge/PAP and non-Bridge/non-PAP populations. This allowed the construction of a comparison group that was most similar to the treatment group (i.e., the Bridge/PAP population) without the use of randomized selection. Thus, the propensity score was used to reduce bias in the results and control for multiple confounders.

The covariates were used to determine a propensity score for each member through logistic regression. The equation used for the logistic regression is as follows:

$$\Pr(Y_i = 1) = \frac{1}{1 + \exp[-(\beta_0 + \beta_1 X_{i1} + \beta_2 X_{i2} + \dots + \beta_k X_{ik})]}$$

Where $\Pr(Y_i = 1)$ is the propensity score, the β s are parameters to be estimated the X s are the covariates.^{A-4}

A Greedy 5→1-digit matching algorithm was used for purposes of matching the populations.^{A-5} The populations were first matched on the propensity score out to the fifth decimal place. For those that did not match, the

^{A-3} HSAG began by identifying health conditions using the Agency for Health Research and Quality (AHRQ) Clinical Classification Software (CCS) categories. Certain CCS categories were grouped together in the final covariate selection based on characteristics of the PAP population and clinical relevance (e.g., the CCS category for “diabetes mellitus without complications” and “diabetes mellitus with complications” were grouped together into the Diabetes health condition covariate).

^{A-4} Linden, A., Adams, J.L., and Roberts, N. (2005). “Using propensity scores to construct comparable comparison groups for disease management program evaluation.” *Disease Management Health Outcomes*. 13(2): 107-115.

^{A-5} Parsons, L.S. (2001). “Reducing Bias in Propensity Score Matched-Pair Sample Using Greedy Matching Techniques.” Paper 214-26. Proceedings of the Twenty-Sixth Annual SAS Users Group International Conference. Cary (NC): SAS Institute Inc.

populations were then matched on the propensity score out to the fourth decimal place and continued down to a one-digit match. Any ties were matched randomly, and once a pair had been matched, they were not reconsidered.

Evaluating Matched Populations

Matching on propensity scores has been shown to create a “covariate balance,” such that the matched comparison population is similar for all the covariates included in calculating the propensity score.^{A-6} Covariate balance was assessed through several ways. First, the entire distribution of each covariate for the comparison group after matching was compared against that of the treatment group using either a chi-square test or *t*-test depending on the type of covariate. Given that, traditional statistical tests could find statistical significance on small differences if the sample sizes are large enough, the distributions of each covariate for both groups were compared against each other using standardized differences.^{A-7} The standardized difference represents the difference in averages between the PAP and non-PAP comparison groups in terms of the pooled standard deviation. A rule of thumb when interpreting standardized differences is that an absolute value less than 0.1 generally indicates a minimal difference between the two groups (i.e., the covariate is balanced). Finally, to evaluate covariate balance across the spectrum of covariates, an omnibus test was employed to test the joint hypothesis that the mean difference between the PAP and non-PAP comparison groups across all measured covariates was zero.^{A-8}

While two covariates showed statistical unbalance after matching, the standardized difference on these covariates was well below the 0.1 rule of thumb threshold for unbalance, and the omnibus test failed to reject the joint hypothesis that the mean differences across all covariates was equal to zero. Table A-2 shows the covariate averages before and after matching for the non-PAP comparison and the PAP groups, computed standardized differences, and an indicator of denoting covariates that were statistically balanced using either a chi-square or a *t*-test. Table A-2 shows that, after matching, all but two covariates were statistically balanced. All covariates, including the two that were found statistically unbalanced, had a standardized difference of less than 0.1. The *p*-value on the omnibus test was 0.9639, which indicates the two matched groups across all the covariates as a whole are statistically balanced. Taken together, these results provide strong evidence that the propensity score matching process worked as intended and a non-PAP comparison group similar in composition to the PAP group was identified. For conditions that were disproportionately more prevalent in the full comparison group, such as diabetes, the prevalence of diabetes among the matched comparison group was statistically equivalent to that of the matched PAP group. Furthermore, 80 percent (9,311/11,620) of the full PAP group was matched, which means results from the evaluation are representative of the majority of the PAP population as a whole.

Table A-2: Summary of Covariate Balance

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced
	Comparison	PAP	Comparison	PAP		
Total Member Months	11.434	10.888	11.250	11.206	-0.029	
Age	40.244	38.445	38.763	38.665	-0.007	*
Female	0.634	0.554	0.587	0.577	-0.020	*
Ethnicity: Hispanic	0.039	0.042	0.040	0.039	-0.008	*

^{A-6} Parsons, L.S. (2001). “Reducing Bias in Propensity Score Matched-Pair Sample Using Greedy Matching Techniques.” Paper 214-26. Proceedings of the Twenty-Sixth Annual SAS Users Group International Conference. Cary (NC): SAS Institute Inc.

^{A-7} See, Austin, P.C. (2011) “An Introduction to Propensity Score Methods for Reducing the Effects of Confounding in Observational Studies,” *Multivariate Behavioral Research*. 46(3): 399-424. Available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144483/>; last accessed December 7, 2017.

^{A-8} See, Hansen, B.B. and Bowers, J. (2008). “Covariate Balance in Simple, Stratified, and Clustered Comparative Studies,” *Statistical Science*. 23(2): 219-236.

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced
	Comparison	PAP	Comparison	PAP		
Asthma	0.076	0.039	0.043	0.045	0.009	*
COPD	0.089	0.036	0.039	0.042	0.013	*
Cancer	0.070	0.042	0.047	0.047	0.002	*
Congestive Heart Failure	0.011	0.003	0.003	0.003	0.004	*
Coronary Artery Disease	0.020	0.008	0.009	0.009	0.004	*
Diabetes	0.126	0.063	0.069	0.071	0.008	*
Hypertension	0.099	0.075	0.080	0.077	-0.010	*
Mental Health Disorders	0.432	0.214	0.242	0.254	0.029	
Other Cardiac Conditions	0.078	0.046	0.050	0.051	0.003	*
Other Respiratory Conditions	0.202	0.128	0.138	0.138	0.002	*
Pregnancy	0.051	0.036	0.039	0.039	0.001	*
Stroke	0.008	0.003	0.003	0.003	-0.002	*
Substance Abuse	0.118	0.104	0.107	0.103	-0.011	*
County: Belknap	0.063	0.064	0.062	0.063	0.003	*
County: Carroll	0.037	0.052	0.044	0.047	0.012	*
County: Cheshire	0.057	0.068	0.063	0.063	0.002	*
County: Coos	0.045	0.044	0.047	0.048	0.006	*
County: Grafton	0.057	0.068	0.062	0.065	0.010	*
County: Hillsborough	0.315	0.301	0.315	0.303	-0.025	*
County: Merrimack	0.122	0.117	0.117	0.118	0.003	*
County: Rockingham	0.128	0.145	0.138	0.142	0.010	*
County: Strafford	0.111	0.083	0.091	0.092	0.002	*
County: Sullivan	0.049	0.042	0.047	0.046	-0.005	*
County: Unknown	0.015	0.016	0.014	0.014	0.001	*
Race: African American	0.020	0.023	0.020	0.020	0.003	*
Race: American Indian	0.002	0.004	0.003	0.003	0.000	*
Race: Multiple	0.010	0.010	0.010	0.010	-0.001	*
Race: Other	0.013	0.019	0.015	0.014	-0.004	*
Race: Native Hawaiian	0.000	0.001	0.001	0.001	0.000	*
Race: Asian	0.007	0.021	0.010	0.010	0.001	*
Race: White	0.943	0.875	0.936	0.933	-0.010	*
Race: None	0.004	0.048	0.006	0.008	0.028	*
N=	14,525	11,620	9,311	9,311		

Difference-in-Differences

A difference-in-differences analysis was performed on all measures for which baseline and evaluation period data are available for both the treatment and comparison groups. This analysis compared the changes in the rates or outcomes between the baseline period and the evaluation period for the two populations. This allowed for estimation of rates for the matched treatment group (i.e., matched Bridge/PAP members) to be calculated while controlling for expected changes in rates had the PAP not been implemented. This was done by subtracting the average change in the comparison group from the average change in the treatment group, thus removing biases from the evaluation period comparisons due to permanent differences between the two groups. In other words, any rate changes caused by factors external to the PAP would apply to both groups equally, and the difference-in-differences methodology removes the potential bias. The result is a clearer picture of the actual effect of the program on the evaluated outcomes. The generic difference-in-differences model is:

$$Y_{it} = \beta_0 + \beta_1 T_i + \beta_2 R_t + \delta_1 (R_t * T_i) + u_{it}$$

where Y_{it} is the outcome of interest for individual i in time period t . R_t is a dummy variable for the re-measurement time period (i.e., evaluation period). The dummy variable T_i identifies the treatment group with a 1 and the comparison group with a 0. The coefficient, β_1 , identifies the average difference between the groups prior to implementation of the PAP. The time period dummy, R , captures factors that would have changed in the absence of the intervention. The coefficient of interest, δ_1 , multiplies the interaction term, $R_t * T_i$, which is the same as the dummy variable equal to one for those observations in the treatment group in the re-measurement period. The final difference-in-differences estimate is:

$$\hat{\delta}_1 = (\bar{y}_{T,R} - \bar{y}_{T,B}) - (\bar{y}_{C,R} - \bar{y}_{C,B})$$

The estimate provides the expected costs and rates without intervention. If the δ_1 coefficient is significantly different from zero, then it is reasonable to conclude that the outcome differed between the treatment and comparison group after the PAP went into effect. For this analysis, a statistically significant difference is represented by a p -value of 0.05 or less, indicating the probability of the results occurring by chance is less than 5 percent. The confidence interval is defined as 1 minus the p -value; confidence values are reported in the results tables.

A proportional z -test is typically used to compare two samples when the measurement data are discrete, or categorical, in nature (such as gender or whether a respondent answer “yes” to a particular survey question). For Consumer Assessment of Healthcare Providers and Systems (CAHPS®) questions that were not part of the 2015 CAHPS survey and, therefore, did not have available baseline data, a two proportion z -test was used to test the hypothesis.^{A-9} The treatment group’s outcomes are measured against the comparison group’s outcomes, and the z -test determines whether the two groups are statistically significantly different.

Some measures with baseline data that are represented as categories also used a proportional z -test. This test indicated whether there was a significant change in measure rates/outcomes between time periods, but did not indicate the magnitude of the impact or change.

^{A-9} CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS Questions Measurement

Data from CAHPS questions in this study were gathered using three different scales. Some questions used a simple binary “yes/no” response. Other survey questions used a four-point scale with responses of “never,” “sometimes,” “usually,” or “always.” The remaining survey questions used an 11-point scale with responses ranging from 0 to 10. Table A-3 below shows the response levels for each CAHPS measure question.

Table A-3: Response Levels for CAHPS Questions

Measure	Response Level
1-3: Patient Perspective on Continuity in Health Insurance Coverage	Binary
2-2: Patient Perspective on Continuity in Same Plan Coverage	Binary
2-3: Patient Perspective on Continuous Access to Providers	4-Point Scale
3-3: Patient Perspective on Continuity of Care	Binary
8-4: Patients’ Perception of Quick Access to Needed Care	4-Point Scale
8-5: Patients’ Perception of Ease of Getting Appointments with Specialists	Binary
9-3: Annual Influenza Immunization, 19-64	Binary
10-1: Patients’ Rating of Overall Health Care	11-Point Scale
10-2: Patients’ Rating of the Health Plan	11-Point Scale

Binary Response

The proportion of “yes” responses for the treatment and comparison groups were evaluated using a z-test.

Four-Point Scale Response

Measures using a four-point scale response with choices for “never,” “sometimes,” “usually,” or “always” were evaluated using a “usually+always” top box approach, where four responses are recoded as a binary indicator as defined in Table A-4. Statistical testing was done using a proportional z-test.

Table A-4: Four-Point Scale Top Box Coding

Response Choices	Top Box (Usually + Always)
Never	0
Sometimes	0
Usually	1
Always	1

Eleven-Point Scale Response

Measures that used an eleven-point scale response ranging from 0 to 10 were evaluated using a “8+9+10” top box approach, following guidance from Healthcare Effectiveness Data and Information Set (HEDIS®) specifications.^{A-10} Similar to the four-point scale top box, the “8+9+10” top box converts the numeric responses to a binary indicator following the coding system defined in Table A-5. Statistical testing for this binary indicator was done using a proportional z-test.

^{A-10} HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).

Table A-5: Eleven-Point Scale Top Box Coding

Response Choices	Top Box (8 + 9 + 10)
0 – Worst	0
1	0
2	0
3	0
4	0
5	0
6	0
7	0
8	1
9	1
10 – Best	1

Self-Declared Medically Frail (SDMF)

Measures

In addition to analysis of the outcomes for individuals participating in the PAP, it is equally important to understand the characteristics of the individuals who elect not to participate in the PAP by a self-declaration of medical frailty.

SDMF individuals were counted for each month of the interim evaluation period and reported for each month both as raw numbers as well as a percentage of the total number of individuals participating in PAP.

SDMF individuals were compared to all PAP participants based on a number of demographic and medical characteristics. The demographic characteristics evaluated were:

- Age
- Gender
- County
- Race/Ethnicity

The health conditions that were used in the comparison were as follows:

- Asthma
- COPD
- Cancer
- CHF
- CAD
- Diabetes
- Hypertension

- Mental Health Disorders
- Other Cardiac Conditions
- Other Respiratory Conditions
- Pregnancy
- Stroke
- Substance Abuse

Encounter and FFS claims data prior to December 31, 2016, were used to identify members who had a primary diagnosis for any of the health conditions listed above.

Statistical Testing

Differences between the SDMF and PAP participants was tested to determine the extent to which there are statistically significant differences between the two populations. Statistical testing was conducted using the two-proportion *z*-test or *t*-test, depending on the type of condition under evaluation.

Changes from CMS Approved Plan

In developing the Analytic Plan and the Interim Evaluation Report, New Hampshire Department of Health and Human Services (DHHS) and HSAG made several revisions to the measure list that deviated from the original analytic plan approved by the Centers for Medicare & Medicaid Services (CMS). These revisions help tie outcomes measures more closely to the hypothesis. The list below outlines the substantive changes from the original analytic plan and Appendix B provides detailed measure definitions and specifications.

- Removed Measure 2-4: Number of Medically Frail Self-Declarations. Added discussion of these members as separate section to the report.
- Split Measure 9-1: Adults' Access to (use of) Preventive/Ambulatory Health Services Adults by Age Group into two measures: (1) Preventive services only (Measure 8-6), and (2) full HEDIS Adults' Access to Preventive (AAP) Health Services (Measure 9-1).
- Added Measure 9-7: Cervical Cancer Screening to Hypothesis 9 (PAP beneficiaries will have equal or better access to preventive care services).
- Revised Measure 9-7: Mental Health Utilization – 1 to follow HEDIS specifications for Mental Health Utilization outpatient visits, with revisions to remove emergency care and crisis management, and updated measure ID to be Measure 13-1 (see below).
- Removed Measure 9-8: Mental Health Utilization – 2.
- Split Measure 11-1: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Screening into two measures: (1) Well-Care Visits, and (2) Preventive Dental Visits.
- Added Measure 12-2: Non-Emergency Medical Transportation (NEMT) Requests Delivered by Type of Medical Service.
- Added new Hypothesis 13: Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.
 - Moved Measure 9-2: Follow-Up After Hospitalization (FUH) to this hypothesis and updated measure ID to be Measure 13-1.

- Moved revised Measure 9-7: Mental Health Outpatient Utilization under this hypothesis and updated measure ID to be Measure 13-3.
- Added Measure 13-2: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).
- Added new Hypothesis 14: PAP will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.
 - Moved Measures 14-1 (Total Costs by Group), 14-2 (Medical Costs by Group), and 14-3 (Members' Administrative Cost).

B. Measure Definitions

The performance measure specifications and definitions included in Appendix B have been selected to determine the cost and effectiveness of the Premium Assistance Program (PAP). Health Services Advisory Group, Inc. (HSAG) utilized each of these measures to assess the dimensions of access and quality of care by:

- Comparing provider networks
- Member satisfaction and experience
- Provider experience
- Evidence of improved access and quality of care

Each measure being evaluated is categorized into the four waiver goals and spread across the 14 hypotheses. The measure definitions are based on the most recent information available about the data to be used in the evaluation. Some definitions for some measures may require adjustment as additional information about the data is received.

Continuity of Coverage

Continuity in Member Health Insurance Coverage—Average Number of Gaps in Medicaid Coverage

Continuity in Member Health Insurance Coverage	
Domain	Continuity of Coverage
Waiver Goal	For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.
Hypothesis 1	Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
Measure Description	The average number of gaps in Medicaid coverage per 100 members during the measurement period.
Eligible Population	PAP and non-PAP members continuously enrolled for six months or more during the measurement year.
Numerator	The number of gaps in Medicaid enrollment. A gap is defined as a lapse in coverage lasting more than 45 calendar days, or at least two gaps of between one and 45 calendar days during the measurement year.
Denominator	The eligible population
Data Source(s)	State eligibility and enrollment databases
Measure ID	1-1

Statistical Testing

- Difference-in-differences

Continuity in Member Health Insurance Coverage—Percentage of Eligible Members With Medicaid Coverage Gaps

Continuity in Member Health Insurance Coverage	
Domain	Continuity of Coverage
Waiver Goal	For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.
Hypothesis 1	Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
Measure Description	The percentage of eligible members with gaps in Medicaid coverage.
Eligible Population	PAP and non-PAP members continuously enrolled for six months or more during the measurement year.
Numerator	The number of members with one or more gaps in Medicaid enrollment. A gap is defined as a lapse in coverage lasting more than 45 calendar days, or at least two gaps of between one and 45 calendar days during the measurement year.
Denominator	The eligible population
Data Source(s)	State eligibility and enrollment databases
Measure ID	1-2

Statistical Testing

- Difference-in-differences

Patient Perspective on Continuity in Health Insurance Coverage

Patient Perspective on Continuity in Health Insurance Coverage	
Domain	Continuity of Coverage
Waiver Goal	For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.
Hypothesis 1	Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
Measure Description	Eligible recipients will be surveyed to whether the members reported being without health insurance during the previous 12 months. “In the last 12 months, were you without health insurance at any time?” (Use CAHPS’ standard Yes/No response categories and format).
Eligible Population	PAP and non-PAP sample frame.
Numerator	The number of members who answered “Yes” to the following question: “In the last 12 months, were you without health insurance at any time?”
Denominator	The number of valid responses from the eligible population.
Data Source(s)	CAHPS 2017 Survey
Measure ID	1-3

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Continuous Access to the Same Health Plan

Continuous Access to the Same Health Plan	
Domain	Continuity of Coverage
Waiver Goal	For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.
Hypothesis 2	Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
Measure Description	The percentage of members with continuous access to the same health plan.
Eligible Population	PAP and non-PAP members continuously enrolled for six months or more during the measurement year.
Numerator	The number of members who were continuously enrolled in one Managed Care Organization (MCO) during the measurement year. If a member had at least one gap in coverage OR a member switched health plans during the measurement year, then the member did not have continuous access and is therefore not numerator compliant. A gap is defined as a lapse in coverage lasting more than 45 calendar days, or at least two gaps of between one and 45 calendar days during the measurement year. Health plan will be identified by the Health care organization name field in Benefit Plan Spans data.
Denominator	The eligible population.
Data Source(s)	Eligibility and enrollment files
Measure ID	2-1

Statistical Testing

- Difference-in-differences

Patient Perspective on Continuity in Same Plan Coverage

Patient Perspective on Continuity in Same Plan Coverage	
Domain	Continuity of Coverage
Waiver Goal	For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.
Hypothesis 2	Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
Measure Description	Eligible recipients will be surveyed to whether the members had continuous access to the same health care plan during the previous six months. “In the last six months, did you switch to a different health care plan?” (Use CAHPS’ standard Yes/No response categories and format)
Eligible Population	PAP and non-PAP sample frame.
Numerator	The number of members responding “Yes” to the following question: “In the last six months, did you switch to a different health care plan?”
Denominator	The number of valid responses from the eligible population.
Data Source(s)	CAHPS 2017 Survey
Measure ID	2-2

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Continuous Care During Marketplace Transition

Continuous Care During Marketplace Transition									
Domain	Continuity of Coverage								
Waiver Goal	For individuals, whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks.								
Hypothesis 2	Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.								
Measure Description	The percentage of members who transitioned from NH Healthy Families Medicaid coverage to Ambetter QHP, and the percentage of members who transitioned from Ambetter QHP to NH Health Families Medicaid.								
Eligible Population	All Medicaid members enrolled in NH Healthy Families who transitioned to a QHP, and all Ambetter members.								
Numerator	<p>1) Number of NH Healthy Families members who gained coverage under Ambetter. 2) Number of Ambetter members who gained coverage under NH Family Services.</p> <p>Enrollment in a NH Healthy Families, Ambetter, or another qualifying QHP will be identified using the BP ID in the Benefit Plan enrollment spans file. The following BP IDs designate enrollment in either an MCM or QHP.</p> <table border="1"> <thead> <tr> <th colspan="2">List of Medicaid Care Management and Qualified Health Plan IDs</th></tr> </thead> <tbody> <tr> <td>NH Healthy Families Plan ID</td><td>NHHLFM</td></tr> <tr> <td>Ambetter Plan ID</td><td>AMBBC1, AMBBC2</td></tr> <tr> <td>QHP Plan ID</td><td>ATHSL1, ATHSL2, CHOCA1, CHOCA2, HPPEH1, HPPEH2, HPPEH3, HPPEH4, HPHSH1, HPHSH2, HPHSH3, HPHSH4, MMHSA1, MMHSA2, MMHSA3, MMHSA4</td></tr> </tbody> </table>	List of Medicaid Care Management and Qualified Health Plan IDs		NH Healthy Families Plan ID	NHHLFM	Ambetter Plan ID	AMBBC1, AMBBC2	QHP Plan ID	ATHSL1, ATHSL2, CHOCA1, CHOCA2, HPPEH1, HPPEH2, HPPEH3, HPPEH4, HPHSH1, HPHSH2, HPHSH3, HPHSH4, MMHSA1, MMHSA2, MMHSA3, MMHSA4
List of Medicaid Care Management and Qualified Health Plan IDs									
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Denominator	The eligible population.								
Data Source(s)	Eligibility and enrollment files								
Measure ID	2-4								

Plan Variety

Continuity in Plan Enrollment—Average Number of Gaps in Enrollment

Continuity in Plan Enrollment	
Domain	Plan Variety
Waiver Goal	The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts.
Hypothesis 3	Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
Measure Description	The average number of gaps in enrollment from any MCO or PAP QHP per 100 enrollee years.
Eligible Population	PAP and non-PAP members continuously enrolled for six months or more during 2016.
Numerator	The number of gaps in any member's MCO or PAP QHP enrollment. A gap is defined as a lapse in coverage lasting more than 45 calendar days, or at least two gaps of between one and 45 calendar days during the measurement year.
Denominator	Total number of enrolled months for the eligible population, divided by 12 and divided by 100.
Data Source(s)	Eligibility and enrollment databases
Measure ID	3-1

Statistical Testing

- Difference-in-differences

Continuity in Plan Enrollment—Percentage of Eligible Members With Continuous Access to Health Plan

Continuity in Plan Enrollment	
Domain	Plan Variety
Waiver Goal	The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts.
Hypothesis 3	Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
Measure Description	Percentage of eligible members with continuous access to any Medicaid MCO or PAP health plan during the measurement period.
Eligible Population	PAP and non-PAP members continuously enrolled for six months or more during 2016.
Numerator	The number of members who did not have any gaps in MCO or PAP QHP coverage during the measurement period. A gap is defined as a lapse in coverage lasting more than 45 calendar days, or at least two gaps of between one and 45 calendar days during the measurement year.
Denominator	The eligible population
Data Source(s)	Eligibility and enrollment databases
Measure ID	3-2

Statistical Testing

- Difference-in-differences

Patient Perspective on Continuity of Care

Patient Perspective on Continuity of Care											
Domain	Plan Variety										
Waiver Goal	The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts.										
Hypothesis 3	Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.										
Measure Description	<p>The percentage of members who respond “usually” or “always” to the following question: “In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?”</p> <p>Responses and their corresponding coding values for statistical testing are as follows:</p> <table border="1"> <thead> <tr> <th>Response Choices</th><th>Coding Value</th></tr> </thead> <tbody> <tr> <td>Never</td><td>0</td></tr> <tr> <td>Sometimes</td><td>0</td></tr> <tr> <td>Usually</td><td>1</td></tr> <tr> <td>Always</td><td>1</td></tr> </tbody> </table>	Response Choices	Coding Value	Never	0	Sometimes	0	Usually	1	Always	1
Response Choices	Coding Value										
Never	0										
Sometimes	0										
Usually	1										
Always	1										
Eligible Population	PAP and non-PAP sample frame.										
Numerator	The number of members who respond “yes” to the following question: “In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?”										
Denominator	The number of valid responses from the eligible population.										
Data Source(s)	CAHPS 2017 Survey										
Measure ID	3-3										

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Plan Perspective on Continuity of Enrollment on Administrative Costs

Plan Perspective on Continuity of Enrollment on Administrative Costs	
Domain	Plan Variety
Waiver Goal	The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts.
Hypothesis 3	Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
Measure Description	Ask the plans the extent to which members changing plans increases their administrative costs. Ask to what extent the implementation of PAP has reduced the number/percent of members changing plans.
Eligible Population	PAP QHPs and Medicaid MCOs
Data Source(s)	2017 Plan Interviews
Measure ID	3-4

Statistical Testing

- Interim Evaluation Report
 - Qualitative Review of Interview Responses
- Final Evaluation Report
 - Qualitative Review of Interview Responses

Medicaid Managed Care Carriers Offering QHPs in the Marketplace

Medicaid Managed Care Carriers Offering QHPs in the Marketplace	
Domain	Plan Variety
Waiver Goal	The Demonstration encourages Medicaid Managed Care carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts.
Hypothesis 4	The Demonstration leads to an increase in plan variety by encouraging Medicaid Managed Care carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts.
Measure Description	Desk audit for the number of Medicaid Managed Care carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter for which dual participation could be an option.
Eligible Population	All Bridge Plans, PAP Plans, QHP Plans, and MCOs
Numerator	Count of the number of Medicaid Managed Care carriers offering QHPs in the Marketplace for which dual participation could be an option.
Data Source(s)	Internet Research
Measure ID	4-1

Statistical Testing

- None

QHPs in the Marketplace Offering Medicaid MCO Plans

QHPs in the Marketplace Offering Medicaid MCO Plans	
Domain	Plan Variety
Waiver Goal	The Demonstration encourages Medicaid Managed Care carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts.
Hypothesis 4	The Demonstration leads to an increase in plan variety by encouraging Medicaid Managed Care carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts.
Measure Description	Desk audit for the number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO Plans at the start of the waiver and annually thereafter.
Eligible Population	All Bridge Plans, PAP Plans, QHP Plans, and MCOs
Numerator	Count of the number of QHPs in the Marketplace offering Medicaid MCO Plans.
Data Source(s)	Internet Research
Measure ID	4-2

Statistical Testing

- None

Cost-Effective Coverage

Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care

Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care	
Domain	Cost-Effective Coverage
Waiver Goal	The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.
Hypothesis 5	Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.
Measure Description	<p>Ambulatory ED visits for conditions potentially treatable in primary care per 1,000 member months.</p> <p><u>Reporting Units</u></p> <ul style="list-style-type: none"> Age 19–44 years Age 45–64 years <p>Member age for the numerator should be based on the last day of the month regardless of the age of the member at the time of service.</p>
Eligible Population	Matched treatment group and comparison group.
Numerator	<p>The number of ED visits for conditions potentially treatable in primary care.</p> <p><i>Step 1</i>—Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits during the measurement year using either of the following:</p> <ul style="list-style-type: none"> An ED Visit (<u>ED Value Set</u>) with a primary diagnosis of (<u>Conditions Potentially Preventable in Primary Care DHHS Value Set</u>) A procedure code (<u>ED Procedure Code Value Set</u>) with an ED place of service code (<u>ED POS Value Set</u>) with a primary diagnosis of (<u>Conditions Potentially Preventable in Primary Care DHHS Value Set</u>) <p>Do not include ED visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.</p> <p><i>Step 2</i>—Exclude visits with any of the following:</p> <ul style="list-style-type: none"> A principal diagnosis of mental health or chemical dependency (<u>Mental and Behavioral Disorders Value Set</u>). Psychiatry (<u>Psychiatry Value Set</u>). Electroconvulsive therapy (<u>Electroconvulsive Therapy Value Set</u>). Alcohol or drug rehabilitation or detoxification (<u>AOD Rehab and Detox Value Set</u>).
Denominator	The number of member months for the eligible population.
Data Source(s)	PAP encounter data, Electronic Data Interchange (EDI) transaction encounters, and Medicaid Management Information System (MMIS) FFS claims data
Measure Steward	NCQA: HEDIS 2017/NH DHHS
Measure Source	Ambulatory Care (AMB) – with modifications based on AMBCARE.07: Emergency Department Visits – Potentially Treatable in Primary Care by Age Group - Excluding NHHP Members
Measure ID	5-1

Statistical Testing

- Difference-in-differences

Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members

Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	
Domain	Cost-Effective Coverage
Waiver Goal	The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.
Hypothesis 6	Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions.
Measure Description	Quarterly rate of inpatient hospital utilization for ambulatory care sensitive conditions for overall AHRQ Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid member months.
Eligible Population	Matched treatment group and comparison group.
Numerator	<p>Acute inpatient discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:</p> <ul style="list-style-type: none"> • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 COPD or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI #10 Dehydration Admission Rate • PQI #11 Bacterial Pneumonia Admission Rate • PQI #12 Urinary Tract Infection Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate <p>Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.</p> <p>To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. <p>PQI 1: Diabetes Short-Term Complications Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for diabetes short-term complications (<u>Diabetes with Short Term Complications PQI Value Set</u>).</p> <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 3: Diabetes Long-Term Complications Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for diabetes long-term complications (<u>Diabetes with Long Term Complications PQI Value Set</u>).</p> <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 5: COPD or Asthma in Older Adults Admission</p> <p>Numerator: Number of discharges of members ages 40 and older with any one of the following:</p> <ul style="list-style-type: none"> • Principal diagnosis code for COPD (excluding acute bronchitis—<u>COPD PQI Value Set</u>) • Principal diagnosis code for asthma (<u>Asthma PQI Value Set</u>)

Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	
	<p>Exclusions: Members with a diagnosis for cystic fibrosis and anomalies of the respiratory system (<u>Cystic Fibrosis PQI Value Set</u>). Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 7: Hypertension Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for hypertension (<u>Hypertension PQI Value Set</u>).</p> <p>Exclusions: Members with a procedure code for cardiac procedure (<u>Cardiac Procedures Value Set</u>). Also, exclude members with a diagnosis for Stage I–IV kidney disease if the diagnosis is accompanied by a procedure code for dialysis (<u>Kidney Disease PQI Value Set</u> with <u>Dialysis Access Procedures PQI Value Set</u>). Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 8: Heart Failure Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for heart failure (<u>Heart Failure PQI Value Set</u>).</p> <p>Exclusions: Exclude patients with a listed procedure code for cardiac procedure (<u>Cardiac Procedures PQI Value Set</u>). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI–A). Patients with a missing principal diagnosis on admission are excluded.</p> <p>PQI 10: Dehydration Admission Rate</p> <p>Numerator: Number of discharges for members ages 18 years and older with either:</p> <ul style="list-style-type: none"> • A principal ICD-9-CM or ICD-10-CM diagnosis code for dehydration (<u>Dehydration PQI Value Set</u>) • Any secondary ICD-9-CM or ICD-10-CM diagnosis codes for dehydration (<u>Dehydration PQI Value Set</u>) and a principal ICD-9-CM or ICD-10-CM diagnosis code for hyperosmolality and/or hyponatremia (<u>Hyperosmolality and Hyponatremia PQI Value Set</u>), gastroenteritis (<u>Gastroenteritis PQI Value Set</u>), or acute kidney injury (<u>Acute Kidney Failure PQI Value Set</u>) <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded. Exclude any listed ICD-9-CM or ICD-10-CM diagnosis code for chronic renal failure (<u>Chronic Renal Failure PQI Value Set</u>).</p> <p>PQI 11: Bacterial Pneumonia Admission Rate</p> <p>Numerator: Number of discharges for members ages 18 years and older, with a principal ICD-9-CM or ICD-10-CM diagnosis code for bacterial pneumonia (<u>Bacterial Pneumonia PQI Value Set</u>).</p> <p>Exclusions: Members with any ICD-9-CM or ICD-10-CM diagnosis codes for sickle cell anemia or HB-S disease (<u>Sickle Cell Anemia or HB-S Disease PQI Value Set</u>) or members with immunocompromised state (<u>Immunocompromised State PQI Value Set</u>). Exclude members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 12: Urinary Tract Infection Admission Rate</p> <p>Numerator: Number of discharges for members ages 18 years and older with a principal ICD-9-CM or ICD-10-CM diagnosis code for urinary tract infection (<u>Urinary Tract Infection PQI Value Set</u>).</p> <p>Exclusions: Members with a kidney/urinary tract disorder (<u>Kidney or Urinary Tract Disorder PQI Value Set</u>) or members with immunocompromised state (<u>Immunocompromised State PQI Value Set</u>). Exclude members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 14: Uncontrolled Diabetes Admission</p>

Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	
	<p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication (<u>Diabetes Uncontrolled PQI Value Set</u>).</p> <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 15: Asthma in Younger Adults Admission</p> <p>Numerator: Number of discharges of members ages 18 through 39 years with an ICD-9-CM or ICD-10-CM principal diagnosis code for asthma (<u>Asthma PQI Value Set</u>).</p> <p>Exclusions: Members with a diagnosis for cystic fibrosis and anomalies of the respiratory system (<u>Cystic Fibrosis PQI Value Set</u>). Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 16: Lower-Extremity Amputations Among Patients with Diabetes</p> <p>Numerator: Number of discharges of members ages 18 and older with any listed diagnosis code for lower-extremity amputation and any listed diagnosis code of diabetes (<u>Lower Extremity Amputation PQI Value Set</u> and <u>Diabetes PQI Value Set</u>).</p> <p>Exclusions: Members with any listed diagnosis for traumatic amputation of the lower extremity (<u>Traumatic Amputation Lower Extremity PQI Value Set</u>), members with an obstetric discharge, (<u>Obstetric Discharge PQI Value Set</u>), and members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded.</p>
Denominator	The number of member months for the eligible population.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	AHRQ Version 6.0
Measure Source	PQI 92 AHRQ Quality Indicators
Measure ID	6-1

Table PQI-A: Admission Codes for Transfers	
Point of Origin UB-04 Code	Description
4	Transfer from a hospital
5	Transfer from a skilled nursing facility or intermediate care facility
6	Transfer from another health care facility

Statistical Testing

- Difference-in-differences

Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members

Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	
Domain	Cost-Effective Coverage
Waiver Goal	The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.
Hypothesis 6	Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions.
Measure Description	Quarterly rate of ED utilization for ambulatory care sensitive conditions for overall AHRQ PQI Composite per 1,000 adult Medicaid member months.
Eligible Population	Matched treatment group and comparison group.
Numerator	<p>Emergency department visits, for patients ages 19 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:</p> <ul style="list-style-type: none"> • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 COPD or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI #10 Dehydration Admission Rate • PQI #11 Bacterial Pneumonia Admission Rate • PQI #12 Urinary Tract Infection Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate <p>ED visits that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.</p> <p>Identify ED visits during the measurement year using either of the following:</p> <ul style="list-style-type: none"> • An ED Visit (ED Value Set) • A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set) <p>Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.</p> <p>Exclusions: ED Visits with any of the following:</p> <ul style="list-style-type: none"> • A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set) • Psychiatry (Psychiatry Value Set) • Electroconvulsive therapy (Electroconvulsive Therapy Value Set) • Alcohol of drug rehabilitation or detoxification (AOD Rehab and Detox Value Set) <p>PQI 1: Diabetes Short-Term Complications Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for diabetes short-term complications (Diabetes with Short Term Complications PQI Value Set).</p> <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 3: Diabetes Long-Term Complications Admission</p>

Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	
	<p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for diabetes long-term complications (<u>Diabetes with Long Term Complications PQI Value Set</u>).</p> <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 5: COPD or Asthma in Older Adults Admission</p> <p>Numerator: Number of discharges of members ages 40 and older with any one of the following:</p> <ul style="list-style-type: none"> Principal diagnosis code for COPD (excluding acute bronchitis—<u>COPD PQI Value Set</u>) Principal diagnosis code for asthma (<u>Asthma PQI Value Set</u>) <p>Exclusions: Members with a diagnosis for cystic fibrosis and anomalies of the respiratory system (<u>Cystic Fibrosis PQI Value Set</u>). Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 7: Hypertension Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for hypertension (<u>Hypertension PQI Value Set</u>).</p> <p>Exclusions: Members with a procedure code for cardiac procedure (<u>Cardiac Procedures Value Set</u>). Also, exclude members with a diagnosis for Stage I-IV kidney disease if the diagnosis is accompanied by a procedure code for dialysis (<u>Kidney Disease PQI Value Set</u> with <u>Dialysis Access Procedures PQI Value Set</u>). Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 8: Heart Failure Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for heart failure (<u>Heart Failure PQI Value Set</u>).</p> <p>Exclusions: Exclude patients with a listed procedure code for cardiac procedure (<u>Cardiac Procedures PQI Value Set</u>). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI-A). Patients with a missing principal diagnosis on admission are excluded.</p> <p>PQI 10: Dehydration Admission Rate</p> <p>Numerator: Number of discharges for members ages 18 years and older with either:</p> <ul style="list-style-type: none"> A principal ICD-9-CM or ICD-10-CM diagnosis code for dehydration (<u>Dehydration PQI Value Set</u>) Any secondary ICD-9-CM or ICD-10-CM diagnosis codes for dehydration (<u>Dehydration PQI Value Set</u>) and a principal ICD-9-CM or ICD-10-CM diagnosis code for hyperosmolality and/or hyponatremia (<u>Hyperosmolality and Hyponatremia PQI Value Set</u>), gastroenteritis (<u>Gastroenteritis PQI Value Set</u>), or acute kidney injury (<u>Acute Kidney Failure PQI Value Set</u>) <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI-A). In addition, members with missing principal diagnosis codes on admission are excluded. Exclude any listed ICD-9-CM or ICD-10-CM diagnosis code for chronic renal failure (<u>Chronic Renal Failure PQI Value Set</u>).</p> <p>PQI 11: Bacterial Pneumonia Admission Rate</p> <p>Numerator: Number of discharges for members ages 18 years and older, with a principal ICD-9-CM or ICD-10-CM diagnosis code for bacterial pneumonia (<u>Bacterial Pneumonia PQI Value Set</u>).</p> <p>Exclusions: Members with any ICD-9-CM or ICD-10-CM diagnosis codes for sickle cell anemia or HB-S disease (<u>Sickle Cell Anemia or HB-S Disease PQI Value Set</u>) or members with immunocompromised state (<u>Immunocompromised State PQI Value Set</u>). Exclude members who transferred to a hospital from another</p>

Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members	
	<p>hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 12: Urinary Tract Infection Admission Rate</p> <p>Numerator: Number of discharges for members ages 18 years and older with a principal ICD-9-CM or ICD-10-CM diagnosis code for urinary tract infection (<u>Urinary Tract Infection PQI Value Set</u>).</p> <p>Exclusions: Members with a kidney/urinary tract disorder (<u>Kidney or Urinary Tract Disorder PQI Value Set</u>) or members with immunocompromised state (<u>Immunocompromised State PQI Value Set</u>). Exclude members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 14: Uncontrolled Diabetes Admission</p> <p>Numerator: Number of discharges of members ages 18 and older with an ICD-9-CM or ICD-10-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication (<u>Diabetes Uncontrolled PQI Value Set</u>).</p> <p>Exclusions: Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 15: Asthma in Younger Adults Admission</p> <p>Numerator: Number of discharges of members ages 18 through 39 years with an ICD-9-CM or ICD-10-CM principal diagnosis code for asthma (<u>Asthma PQI Value Set</u>).</p> <p>Exclusions: Members with a diagnosis for cystic fibrosis and anomalies of the respiratory system (<u>Cystic Fibrosis PQI Value Set</u>). Members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p> <p>PQI 16: Lower-Extremity Amputations Among Patients with Diabetes</p> <p>Numerator: Number of discharges of members ages 18 and older with any listed diagnosis code for lower-extremity amputation and any listed diagnosis code of diabetes (<u>Lower Extremity Amputation PQI Value Set</u> and <u>Diabetes PQI Value Set</u>).</p> <p>Exclusions: Members with any listed diagnosis for traumatic amputation of the lower extremity (<u>Traumatic Amputation Lower Extremity PQI Value Set</u>), members with an obstetric discharge, (<u>Obstetric Discharge PQI Value Set</u>), and members who transferred to a hospital from another hospital (different facility), SNF or ICF, or another health care facility (Table PQI–A). In addition, members with missing principal diagnosis codes on admission are excluded.</p>
Denominator	The number of member months for the eligible population
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	AHRQ Version 6.0
Measure Source	PQI 92 AHRQ Quality Indicators
Measure ID	6-2

Table PQI-A: Admission Codes for Transfers

Point of Origin UB-04 Code	Description
4	Transfer from a hospital
5	Transfer from a skilled nursing facility or intermediate care facility
6	Transfer from another health care facility

Statistical Testing

- Difference-in-differences

Plan Perspective on Program Impact on Marketplace Entry

Plan Perspective on Program Impact on Marketplace Entry	
Domain	Cost Effective Coverage
Waiver Goal	The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs.
Hypothesis 7	Implementation of the program will result in more Medicaid plans deciding to enter the NH health insurance marketplace.
Measure Description	Ask Medicaid plans the extent to which implementation of the PAP program has influenced their decision to expand into the NH marketplace or the extent to which they have considered such expansions. Ask QHPs to what extent PAP influenced their decision to enter the NH marketplace.
Eligible Population	PAP QHPs and Medicaid MCOs
Data Source(s)	2017 Plan Interviews
Measure ID	7-1

Statistical Testing

- Interim Evaluation Report
 - Qualitative Review of Interview Responses
- Final Evaluation Report
 - Qualitative Review of Interview Responses

Uniform Provider Access

Medication Management for People with Asthma (MMA)

Medication Management for People with Asthma (MMA)	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 8	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
Measure Description	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75 percent of their treatment period.
Eligible Population	Matched treatment group and comparison group with continuous enrollment in the measurement year and the year prior to the measurement year. Members cannot have more than one gap in enrollment of up to 45 days during each year of continuous enrollment. Member must be enrolled on the last day of the measurement year.
Numerator	<p>The number of members who achieved a proportion of days covered (PDC) of at least 75 percent for their asthma controller medications (Table MMA-B) during the measurement year.</p> <p><i>Step 1</i>—Identify the Index Prescription Start Date (IPSD). The earliest dispensing event for any asthma controller medication (Table MMA-B) during the measurement year.</p> <p><i>Step 2</i>—The treatment period is the period beginning on the IPSD through the end of the measurement year. Count the number of days during the member's treatment period.</p> <p><i>Step 3</i>—Count the days covered by at least one prescription for an asthma controller medication (Table MMA-B) during the treatment period.</p> <p><i>Step 4</i>—Calculate the member's PDC as the count of days from Step 3/count of days from Step 2.</p>

Medication Management for People with Asthma (MMA)	
Denominator	<p><i>Step 1</i>—Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.</p> <ul style="list-style-type: none"> • At least one ED visit (<u>ED Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>). • At least one acute inpatient stay (<u>Acute Inpatient Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>). • At least four outpatient visits (<u>Outpatient Value Set</u>) or observation visits (<u>Observation Value Set</u>) on different dates of service, with any diagnosis of asthma (<u>Asthma Value Set</u>) and at least two asthma medication dispensing events (Table MMA-A). Visit type need not be the same for the four visits. • At least four asthma medication dispensing events (Table MMA-A). <p><i>Step 2</i>—A member identified in Step 1 where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (<u>Asthma Value Set</u>) in the same year as the dispensing event.</p> <p><i>Step 3</i>—Exclude members who met any of the following criteria:</p> <ul style="list-style-type: none"> • Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year. <ul style="list-style-type: none"> ○ <u>Emphysema Value Set</u> ○ <u>Other Emphysema Value Set</u> ○ <u>COPD Value Set</u> ○ <u>Obstructive Chronic Bronchitis Value Set</u> ○ <u>Chronic Respiratory Conditions Due to Fumes/Vapors Value Set</u> ○ <u>Cystic Fibrosis Value Set</u> ○ <u>Acute Respiratory Failure Value Set</u> • Members who had no asthma controlling medications (Table MMA-B) dispensed during the measurement year.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Medication Management for People with Asthma (MMA)
Measure ID	8-1

Table MMA-A: Asthma Medications		
Description	Prescription	
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline
Antibody inhibitor	• Omalizumab	
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast • Zafirlukast	• Zileuton
Mast cell stabilizers	• Cromolyn	
Methylxanthines	• Aminophylline • Dyphylline	• Theophylline
Short acting, inhaled beta-2 agonists	• Albuterol • Levalbuterol	• Pirbuterol

Table MMA-B: Asthma Controller Medications		
Description	Prescription	
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline
Antibody inhibitor	• Omalizumab	
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast • Zafirlukast	• Zileuton
Mast cell stabilizers	• Cromolyn	
Methylxanthines	• Aminophylline • Dyphylline	• Theophylline

Statistical Testing

- Difference-in-differences

Timeliness of Prenatal Care

Timeliness of Prenatal Care	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 8	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
Measure Description	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received prenatal care according to HEDIS specifications for the measure.
Eligible Population	Matched treatment group and comparison group continuously enrolled 43 days prior to delivery through 56 days after delivery.
Numerator	<p>A prenatal visit in the first trimester on the enrollment start date or within 42 days of enrollment, depending on the date of enrollment and the gaps in enrollment during the pregnancy.</p> <p><i>Include only visits that occur while the member was enrolled in the respective program. The respective program is Medicaid MCO enrollment for matched non-PAP members and PAP members during the baseline year, and the PAP for PAP members during the evaluation year.</i></p> <p>Step 1—Determine enrollment status during the first trimester. Identify women who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to Step 2.</p> <p>For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to Step 3.</p> <p>Step 2—Determine continuous enrollment for the first trimester. Identify women from Step 1 who were continuously enrolled during the first trimester (176-280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for <i>Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester</i>.</p> <p>For women who were not continuously enrolled during the first trimester (e.g. had a gap between 176 and 280 days before delivery), proceed to Step 3.</p> <p>Step 3—Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).</p> <ul style="list-style-type: none"> For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to Step 4. For women whose last enrollment started less than 219 days before delivery, proceed to Step 5. <p>Step 4—Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for <i>Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester</i> and find a visit on or between the last enrollment start date and 176 days before delivery.</p> <p>Step 5—Determine numerator compliance. If the last enrollment segment started between 219 days and the date of delivery (exclusive), determine numerator compliance using the instructions for <i>Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester</i> and find a visit on the enrollment start date or within 42 days after enrollment.</p> <p>Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester</p> <p>There are three decision rules for identifying prenatal visits. The dates of service for all criteria must be during the first trimester (between 176 and 280 days prior to the delivery date or EDD).</p> <p>Decision Rule 1: A visit for prenatal care (Stand Alone Prenatal Visits Value Set) or bundled service (Prenatal Bundled Services Value Set) during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner, or PCP. Vital statistics will be used to determine the date that bundled services were initiated.</p>

Timeliness of Prenatal Care	<p>Decision Rule 2: Any visit to an OB/GYN or other prenatal care practitioner with a prenatal visit (<u>Prenatal Visits Value Set</u>) with one of the following:</p> <ul style="list-style-type: none"> • An obstetric panel (<u>Obstetric Panel Value Set</u>). • An ultrasound (echocardiography) of the pregnant uterus (<u>Prenatal Ultrasound Value Set</u>). • A pregnancy-related diagnosis code (<u>Pregnancy Diagnosis Value Set</u>). • All of the following: <ul style="list-style-type: none"> ○ Toxoplasma (<u>Toxoplasma Antibody Value Set</u>) ○ Rubella (<u>Rubella Antibody Value Set</u>) ○ Cytomegalovirus (<u>Cytomegalovirus Antibody Value Set</u>) ○ Herpes simplex (<u>Herpes Simplex Antibody Value Set</u>) • Rubella (<u>Rubella Antibody Value Set</u>) and at least one of the following: <ul style="list-style-type: none"> ○ ABO (<u>ABO Value Set</u>) ○ Rh (<u>Rh Value Set</u>) <p>Decision Rule 3: Any of the following during the first trimester, where the practitioner type is a PCP with a pregnancy related ICD-CM diagnosis code (<u>Pregnancy Diagnosis Value Set</u>) and a prenatal visit (<u>Prenatal Visits Value Set</u>) <i>and</i> one of the following:</p> <ul style="list-style-type: none"> • An obstetric panel (<u>Obstetric Panel Value Set</u>) • An ultrasound (echocardiography) of the pregnant uterus (<u>Prenatal Ultrasound Value Set</u>) • All of the following: <ul style="list-style-type: none"> ○ Toxoplasma (<u>Toxoplasma Antibody Value Set</u>) ○ Rubella (<u>Rubella Antibody Value Set</u>) ○ Cytomegalovirus (<u>Cytomegalovirus Antibody Value Set</u>) ○ Herpes simplex (<u>Herpes Simplex Antibody Value Set</u>) • Rubella (<u>Rubella Antibody Value Set</u>) and at least one of the following: <ul style="list-style-type: none"> ○ ABO (<u>ABO Value Set</u>) ○ Rh (<u>Rh Value Set</u>) <p>Note: For Decision Rule 3 criteria that require a prenatal visit code <i>and</i> a pregnancy-related diagnosis code, codes must be on the same claim.</p> <p>Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester</p> <p>Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet the criteria:</p> <ul style="list-style-type: none"> • A bundled service (<u>Prenatal Bundled Services Value Set</u>). Vital statistics will be used to determine the date that bundled services were initiated • A visit for prenatal care (<u>Stand Alone Prenatal Visits Value Set</u>) • A prenatal visit (<u>Prenatal Visits Value Set</u>) with an ultrasound of the pregnant uterus (<u>Prenatal Ultrasound Value Set</u>) • A prenatal visit (<u>Prenatal Visits Value Set</u>) with a principal pregnancy-related diagnosis code (<u>Pregnancy Diagnosis Value Set</u>) <p>Note: For criteria that require a prenatal visit code and a pregnancy-related diagnosis code, codes must be on the same claim.</p>
Denominator	<p>Women with a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Delivery can be in any setting.</p> <p>Multiple births: Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Dates of service must be 210 or more calendar days apart. Women who had multiple live births during one pregnancy (within 210 calendar days) count once.</p>

Timeliness of Prenatal Care	
	<p>Identify live births:</p> <ol style="list-style-type: none"> 1. Identify all women with a delivery (<u>Deliveries Value Set</u>) on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. 2. Exclude non-live births (<u>Non-live Births Value Set</u>) <p>Determine if enrollment in respective program was continuous 43 days prior to delivery through 56 days after delivery, with no gaps.</p>
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data; Matched vital statistics
Measure Steward	HEDIS 2017
Measure Source	Prenatal and Postpartum Care (PPC)
Measure ID	8-2

Statistical Testing

- Difference-in-differences

Postpartum Care

Postpartum Care	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 8	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
Measure Description	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received postpartum care according to HEDIS specifications for the measure.
Eligible Population	Matched treatment group and comparison group continuously enrolled 43 days prior to delivery through 56 days after delivery.
Numerator	Any of the following on or between 21 and 56 days after delivery meet criteria: <ul style="list-style-type: none"> A postpartum visit (Postpartum Visits Value Set) Cervical cytology (Cervical Cytology Value Set) A bundled service (Postpartum Bundled Services Value Set). Vital statistics will be used to determine the date that bundled services were initiated, if available.
Denominator	Women with a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Delivery can be in any setting. Multiple births: Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Dates of service must be 210 or more calendar days apart. Women who had multiple live births during one pregnancy (within 210 calendar days) count once. Matched vital statistics will be used where applicable to identify the delivery date of live births. For members where vital statistics cannot be used to identify the delivery date, use the following steps to identify live births: <ol style="list-style-type: none"> Identify all women with a delivery (Deliveries Value Set) on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Exclude non-live births (Non-live Births Value Set) Determine if enrollment in respective program was continuous 43 days prior to delivery through 56 days after delivery, with no gaps.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data; Matched vital statistics
Measure Steward	HEDIS 2017
Measure Source	Prenatal and Postpartum Care (PPC)
Measure ID	8-3

Statistical Testing

- Difference-in-differences

Patients' Perception of Quick Access to Needed Care

Patients' Perception of Quick Access to Needed Care											
Domain	Uniform Provider Access										
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.										
Hypothesis 8	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.										
Measure Description	For respondents, a proportional choice for "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?" for responses "Never/Sometimes/Usually/Always".										
Eligible Population	PAP and non-PAP sample frame.										
Numerator	<p>Three summary rates will be evaluated based on different numeric representation of the responses to the following question:</p> <p style="padding-left: 40px;">"In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?"</p> <p>Responses and their corresponding coding values for statistical testing are as follows:</p> <table border="1" data-bbox="760 940 1138 1146"> <thead> <tr> <th>Response Choices</th><th>Coding Value</th></tr> </thead> <tbody> <tr> <td>Never</td><td>0</td></tr> <tr> <td>Sometimes</td><td>0</td></tr> <tr> <td>Usually</td><td>1</td></tr> <tr> <td>Always</td><td>1</td></tr> </tbody> </table>	Response Choices	Coding Value	Never	0	Sometimes	0	Usually	1	Always	1
Response Choices	Coding Value										
Never	0										
Sometimes	0										
Usually	1										
Always	1										
Denominator	The number of valid responses from the eligible population.										
Data Source(s)	CAHPS 2015 and 2017 Survey										
Measure ID	8-4										

Note: this was measure 8-5 in the original evaluation plan.

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Patients' Perception of Ease of Getting Appointments with Specialists

Patients' Perception of Ease of Getting Appointments with Specialists											
Domain	Uniform Provider Access										
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.										
Hypothesis 8	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.										
Measure Description	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?" for responses "Never/Sometimes/Usually/Always".										
Eligible Population	PAP and non-PAP sample frame.										
Numerator	<p>Three summary rates will be evaluated based on different numeric representation of the responses to the following question:</p> <p>"In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?"</p> <p>Responses and their corresponding coding values for statistical testing are as follows:</p> <table border="1"> <thead> <tr> <th>Response Choices</th><th>Coding Value</th></tr> </thead> <tbody> <tr> <td>Never</td><td>0</td></tr> <tr> <td>Sometimes</td><td>0</td></tr> <tr> <td>Usually</td><td>1</td></tr> <tr> <td>Always</td><td>1</td></tr> </tbody> </table>	Response Choices	Coding Value	Never	0	Sometimes	0	Usually	1	Always	1
Response Choices	Coding Value										
Never	0										
Sometimes	0										
Usually	1										
Always	1										
Denominator	The number of valid responses from the eligible population.										
Data Source(s)	CAHPS 2015 and 2017 Survey										
Measure ID	8-5										

Note: this was measure 8-4 in the original evaluation plan.

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Adults' Access to Ambulatory/Preventive Health Services

Adults' Access to Ambulatory/Preventive Health Services	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 8	Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
Measure Description	The percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit, by age group.
Eligible Population	Matched treatment group and comparison group members with continuous enrollment in the measurement year. Members can have one gap in enrollment of up to 45 days. Member must be enrolled on the last day of the measurement year.
Numerator	One or more ambulatory or preventive care visits during the measurement year (<u>Ambulatory Visits Value Set</u> or <u>Other Ambulatory Visits Value Set</u>).
Denominator	The eligible population.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure ID	8-6

Note: this measure was not included in the original evaluation plan.

Statistical Testing

- Difference-in-differences

Adults' Access to Preventive Health Services

Adults' Access to Preventive Health Services	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.
Measure Description	The percentage of eligible members, age 20 years through 64 years, who had an preventive care visit, by age group.
Eligible Population	Matched treatment group and comparison group members with continuous enrollment in the measurement year. Members cannot have one gap in enrollment of up to 45 days. Member must be enrolled on the last day of the measurement year.
Numerator	One or more ambulatory or preventive care visits during the measurement year (<u>Preventive Ambulatory Visits Value Set</u> or <u>Other Preventive Ambulatory Visits Value Set</u>).
Denominator	The eligible population.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Revised version of Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure ID	9-1

Statistical Testing

- Difference-in-differences

Annual Influenza Immunization

Annual Influenza Immunization	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.
Measure Description	Flu vaccinations for adults ages 18 to 64: percentage of members 18 to 64 years of age who received an influenza vaccination between July 1 of the measurement year and the date on which the CAHPS 5.0 survey was completed.
Eligible Population	PAP and non-PAP sample frame.
Numerator	Number of members who responded “Yes” to the following question: “Have you had either a flu shot or flu spray in the nose since July 1, 2016?”
Denominator	Number of members who responded “Yes” or “No” to the following question: “Have you had either a flu shot or flu spray in the nose since July 1, 2016?”
Data Source(s)	CAHPS 2015 and 2017 Survey
Measure ID	9-3

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Comprehensive Diabetes Care—Eye Exam

Comprehensive Diabetes Care – Eye Exam	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.
Measure Description	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who had an eye exam (retinal exam) performed.
Eligible Population	Matched treatment group and comparison group members with continuous enrollment in the measurement year and the year prior to the measurement year. Members cannot have more than one gap in enrollment of up to 45 days during each year of continuous enrollment. Member must be enrolled on the last day of the measurement year.
Numerator	<p>Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:</p> <ul style="list-style-type: none"> A retinal dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. <p>Any of the following meet criteria:</p> <ul style="list-style-type: none"> Any code in the <u>Diabetic Retinal Screening Value Set</u> billed by an eye care professional during the measurement year. Any code in the <u>Diabetic Retinal Screening Value Set</u> billed by an eye care professional during the year prior to the measurement year, with a negative result (negative for retinopathy). Any code in the <u>Diabetic Retinal Screening Value Set</u> billed by an eye care professional during the year prior to the measurement year, with a diagnosis of diabetes without complications (<u>Diabetes Mellitus Without Complications Value Set</u>). All codes must be on the same claim. Any code in the <u>Diabetic Retinal Screening With Eye Care Professional Value Set</u> billed by any provider type during the measurement year. Any code in the <u>Diabetic Retinal Screening With Eye Care Professional Value Set</u> billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy). Any code in the <u>Diabetic Retinal Screening Negative Value Set</u> billed by any provider type during the measurement year. <p>Exclusions (optional)</p> <ul style="list-style-type: none"> Members who do not have a diagnosis of diabetes (<u>Diabetes Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (<u>Diabetes Exclusions Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year. Exclude members from Measure 9-4 if they were excluded through optional exclusions for Measure 9-5.
Denominator	<p>Members who met any of the following criteria during the measurement year or the year prior to the measurement year:</p> <ul style="list-style-type: none"> At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits. At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Member was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis (Table CDC-A).

Comprehensive Diabetes Care – Eye Exam	
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Comprehensive Diabetes Care (CDC)
Measure ID	9-4

Table CDC-A: Prescriptions to Identify Diabetics Using Pharmacy Data	
Description	Prescription
Alpha-glucosidase inhibitors	<ul style="list-style-type: none"> Acarbose Miglitol
Amylin analogs	<ul style="list-style-type: none"> Pramlintide
Antidiabetic combinations	<ul style="list-style-type: none"> Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Sitagliptin-simvastatin
Insulin	<ul style="list-style-type: none"> Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin human inhaled
Meglitinides	<ul style="list-style-type: none"> Nateglinide Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> Exenatide Dualaglutide Liraglutide Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> Canagliflozin Dapagliflozin Empagliflozin
Sulfonylureas	<ul style="list-style-type: none"> Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	<ul style="list-style-type: none"> Pioglitazone Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	<ul style="list-style-type: none"> Alogliptin Linagliptin Saxagliptin Sitagliptin

Statistical Testing

- Difference-in-differences

Comprehensive Diabetes Care—HbA1c Testing

Comprehensive Diabetes Care – HbA1c Testing	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.
Measure Description	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who had an HbA1c test performed.
Eligible Population	Matched treatment group and comparison group members with continuous enrollment in the measurement year and the year prior to the measurement year. Members cannot have more than one gap in enrollment of up to 45 days during each year of continuous enrollment. Member must be enrolled on the last day of the measurement year.
Numerator	<p>An HbA1c test (<u>HbA1c Tests Value Set</u>) performed during the measurement year.</p> <p>Exclusions (optional)</p> <ul style="list-style-type: none"> Members who do not have a diagnosis of diabetes (<u>Diabetes Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (<u>Diabetes Exclusions Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year. Exclude members from Measure 9-5 if they were excluded through optional exclusions for Measure 9-4.
Denominator	<p>Members who met any of the following criteria during the measurement year or the year prior to the measurement year:</p> <ul style="list-style-type: none"> At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits. At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Member was dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis (Table CDC-A).
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Comprehensive Diabetes Care (CDC)
Measure ID	9-5

Table CDC-A: Prescriptions to Identify Diabetics Using Pharmacy Data		
Description	Prescription	
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol
Amylin analogs	• Pramlintide	
Antidiabetic combinations	<ul style="list-style-type: none"> • Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin 	<ul style="list-style-type: none"> • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	<ul style="list-style-type: none"> • Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin isophane human 	<ul style="list-style-type: none"> • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled
Meglitinides	• Nateglinide	• Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> • Exenatide • Dualaglutide 	<ul style="list-style-type: none"> • Liraglutide • Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> • Canagliflozin • Dapagliflozin 	• Empagliflozin
Sulfonylureas	<ul style="list-style-type: none"> • Chlorpropamide • Glimepiride • Glipizide 	<ul style="list-style-type: none"> • Glyburide • Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	<ul style="list-style-type: none"> • Alogliptin • Linagliptin 	<ul style="list-style-type: none"> • Saxagliptin • Sitagliptin

Statistical Testing

- Difference-in-differences

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Use of Spirometry Testing in the Assessment and Diagnosis of COPD	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.
Measure Description	The percentage of members 40 years of age and older with a diagnosis of COPD, who received appropriate spirometry testing to confirm the diagnosis or for the management of COPD.
Eligible Population	Matched treatment group and comparison group members aged 40 years or older as of December 31 of the measurement year, with continuous enrollment in the measurement year with up to one gap in enrollment of up to 45 days. The member must be enrolled in the relevant program on the Index Episode Start Date (IESD).
Numerator	At least one claim or encounter for spirometry (<u>Spirometry Value Set</u>) during the measurement year.
Denominator	<p>The Index Episode Start Date is the first visit with a diagnosis of COPD during the Intake Period, which begins on February 1 to November 30 of the measurement year. The steps below identify the eligible population.</p> <p><i>Step 1</i>—Identify all members who had any of the following during the Intake Period.</p> <ul style="list-style-type: none"> An outpatient visit (<u>Outpatient Value Set</u>), an observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) with any diagnosis of COPD (<u>COPD Value Set</u>), emphysema (<u>Emphysema Value Set</u>) or chronic bronchitis (<u>Chronic Bronchitis Value Set</u>). <ul style="list-style-type: none"> Do not include ED visits or observation visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less. An acute inpatient discharge with any diagnosis of COPD (<u>COPD Value Set</u>), emphysema (<u>Emphysema Value Set</u>) or chronic bronchitis (<u>Chronic Bronchitis Value Set</u>). To identify acute inpatient discharges: <ol style="list-style-type: none"> Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). Identify the discharge date for the stay. <p>If the member had more than one eligible visit, include only the first stay.</p> <p><i>Step 3</i>—Calculate continuous enrollment. Members must be continuously enrolled in the measurement year.</p>
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Measure ID	9-6

Statistical Testing

- Difference-in-differences

Cervical Cancer Screening

Cervical Cancer Screening	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.
Measure Description	<p>The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:</p> <p>Women age 21-64 who had cervical cytology performed every 3 years.</p> <p>Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.</p>
Eligible Population	Matched treatment group and comparison group with continuous enrollment in the measurement year. Members can have one gap in enrollment of up to 45 days. Member must be enrolled on the last day of the measurement year.
Numerator	<p>The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.</p> <p><i>Step 1</i>—Identify women 24-64 years of age as of December 31 of the measurement year who had cervical cytology (<u>Cervical Cytology Value Set</u>) during the measurement year or the two years prior to the measurement year.</p> <p><i>Step 2</i>—From the women who did not meet step 1 criteria, identify women 30-64 years of age as of December 31 of the measurement year who had cervical cytology (<u>Cervical Cytology Value Set</u>) and a HPV test (<u>HPV Tests Value Set</u>) with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests.</p> <p><i>Step 3</i>—Sum the events from steps 1 and 2 to obtain rate.</p> <p>Exclusions (optional)</p> <p>Exclude hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (<u>Absence of Cervix Value Set</u>) any time during the member's history through December 31 of the measurement year.</p>
Denominator	The eligible population.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Cervical Cancer Screening (CCS)
Measure ID	9-7

Note: this measure was not included in the original evaluation plan.

Statistical Testing

- Difference-in-differences

Timeliness of Check-Up or Routine Care Appointments

Timeliness of Check-Up or Routine Care Appointments											
Domain	Uniform Provider Access										
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.										
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.										
Measure Description	Number of members who report “usually” or always” getting an appointment for a check-up or routine care at a doctor’s office or clinic as soon as they needed.										
Eligible Population	PAP and non-PAP sample frame.										
Numerator	<p>Three summary rates will be evaluated based on different numeric representation of the responses to the following question:</p> <p>“In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed?”</p> <p>Responses and their corresponding coding values for statistical testing are as follows:</p> <table border="1"> <thead> <tr> <th>Response Choices</th><th>Coding Value</th></tr> </thead> <tbody> <tr> <td>Never</td><td>0</td></tr> <tr> <td>Sometimes</td><td>0</td></tr> <tr> <td>Usually</td><td>1</td></tr> <tr> <td>Always</td><td>1</td></tr> </tbody> </table>	Response Choices	Coding Value	Never	0	Sometimes	0	Usually	1	Always	1
Response Choices	Coding Value										
Never	0										
Sometimes	0										
Usually	1										
Always	1										
Denominator	The number of valid responses from the eligible population.										
Data Source(s)	CAHPS 2015 and 2017 Survey										
Measure ID	9-8										

Note: This measure was not included in the original evaluation plan.

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 9	Premium assistance beneficiaries will have equal or better access to preventive care services.
Measure Description	The percentage of members 19–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Eligible Population	Matched treatment group and comparison group members with continuous enrollment in the measurement year. Members can have one gap in enrollment of up to 45 days during the measurement year. Member must be enrolled on the last day of the measurement year.
Numerator	Members in the eligible population and in the denominator who have had a diabetes screening, defined by a glucose test (<u>Glucose Tests Value Set</u>) or an HbA1c test (<u>HbA1c Tests Value Set</u>) performed during the measurement year, as identified by claim/encounter or automated laboratory data.
Denominator	<p><i>Step 1</i>—Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.</p> <ul style="list-style-type: none"> At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> <u>BH Stand Alone Acute Inpatient Value Set</u> <i>with</i> <u>Schizophrenia Value Set</u>. <u>BH Stand Alone Acute Inpatient Value Set</u> <i>with</i> <u>Bipolar Disorder Value Set</u>. <u>BH Stand Alone Acute Inpatient Value Set</u> <i>with</i> <u>Other Bipolar Disorder Value Set</u>. <u>BH Acute Inpatient Value Set</u> <i>with</i> <u>BH Acute Inpatient POS Value Set</u> <i>and</i> <u>Schizophrenia Value Set</u>. <u>BH Acute Inpatient Value Set</u> <i>with</i> <u>BH Acute Inpatient POS Value Set</u> <i>and</i> <u>Bipolar Disorder Value Set</u>. <u>BH Acute Inpatient Value Set</u> <i>with</i> <u>BH Acute Inpatient POS Value Set</u> <i>and</i> <u>Other Bipolar Disorder Value Set</u>. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: <ul style="list-style-type: none"> <u>BH Stand Alone Outpatient/PH/IOP Value Set</u> <i>with</i> <u>Schizophrenia Value Set</u>. <u>BH Outpatient/PH/IOP Value Set</u> <i>with</i> <u>BH Outpatient/PH/IOP POS Value Set</u> <i>and</i> <u>Schizophrenia Value Set</u>. <u>ED Value Set</u> <i>with</i> <u>Schizophrenia Value Set</u>. <u>BH ED Value Set</u> <i>with</i> <u>ED POS Value Set</u> <i>and</i> <u>Schizophrenia Value Set</u>. <u>BH Stand Alone Nonacute Inpatient Value Set</u> <i>with</i> <u>Schizophrenia Value Set</u>. <u>BH Nonacute Inpatient Value Set</u> <i>with</i> <u>BH Nonacute Inpatient POS Value Set</u> <i>and</i> <u>Schizophrenia Value Set</u>. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria: <ul style="list-style-type: none"> <u>BH Stand Alone Outpatient/PH/IOP Value Set</u> <i>with</i> <u>Bipolar Disorder Value Set</u>. <u>BH Stand Alone Outpatient/PH/IOP Value Set</u> <i>with</i> <u>Other Bipolar Disorder Value Set</u>. <u>BH Outpatient/PH/IOP Value Set</u> <i>with</i> <u>BH Outpatient/PH/IOP POS Value Set</u> <i>and</i> <u>Bipolar Disorder Value Set</u>. <u>BH Outpatient/PH/IOP Value Set</u> <i>with</i> <u>BH Outpatient/PH/IOP POS Value Set</u> <i>and</i> <u>Other Bipolar Disorder Value Set</u>. <u>ED Value Set</u> <i>with</i> <u>Bipolar Disorder Value Set</u>.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
	<ul style="list-style-type: none"> • <u>ED Value Set with Other Bipolar Disorder Value Set.</u> • <u>BH ED Value Set with ED POS Value Set and Bipolar Disorder Value Set.</u> • <u>BH ED Value Set with ED POS Value Set and Other Bipolar Disorder Value Set.</u> • <u>BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set.</u> • <u>BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.</u> • <u>BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Bipolar Disorder Value Set.</u> • <u>BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Other Bipolar Disorder Value Set.</u> <p>Step 2—Exclude members who met any of the following criteria:</p> <ul style="list-style-type: none"> • Members with diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. <ul style="list-style-type: none"> ○ Claim/encounter data. Members who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years). <ul style="list-style-type: none"> ▪ At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits. ▪ At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>). • Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A). • Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. <ul style="list-style-type: none"> ○ Claim/encounter data. An antipsychotic medication (<u>Long-Acting Injections Value Set</u>). ○ Pharmacy data. Dispensed an antipsychotic medication (Table SSD-D) on an ambulatory basis.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017
Measure Source	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Measure ID	9-9

Table CDC-A: Prescriptions to Identify Diabetics Using Pharmacy Data		
Description	Prescription	
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol
Amylin analogs	• Pramlintide	
Antidiabetic combinations	<ul style="list-style-type: none"> • Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin 	<ul style="list-style-type: none"> • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	<ul style="list-style-type: none"> • Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin isophane human 	<ul style="list-style-type: none"> • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled
Meglitinides	• Nateglinide	• Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> • Exenatide • Dualaglutide 	<ul style="list-style-type: none"> • Liraglutide • Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> • Canagliflozin • Dapagliflozin 	• Empagliflozin
Sulfonylureas	<ul style="list-style-type: none"> • Chlorpropamide • Glimepiride • Glipizide 	<ul style="list-style-type: none"> • Glyburide • Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	<ul style="list-style-type: none"> • Alogliptin • Linagliptin 	<ul style="list-style-type: none"> • Saxagliptin • Sitagliptin

Table SSD-D: Antipsychotic Medications		
Description	Prescription	
Miscellaneous antipsychotic agents	<ul style="list-style-type: none"> • Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol • Iloperidone 	<ul style="list-style-type: none"> • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone • Pimozide • Quetiapine
Phenothiazine antipsychotics	<ul style="list-style-type: none"> • Chlorpromazine • Fluphenazine • Perphenazine 	<ul style="list-style-type: none"> • Perphenazine-amitriptyline • Prochlorperazine • Thioridazine • Trifluoperazine
Psychotherapeutic combinations	• Fluoxetine-olanzapine	
Thioxanthenes	• Thiothixene	
Long-acting injections	<ul style="list-style-type: none"> • Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate 	<ul style="list-style-type: none"> • Olanzapine • Paliperidone palmitate • Risperidone

Statistical Testing

- Difference-in-differences

Patients' Rating of Overall Health Care

Patients' Rating of Overall Health Care																									
Domain	Uniform Provider Access																								
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.																								
Hypothesis 10	Premium assistance beneficiaries will report equal or better satisfaction in the care provided.																								
Measure Description	For respondents, a proportional choice for "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?"																								
Eligible Population	PAP and non-PAP Sample Frame																								
Numerator	<p>Three summary rates will be evaluated based on different numeric representations of the outcome. An 11-point non-recoded scale will be used and two top-box ratings will be used. The numerator value will be defined as the response score value or numerator compliance for each member answering the following question:</p> <p>"Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?"</p> <p>Responses and their corresponding score values and numerator compliance are as follows:</p> <table border="1"> <thead> <tr> <th>Response Choices</th><th>Score Value</th></tr> </thead> <tbody> <tr> <td>0 – Worst health care possible</td><td>0</td></tr> <tr> <td>1</td><td>0</td></tr> <tr> <td>2</td><td>0</td></tr> <tr> <td>3</td><td>0</td></tr> <tr> <td>4</td><td>0</td></tr> <tr> <td>5</td><td>0</td></tr> <tr> <td>6</td><td>0</td></tr> <tr> <td>7</td><td>0</td></tr> <tr> <td>8</td><td>1</td></tr> <tr> <td>9</td><td>1</td></tr> <tr> <td>10 – Best health care possible</td><td>1</td></tr> </tbody> </table>	Response Choices	Score Value	0 – Worst health care possible	0	1	0	2	0	3	0	4	0	5	0	6	0	7	0	8	1	9	1	10 – Best health care possible	1
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5	0																								
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Denominator	The number of valid responses from the eligible population.																								
Data Source(s)	CAHPS 2015 and 2017 Survey																								
Measure ID	10-1																								

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

Patients' Rating the Health Plan

Patients' Rating the Health Plan																									
Domain	Uniform Provider Access																								
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.																								
Hypothesis 10	Premium assistance beneficiaries will report equal or better satisfaction in the care provided.																								
Measure Description	For respondents, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"																								
Eligible Population	PAP and non-PAP sample frame																								
Numerator	<p>Three summary rates will be evaluated based on different numeric representations of the outcome. An 11-point non-recoded scale will be used and two top-box ratings will be used. The numerator value will be defined as the response score value or numerator compliance for each member answering the following question:</p> <p>"Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"</p> <p>Responses and their corresponding score values are as follows:</p> <table border="1"> <thead> <tr> <th>Response Choices</th><th>Score Value</th></tr> </thead> <tbody> <tr> <td>0 – Worst health plan possible</td><td>0</td></tr> <tr> <td>1</td><td>0</td></tr> <tr> <td>2</td><td>0</td></tr> <tr> <td>3</td><td>0</td></tr> <tr> <td>4</td><td>0</td></tr> <tr> <td>5</td><td>0</td></tr> <tr> <td>6</td><td>0</td></tr> <tr> <td>7</td><td>0</td></tr> <tr> <td>8</td><td>1</td></tr> <tr> <td>9</td><td>1</td></tr> <tr> <td>10 – Best health plan possible</td><td>1</td></tr> </tbody> </table>	Response Choices	Score Value	0 – Worst health plan possible	0	1	0	2	0	3	0	4	0	5	0	6	0	7	0	8	1	9	1	10 – Best health plan possible	1
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Denominator	The number of valid responses from the eligible population.																								
Data Source(s)	CAHPS																								
Measure ID	10-2																								

Statistical Testing

- Interim Evaluation Report
 - z-test
- Final Evaluation Report
 - Difference-in-differences

EPSDT Screening—Well-Care Visits

EPSDT Screening—Well-Care Visits	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 11	Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these Benefits.
Measure Description	Percentage of members aged 19 and 20 who received at least one initial or periodic screen.
Eligible Population	Matched treatment group and comparison group aged 19 or 20 years old as of the last day of the measurement year.
Numerator	At least one comprehensive well-care visit (<u>Well-Care Value Set</u>) with a PCP or an OB/GYN practitioner during the measurement year.
Denominator	<p>Matched treatment group and comparison group aged 19 or 20 years old as of the last day of the measurement year. Exclude members for whom EPSDT services may not be available:</p> <ul style="list-style-type: none"> Medically needy individuals if the state does not provide EPSDT services for the medically needy. Waiver expansion population for which the full complement of EPSDT services is not available. Undocumented aliens who are eligible only for emergency Medicaid services. Children in separate state CHIP programs. Those who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	CMS Child Core Set (June 2016)
Measure Source	AWC-CH: Adolescent Well-Care Visit
Measure ID	11-1

Statistical Testing

- Difference-in-differences

EPSDT Screening—Preventive Dental Visits

EPSDT Screening—Preventive Dental Visits	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 11	Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these Benefits.
Measure Description	Percentage of members aged 19 and 20 who received at least one initial or periodic screen.
Eligible Population	Matched treatment group and comparison group aged 19 or 20 years old as of the last day of the measurement year.
Numerator	At least one dental visit (<u>Preventive Dental Visits Value Set</u>) with a dental practitioner during the measurement year.
Denominator	Matched treatment group and comparison group aged 19 or 20 years old as of the last day of the measurement year. Exclude members for whom EPSDT services may not be available: <ul style="list-style-type: none"> Medically needy individuals if the state does not provide EPSDT services for the medically needy. Waiver expansion population for which the full complement of EPSDT services is not available. Undocumented aliens who are eligible only for emergency Medicaid services. Children in separate state CHIP programs. Those who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	CMS Child Core Set (June 2016)
Measure Source	PDENT-CH: Percentage of Eligibles Who Received Preventive Dental Services
Measure ID	11-2

Statistical Testing

- Difference-in-differences

NEMT Request Authorization Approval Rate

NEMT Request Authorization Approval Rate	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 12	Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT).
Measure Description	The percentage of NEMT requests authorized, of those requested during the measure data period, for the eligible population.
Eligible Population	All Participants in PAP and non-PAP Medicaid programs.
Numerator	Number of authorized NEMT requests in each program.
Denominator	Number of NEMT requests in each program.
Data Source(s)	NH DHHS. Office of Quality Assurance and Improvement. Online Report based on NEMT provider self-reported data. [http://medicaidquality.nh.gov]
Measure ID	12-1

Statistical Testing

- z-test

NEMT Requests Delivered by Type of Medical Service

NEMT Requests Delivered by Type of Medical Service	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 12	Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT).
Measure Description	The percentage of NEMT requests authorized, of those requested during the measure data period, by type of medical service (i.e., hospital, medical provider, mental health provider, dentist, pharmacy, Methadone treatment, other), for the eligible population.
Eligible Population	All Participants in PAP and non-PAP Medicaid programs.
Numerator	Number of NEMT requests delivered for each medical service type in each program.
Denominator	Number of NEMT requests delivered in each program.
Data Source(s)	NH DHHS. Office of Quality Assurance and Improvement. Online Report based on NEMT provider self-reported data. [http://medicaidquality.nh.gov]
Measure ID	12-2

Note: this measure was not included in the original evaluation plan.

Statistical Testing

- z-test

Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)

Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 13	Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.
Measure Description	The percentage of discharges for members 19 years through 64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.
Eligible Population	Matched treatment group and comparison group enrolled on the date of discharge through 30 days after discharge.
Numerator	<p>A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.</p> <p>Any of the following meet criteria:</p> <ul style="list-style-type: none"> • A visit (<u>FUH Stand Alone Visits Value Set</u>) with a mental health practitioner. • A visit (<u>FUH Visits Group 1 Value Set</u> and <u>FUH POS Group 1 Value Set</u>) with a mental health practitioner. • A visit (<u>FUH Visits Group 2 Value Set</u> and <u>FUH POS Group 2 Value Set</u>) with a mental health practitioner. • A visit in a behavioral health care setting (<u>FUH RevCodes Group 1 Value Set</u>). • A visit in a nonbehavioral health care setting (<u>FUH RevCodes Group 2 Value Set</u>) with a mental health practitioner. • A visit in a nonbehavioral health care setting (<u>FUH RevCodes Group 2 Value Set</u>) with a diagnosis of mental illness (<u>Mental Illness Value Set</u>). • Transitional care management services (<u>TCM 7 Day Value Set</u>). <p>Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is the date of the face-to-face visit.</p>

Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	
Denominator	<p>The number of discharges for members 19 through 64 years who were discharged from a New Hampshire acute inpatient setting with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays at any New Hampshire acute inpatient hospital (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. <p>Calculate age as of the date of discharge.</p> <p>The member must have been enrolled in the PAP program (PAP members during evaluation period) or Medicaid (matched non-PAP members or PAP members during baseline) on discharge through 7 days after discharge.</p> <p>If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>) within the 7-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. To identify readmissions and direct transfers to an acute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stay. <p>Exclusions: Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 7-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim. 3. Identify the admission date for the stay. <p>Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 7-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the <u>Mental Health Diagnosis Value Set</u>). To identify readmissions and direct transfers to an acute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stay.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data; NH Hospital Stays Data Provided by DHHS
Measure Steward	NCQA: HEDIS 2017
Measure Source	Follow-Up After Hospitalization for Mental Illness
Measure ID	13-1

Note: This was measure 9-2 in the original evaluation plan.

Statistical Testing

- Difference-in-differences

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 13	Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.
Measure Description	<p>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.</p> <p>Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.</p> <p>Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.</p>
Eligible Population	Matched treatment group and comparison group with continuous enrollment 60 days (2 months) prior to the IESD through 48 days after the IESD (109 total days).
Numerator	<p>Initiation of AOD Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, telehealth, intensive outpatient encounter or partial hospitalization or MAT within 14 days of the Index Episode Start Date (IESD).</p> <p><i>If the Index Episode was an inpatient discharge (or an ED visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.</i></p> <p><i>If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, telehealth, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, telehealth, intensive outpatient encounter or partial hospitalization with a diagnosis of AOD abuse or dependence, on the IESD or in the 13 days after the IESD (14 total days). If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria:</i></p> <ul style="list-style-type: none"> Acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. To identify acute and nonacute inpatient admissions: <ol style="list-style-type: none"> Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). Identify the admission date for the stay <u>IET Stand Alone Visits Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). A telephone visit (<u>Telephone Visit Value Set</u>) with a diagnosis matching IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. On online assessment (<u>Online Assessment Value Set</u>) with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	
	<ul style="list-style-type: none"> If the Index Episode was for a diagnosis of alcohol abuse or dependence (<u>Alcohol Abuse and Dependence Value Set</u>) a MAT dispensing event (<i>Table IET-A</i>) or a claim for MAT (<u>Medication Assisted Treatment Value Set</u>) If the Index Episode was for a diagnosis of opioid abuse or dependence (<u>Opioid Abuse and Dependence Value Set</u>) a MAT dispensing event (<i>Table IET-B</i>) or a claim for MAT (<u>Medication Assisted Treatment Value Set</u>) <p>If a member is compliant for the Initiation numerator for any diagnosis cohort (i.e. alcohol, opioid, other drug), count the member once in the Total Initiation numerator. If the member is compliant for multiple cohorts, only count the member once in the Total Initiation Numerator.</p> <p>Exclude the member from the denominator for both indicators if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.</p> <p>Engagement of AOD Treatment: Identify all members who meet the following criteria:</p> <ul style="list-style-type: none"> Numerator compliant for the Initiation of AOD Treatment numerator and <ul style="list-style-type: none"> Two or more inpatient admissions, outpatient visits, telehealth, intensive outpatient encounters or partial hospitalizations with a diagnosis matching the IESD diagnosis, beginning on the day after the initiation encounter through 34 days after the initiation event (34 total days). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> An acute or nonacute inpatient admission (<u>Inpatient Stay Value Set</u>) with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. <u>IET Stand Alone Visits Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). A telephone visit (<u>Telephone Visits Value Set</u>) with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. An online assessment (<u>Online Assessment Value Set</u>) with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. If the initiation of AOD treatment was not a MAT dispensing event, one or more of the MAT dispensing events (<i>Table IET-A</i>; <i>Table IET-B</i>) beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days). <ul style="list-style-type: none"> If the Initiation of AOD treatment was for treatment of a diagnosis of alcohol abuse or dependence (<u>Alcohol Abuse and Dependence Value Set</u>), one or more MAT dispensing events (<i>Table IET-A</i>) or claims for MAT (<u>Medication Assisted Treatment Value Set</u>), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment. If the Initiation of AOD treatment was for treatment of a diagnosis of opioid abuse or dependence (<u>Opioid Abuse and Dependence Value Set</u>), one or more MAT dispensing events (<i>Table IET-B</i>) or claims for MAT (<u>Medication Assisted Treatment Value Set</u>), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	
	<ul style="list-style-type: none"> ○ If the Initiation of AOD treatment was a MAT dispensing event, two or more engagement events where at least one meets criteria for 1. For example, two engagement events from criteria 2 do not meet numerator compliance. <p>If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator.</p> <p>For members who initiated treatment via an inpatient admission, the 34-day period for the two engagement visits begins the day after discharge.</p> <p>The time frame for engagement, which includes the initiation event, is 34 total days.</p>
Denominator	<p>Follow the steps below to identify the denominator.</p> <p><i>Step 1</i>—Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:</p> <ul style="list-style-type: none"> • An outpatient visit, telehealth, intensive outpatient visit, or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> ○ <u>IET Stand Alone Visits Value Set</u> with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). ○ <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). ○ <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>). • A detoxification visit (<u>Detoxification Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u> • An ED visit (<u>ED Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u> • An acute or nonacute inpatient discharge (<u>Inpatient Stay Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u> • A telephone visit (<u>Telephone Visits Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u> • An online assessment (<u>Online Assessments Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u> <p>For members with more than one episode of AOD abuse or dependence, use the first episode.</p> <p>For members whose first episode was an ED visit that resulted in an inpatient stay, use the diagnosis from the ED visit to determine the diagnosis cohort and use the inpatient discharge as the IESD. When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or one calendar day after. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.</p> <p><i>Step 2</i>—Select the Index Episode and stratify based on age and AOD diagnosis cohort. If the member has a claim with a diagnosis of alcohol abuse or dependence (<u>Alcohol Abuse and Dependence Value Set</u>), place the member in the alcohol cohort. If the member has a diagnosis of opioid abuse or dependence (<u>Opioid Abuse and Dependence Value Set</u>), place the member in the opioid cohort. If the member has a drug abuse or dependence that is neither for opioid nor alcohol (<u>Other Drug Abuse and Dependence Value Set</u>), place the member in the other drug cohort. If the member has multiple substance use diagnosis on the same claim, report the member in all AOD diagnosis stratifications for which they meet criteria.</p> <p>The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnosis on the Index Episode claim only once for the total rate for the denominator.</p>

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	
	<p><i>Step 3</i>—Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), Medication Assisted Treatment Value Set or a MAT dispensing event (Table IET-A; Table IET-B) during the 60 days (2 months) before the IESD.</p> <p>For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.</p> <p>For an ED visit that results in an inpatient stay, use the ED date of service to determine the 60-day Negative Diagnosis History period. When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or one calendar day after. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.</p> <p><i>Step 4</i>—Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 48 days after the IESD (109 total days), with no gaps.</p>
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2018
Measure Source	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Measure ID	13-2

Note: this measure was not included in the original evaluation plan.

Table IET-A—MAT for Alcohol Abuse or Dependence Medications	
Description	Prescription
Aldehyde dehydrogenase inhibitor	<ul style="list-style-type: none"> Disulfiram (oral)
Antagonist	<ul style="list-style-type: none"> Naltrexone (oral and injectable)
Other	<ul style="list-style-type: none"> Acamprosate (oral; delayed-release tablet)

Table IET-B—MAT for Opioid Abuse or Dependence Medications	
Description	Prescription
Antagonist	<ul style="list-style-type: none"> Naltrexone (oral and injectable)
Partial agonist	<ul style="list-style-type: none"> Buprenorphine (sublingual tablet and implant) Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Statistical Testing

- Difference-in-differences

Mental Health Utilization^{B-1}

Mental Health Utilization	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 13	Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.
Measure Description	The number mental health outpatient services per 1,000 member months during the measurement year.
Eligible Population	Matched treatment group and comparison group.
Numerator	<p>Any of the following meet criteria:</p> <ul style="list-style-type: none"> • <u>MPT Stand Alone Outpatient Group 1 Value Set</u> <i>with</i> a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>). • MPT Outpatient Visit Group 1 (Table MPT-A) <i>and</i> a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>). • MPT Outpatient Visit Group 2 (Table MPT-A) <i>and</i> a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>), where the organization can confirm that the visit was in an outpatient setting (POS 53 is not specific to setting). • <u>MPT Stand Alone Outpatient Group 2 Value Set</u> <i>with</i> a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>) billed by a mental health practitioner. • <u>Telehealth Value Set</u> <i>with</i> a principal mental diagnosis (<u>Mental Health Diagnosis Value Set</u>). <p>Count services provided by physicians and non-physicians.</p>
Denominator	The number of member months for the eligible population.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017/NH DHHS
Measure Source	Mental Health Utilization (MPT) – with Modifications
Measure ID	13-3

Note: this measure was not included in the original evaluation plan.

Table MPT-A: Codes to Identify Mental Health Outpatient Visits			
Description	CPT Code		POS
MPT Outpatient Visit Group 1	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90847, 90849, 90853, 90867, 90868, 90869, 90870, 90875, 90876	and	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 24, 33, 49, 50, 71, 72
MPT Outpatient Visit Group 2			53

Statistical Testing

- Difference-in-differences

^{B-1} This measure is adapted from the HEDIS 2017 specifications for MPT Outpatient, ED, or telehealth measure indicator.

Chemical Dependency Outpatient Services Utilization^{B-2}

Mental Health Utilization	
Domain	Uniform Provider Access
Waiver Goal	The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.
Hypothesis 13	Premium assistance beneficiaries will have equal or better access to care, including behavioral health services.
Measure Description	The number of chemical dependency outpatient services per 1,000 member months during the measurement year.
Eligible Population	Matched treatment group and comparison group.
Numerator	Any of the following meet criteria: <ul style="list-style-type: none"> IAD Stand Alone Outpatient Group 1 Value Set with Chemical Dependency Value Set. IAD Outpatient Visit Group 1 (Table IAD-A) and Chemical Dependency Value Set. IAD Outpatient Visit Group 2 (Table IAD-A) and Chemical Dependency Value Set, where the organization can confirm that the visit was in an outpatient setting (POS 53 is not specific to setting). Telehealth Value Set with Chemical Dependency Value Set. Count services provided by physicians and non-physicians.
Denominator	The number of member months for the eligible population.
Data Source(s)	PAP encounter data, EDI transaction encounters, and MMIS FFS claims data
Measure Steward	NCQA: HEDIS 2017/NH DHHS
Measure Source	Identification of Alcohol and Other Drug Services (IAD) – with Modifications
Measure ID	13-4

Table IAD-A: Codes to Identify Mental Health Outpatient Visits			
Description	CPT Code		POS
IAD Outpatient Visit Group 1	90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90847, 90849, 90853, 90867, 90868, 90869, 90870, 90875, 90876	and	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 24, 33, 49, 50, 57, 71, 72
IAD Outpatient Visit Group 2			53

Statistical Testing

- Difference-in-differences

^{B-2} This measure is adapted from the HEDIS 2017 specifications for IAD Outpatient, ED, or telehealth measure indicator.

Cost Neutrality

Total Costs by Group

Total Costs by Group	
Domain	Cost Neutrality
Waiver Goal	The premium assistance program will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.
Hypothesis 14	The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
Measure Description	Annual total costs divided by total number of member months, calculated separately for the study and comparison groups. Calculated as the sum of the medical cost component (measure 7-2) and the administrative cost component (measure 3-4).
Eligible Population	PAP Participants and newly eligible members of the Bridge program from September 2014–December 2015 (comparison group).
Numerator	The sum of the medical cost component (measure 7-2) and the administrative cost component (measure 3-4) for each of the two approaches described in detail for the Medical Costs by Group measure (measure 7-2): <ol style="list-style-type: none"> 1. Compare the hypothetical Bridge program capitation rate projections to the average PAP cost. 2. Compare the hypothetical Bridge program capitation rate projections to the carriers' actual cost of covering the PAP population in the exchange.
Denominator	Member months in each population
Data Source(s)	Rate filing information from the New Hampshire Insurance Department; Rate filings and other documents prepared by Milliman; Adjusted CY 2015 Bridge program experience data; New Hampshire CHIS data
Measure ID	14-1

Statistical Testing

- Interim Evaluation Report
 - None
- Final Evaluation Report
 - None

Medical Costs by Group

Medical Costs by Group	
Domain	Cost Neutrality
Waiver Goal	The premium assistance program will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.
Hypothesis 14	The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
Measure Description	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued.
Eligible Population	PAP Participants and newly eligible members of the Bridge program from September 2014–December 2015 (comparison group).
Numerator	<p>Two approaches:</p> <ol style="list-style-type: none"> 1. Compare the Bridge program medical component from the hypothetical capitation rate projections to the average medical cost component from Exchange premiums, CSR payments, deductible funding, and the cost of wraparound services. <ol style="list-style-type: none"> a. Study Group: Average PAP cost developed from the carriers filed premium rates and other documents estimating the other medical cost components such as CSR payment, deductible funding, and the cost of wraparound services. b. Comparison Group: Hypothetical Bridge program medical cost projections developed from adjusted CY 2015 Bridge program experience data. 2. Compare the hypothetical Bridge program medical cost component from the capitation rate projections to the carriers' actual medical cost of covering the PAP population in the exchange. <ol style="list-style-type: none"> a. Study Group: Actual PAP claims experience aggregated from the 2016 CHIS database. b. Comparison Group: Hypothetical Bridge program medical cost projections developed from adjusted CY 2015 Bridge program experience data.
Denominator	Member months in each population
Data Source(s)	Rate filings and other documents prepared by Milliman; Adjusted CY 2015 Bridge program experience data; New Hampshire CHIS data
Measure ID	14-2

Statistical Testing

- Interim Evaluation Report
 - None
- Final Evaluation Report
 - None

Members' Administrative Cost

Members' Administrative Cost	
Domain	Cost Neutrality
Waiver Goal	The premium assistance program will be cost neutral with respect to continuation of the previous New Hampshire Medicaid expansion program.
Hypothesis 14	The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
Measure Description	Annual administrative costs divided by total number of member months, calculated separately for the study and comparison groups.
Eligible Population	PAP Participants and newly eligible members of the Bridge program from September 2014–December 2015 (comparison group).
Numerator	PAP rate filing information for PAP administrative cost levels and administrative cost allowance included in a hypothetical Bridge program capitation rates had the program continued for comparison group.
Denominator	Member months in each population
Data Source(s)	Rate filing information from the New Hampshire Insurance Department
Measure ID	14-3

Statistical Testing

- Interim Evaluation Report
 - None
- Final Evaluation Report
 - None

C. Supplemental Tables and Results

This appendix provides supplemental tables and results (Table C-1–Table C-22) for several measures found in the Findings and Conclusions section of the main body of the Interim Evaluation Report.

Table C-1: Measure 1-1 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	11.272	0.405	27.86	<.0001
PAP	0.493	0.453	1.09	0.2768
Time Indicator	-7.250	0.436	-16.62	<.0001
PAP x Time Indicator	0.399	0.497	0.80	0.4224
Total Observations = 115,696 F-Test: 332.362 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-2: Measure 1-2 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.067	0.002	40.46	<.0001
PAP	0.036	0.002	15.19	<.0001
Time Indicator	-0.035	0.002	-17.76	<.0001
PAP x Time Indicator	-0.022	0.003	-7.75	<.0001
Total Observations = 115,696 F-Test: 498.401 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-3: Measure 2-1 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.869	0.002	358.83	<.0001
PAP	-0.022	0.003	-6.80	<.0001
Time Indicator	0.052	0.003	17.25	<.0001
PAP x Time Indicator	-0.095	0.004	-22.22	<.0001
Total Observations = 105,761 F-Test: 546.605 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-4: Measure 3-1 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	14.891	0.320	46.52	<.0001
PAP	4.020	0.451	8.92	<.0001
Time Indicator	-6.448	0.380	-16.95	<.0001
PAP x Time Indicator	-0.667	0.527	-1.27	0.2056
Total Observations = 105,761 F-Test: 305.505 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-5: Measure 3-2 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.882	0.002	380.68	<.0001
PAP	-0.026	0.003	-8.18	<.0001
Time Indicator	0.045	0.003	15.69	<.0001
PAP x Time Indicator	-0.012	0.004	-2.92	0.0035
Total Observations = 105,761 F-Test: 214.622 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-6: Measure 5-1 Full Regression Results

Age Category	Variable	Estimate	Standard Error	T-Statistic	Prob > t
19 to 44	Intercept	14.923	0.563	26.52	<.0001
	PAP	1.720	0.827	2.08	0.0377
	Time Indicator	0.190	0.819	0.23	0.8165
	PAP x Time Indicator	-1.225	1.151	-1.06	0.2875
N = 216,123 F-Test: 1.729 (Pr > F: 0.1587)					
45 to 64	Intercept	18.431	1.013	18.20	<.0001
	PAP	-4.809	1.268	-3.79	0.0001
	Time Indicator	-2.772	1.336	-2.08	0.0379
	PAP x Time Indicator	-0.181	1.644	-0.11	0.9125
N = 114,770 F-Test: 17.982 (Pr > F: <.0001)					

Note: Standard errors and statistical testing adjusted for heteroskedasticity.

Table C-7: Measure 6-1 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.473	0.075	6.33	<.0001
PAP	0.269	0.123	2.19	0.0283
Time Indicator	0.244	0.123	1.98	0.0472
PAP x Time Indicator	-0.357	0.177	-2.02	0.0439
Total Observations = 343,376 F-Test: 1.849 (Pr > F: 0.1358)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-8: Measure 6-2 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	3.311	0.222	14.90	<.0001
PAP	0.004	0.314	0.01	0.9903
Time Indicator	0.324	0.330	0.98	0.3265
PAP x Time Indicator	-0.857	0.435	-1.97	0.0490
Total Observations = 343,376 F-Test: 2.826 (Pr > F: 0.0371)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-9: Measure 8-1 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.415	0.061	6.80	<.0001
PAP	0.051	0.143	0.36	0.7193
Time Indicator	0.020	0.074	0.27	0.7840
PAP x Time Indicator	-0.058	0.153	-0.38	0.7066
Total Observations = 404 F-Test: 0.052 (Pr > F: 0.9844)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-10: Measure 8-6 Full Regression Results

Age Category	Variable	Estimate	Standard Error	T-Statistic	Prob > t
20 to 44	Intercept	0.813	0.006	138.75	<.0001
	PAP	-0.065	0.009	-7.19	<.0001
	Time Indicator	0.003	0.009	0.37	0.7087
	PAP x Time Indicator	-0.035	0.013	-2.68	0.0074
N = 16,103 F-Test: 56.319 (Pr > F: <.0001)					
45 to 64	Intercept	0.883	0.007	127.03	<.0001
	PAP	-0.060	0.010	-5.87	<.0001
	Time Indicator	0.014	0.010	1.37	0.1704
	PAP x Time Indicator	-0.025	0.015	-1.70	0.0888
N = 9,185 F-Test: 31.844 (Pr > F: <.0001)					

Note: Standard errors and statistical testing adjusted for heteroskedasticity.

Table C-11: Measure 9-1 Full Regression Results

Age Category	Variable	Estimate	Standard Error	T-Statistic	Prob > t
20 to 44	Intercept	0.325	0.007	46.12	<.0001
	PAP	0.022	0.010	2.16	0.0306
	Time Indicator	-0.003	0.011	-0.32	0.7518
	PAP x Time Indicator	-0.025	0.015	-1.68	0.0924
N = 16,103 F-Test: 3.042 (Pr > F: 0.0277)					
45 to 64	Intercept	0.354	0.010	34.29	<.0001
	PAP	0.090	0.014	6.29	<.0001
	Time Indicator	0.000	0.015	0.03	0.9757
	PAP x Time Indicator	-0.011	0.020	-0.55	0.5857
N = 9,185 F-Test: 22.488 (Pr > F: <.0001)					

Note: Standard errors and statistical testing adjusted for heteroskedasticity.

Table C-12: Measure 9-4 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.554	0.026	21.18	<.0001
PAP	0.020	0.036	0.55	0.5811
Time Indicator	0.062	0.038	1.62	0.1065
PAP x Time Indicator	-0.140	0.052	-2.72	0.0066
Total Observations = 1,493 F-Test: 3.818 (Pr > F: 0.0097)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-13: Measure 9-5 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.673	0.025	27.27	<.0001
PAP	0.156	0.031	5.00	<.0001
Time Indicator	0.022	0.036	0.61	0.5393
PAP x Time Indicator	-0.004	0.044	-0.10	0.9231
Total Observations = 1,493 F-Test: 17.541 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-14: Measure 9-6 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.135	0.027	5.04	<.0001
PAP	0.224	0.047	4.79	<.0001
Time Indicator	0.113	0.044	2.58	0.0102
PAP x Time Indicator	-0.191	0.067	-2.84	0.0047
Total Observations = 650 F-Test: 7.501 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-15: Measure 9-7 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.111	0.005	20.46	<.0001
PAP	0.066	0.009	7.58	<.0001
Time Indicator	-0.007	0.008	-0.90	0.3691
PAP x Time Indicator	0.017	0.013	1.35	0.1781
Total Observations = 12,363 F-Test: 46.991 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations include PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-16: Measure 9-9 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.620	0.041	15.21	<.0001
PAP	0.088	0.070	1.26	0.2069
Time Indicator	0.103	0.057	1.80	0.0730
PAP x Time Indicator	-0.045	0.096	-0.46	0.6431
Total Observations = 397 F-Test: 1.908 (Pr > F: 0.1277)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-17: Measure 11-1 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.233	0.029	8.07	<.0001
PAP	0.058	0.033	1.76	0.0779
Time Indicator	0.075	0.050	1.49	0.1367
PAP x Time Indicator	-0.113	0.057	-1.99	0.0463
Total Observations = 1,637 F-Test: 1.571 (Pr > F: 0.1944)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-18: Measure 11-2 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.274	0.030	9.02	<.0001
PAP	0.065	0.034	1.90	0.0574
Time Indicator	0.025	0.051	0.49	0.6253
PAP x Time Indicator	-0.100	0.057	-1.75	0.0808
Total Observations = 1,637 F-Test: 3.025 (Pr > F: 0.0286)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-19: Measure 13-1 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.608	0.068	8.89	<.0001
PAP	-0.241	0.111	-2.16	0.0317
Time Indicator	-0.008	0.093	-0.08	0.9330
PAP x Time Indicator	-0.068	0.142	-0.48	0.6330
Total Observations = 196 F-Test: 5.776 (Pr > F: 0.0008)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-20: Measure 13-2 Full Regression Results

Measure Indicator	Variable	Estimate	Standard Error	T-Statistic	Prob > t
Initiation	Intercept	0.348	0.038	9.10	<.0001
	PAP	-0.008	0.054	-0.15	0.8775
	Time Indicator	-0.059	0.046	-1.28	0.1992
	PAP x Time Indicator	0.045	0.063	0.71	0.4780
N = 1,148 F-Test: 0.775 (Pr > F: 0.5082)					
Engagement	Intercept	0.155	0.029	5.33	<.0001
	PAP	0.025	0.043	0.59	0.5563
	Time Indicator	-0.045	0.034	-1.33	0.1825
	PAP x Time Indicator	0.001	0.049	0.02	0.9835
N = 1,148 F-Test: 1.612 (Pr > F: 0.1847)					

Note: Standard errors and statistical testing adjusted for heteroskedasticity.

Table C-21: Measure 13-3 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.225	0.001	166.98	<.0001
PAP	-0.082	0.002	-45.04	<.0001
Time Indicator	-0.018	0.002	-8.69	<.0001
PAP x Time Indicator	-0.000	0.003	-0.03	0.9793
Total Observations = 356,179 F-Test: 1,442.384 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

Table C-22: Measure 13-4 Full Regression Results

Variable	Estimate	Standard Error	T-Statistic	Prob > t
Intercept	0.070	0.001	85.28	<.0001
PAP	-0.002	0.001	-1.69	0.0914
Time Indicator	0.008	0.001	6.09	<.0001
PAP x Time Indicator	-0.004	0.002	-2.20	0.0281
Total Observations = 356,179 F-Test: 21.177 (Pr > F: <.0001)				

Note: Standard errors and statistical testing adjusted for heteroskedasticity. Total observations included PAP and Non-PAP comparison group members in the baseline and evaluation periods.

D. Financial Methods and Supplemental Tables

This appendix provides the financial methods and supplemental tables.

Financial Outcomes Methods

Treatment Group

The treatment group (i.e., the Bridge/Premium Assistance Program [PAP] population) for the financial measures will be similar to that for the health outcomes measures. Specifically, the treatment group will be composed of members who are either:

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

Comparison Group

For the financial measures the comparison group are the newly eligible members of the Bridge program, which was in effect from September 2014–December 2015. The Bridge program ended on January 1, 2016, when most members were enrolled in PAP coverage and others remained in New Hampshire Health Plan (NHHP) Medically Frail and Transitional population coverage. The comparison group excludes the Medically Frail members who are not eligible to enroll in PAP coverage.

For the cost effectiveness analyses, an estimate was developed of what the comparison group would have cost if the Bridge program had continued past December 2015, adjusting for items such as medical cost trends, demographic differences, acuity differences, and changes to targeted Bridge program provider reimbursement levels. This means that part of this process will consist of developing hypothetical capitation rates for the Bridge program for time periods after December 2015.

Thus, the financial outcomes measures were calculated based on differences across time for essentially the same population, while the health outcome measures were calculated based on differences between the treatment group (PAP participants) and a separate comparison group (Medicaid Managed Care Organization [MCO] members) at the same point in time. The comparison group is different from that described above for health outcomes for a number of reasons.

The Waiver Evaluation Design Plan approved by the Centers for Medicare & Medicaid Services (CMS) specifically defined the financial comparison groups as “Bridge to actual PAP costs compared to estimated costs if the Bridge program were continued”. This methodology parallels the methodologies employed for the initial budget neutrality calculations for CMS approval of the PAP waiver. There are also practical reasons for the different approaches. Current Medicaid MCO capitation rates are calculated differently and are significantly different than those for the Bridge program when it was in existence. Using current MCO capitation rates would require significant adjustments for which little supporting data exists. The result would be less accurate cost estimates.

However, comparing health outcomes across time for the same group of members presents significant issues in identifying PAP impacts. Health outcomes can change over time in the absence of any programmatic changes simply as individuals age and as changes to the entire health care system. When the same members are tracked over time, it becomes difficult to distinguish the impact of the PAP from those changes that occur as a result of changes to the entire health care system and individuals aging. By using a comparison group separate from the treatment group, changes unrelated to participation in the PAP can be controlled for and the result is a more accurate estimate of PAP estimates.

Since the financial measure will be effectively comparing the experience of the same groups of individuals over time, the comparability of the treatment and comparison groups is virtually assured. For this reason, matching methods, such as the propensity score matching method described above, are not necessary for the financial populations.

Financial Measures Analytical Approach

In order to provide a comprehensive picture of the relative costs associated with the PAP and to compare the *actual* experience of the Bridge program population to the *actual* experience of the PAP, two approaches were used to estimate the relative medical costs.

The first method involved comparing the medical component from the hypothetical capitation rate projections for the Bridge program to the average medical cost component from Exchange premiums, Cost Sharing Reduction (CSR) payment, deductible funding, and the cost of wraparound services for the PAP population.

For the PAP population, the average PAP medical cost was based on the carriers' filed premium rates as well as other documents prepared by Milliman for the Department of Health and Human Services (DHHS) to estimate medical costs as well as adjusting for other medical cost components such as CSR payments, deductible funding, and the cost of wraparound services. For the comparison group, medical cost projections were developed based on calendar year (CY) 2015 Bridge program encounter data and trended and adjusted for demographic changes, acuity differences, etc.

The second method involved comparing the hypothetical Bridge program medical cost component from the capitation rate projections to the carriers' actual medical cost of covering the PAP population in the exchange.

For the PAP population, the average PAP medical cost was aggregated from the 2016 New Hampshire Comprehensive Healthcare Information System (CHIS) database to determine the medical cost. The hypothetical Bridge program medical cost projections were developed from CY 2015 Bridge program experience data adjusted for items listed above as necessary.

Administrative costs are based on estimated based on administrative amounts included in PAP premium rates filings and hypothetical Bridge program rates, had the program continued, since the allocation of actual administrative costs for the PAP and Bridge program members is difficult for the carriers and MCOs to estimate.

For the treatment group, administrative costs were taken directly from the PAP rate filing information. For the comparison group, administrative costs were estimated by developing hypothetical Bridge program capitation rates had the program continued based on hypothetical Bridge program capitation rates for CY 2016.

Total costs for both groups were the sum of the Medical and administrative costs estimates. This resulted in two different total cost estimates for each group, one for each of the approaches used to estimate medical costs.

Supplemental Tables and Results

The following section provide additional details and results of Measure 14-2 and Measure 14-3.

Measure 14-2

Approach #1 Study Group Medical Cost Development

For the first approach, Milliman calculated the medical cost for the study group using the medical loss ratios from carriers' exchange rate filings. These ratios were applied to the actual PAP premiums and estimated cost sharing reduction payments to develop the medical costs for these two components. Milliman then included the full value of the deductible and wrap-around services.

Table D-1 below shows the development of the medical cost for the study group under Approach #1.

Table D-1: Medical Cost Development for Study Group – Approach #1

Component	Total Cost	Medical Loss Ratio	Medical Cost
PAP Premium	\$408.57	77.4%	\$316.43
Estimated Cost Sharing Reduction	\$148.12	100.0%	\$148.12
Deductible	\$4.47	100.0%	\$4.47
Wrap-Around Services	\$18.12	100.0%	\$18.12
Total	\$579.28	84.1%	\$487.14

Approach #2 Study Group Cost Development:

For the second approach, Milliman calculated the medical cost for the study group cost using the carriers' actual cost of covering the PAP population in the exchange as reported in the CHIS data.

Table D-2 below shows the development of the projected medical costs for the study group under Approach #2.

Table D-2: Medical Cost Development for Study Group – Approach #2

Service Category	Per Capita Monthly Paid Cost	IBNR Adjustment	Projected Per Capita Monthly Paid Cost
Hospital Inpatient	\$120.92	1.0103	\$122.16
Hospital Outpatient	\$147.21	1.0103	\$147.72
Professional and Other Services	\$130.45	1.0103	\$131.79
Community Mental Health Center	\$1.73	1.0103	\$1.75
Prescription Drugs	\$100.25	1.0103	\$101.27
Wraparound Services	\$18.12	1.0000	\$18.12
Total	\$518.68	1.0099	\$523.81

Base Data

To develop the study group medical cost, Milliman used CY 2016 claims data from the CHIS database to identify the PAP participants and summarize their enrollment and claims information. There are no outside data sources to validate the data collected in the CHIS database, so there could be inconsistencies between the data collected and

carrier financial statements. However, Milliman found no strong indication that such discrepancies exist and believe the encounter data is of appropriate quality and completeness to use in this analysis.

The base experience data covers over 482,000 member months generating more than \$240 million in claims for a base experience period PMPM cost of \$500.56. As discussed below, wraparound services are not included in the CHIS data and were added separately.

Wraparound Service Costs

Milliman added \$18.12 per member per month (PMPM) for wraparound services not included in the CHIS data using a special report provided by DHHS. Wraparound services for PAP enrollees are paid by DHHS directly to providers from their Medicaid Management Information System (MMIS).

Incurred But Not Reported (IBNR) Adjustment

Milliman made a 1.0103 IBNR claims adjustment to capture outstanding claims liability beyond the June 2017 paid through date. Milliman's *Claim Reserve Estimation Workbook (CREW)* was used to calculate the 1.0103 completion factor. CREW calculates IBNR reserve estimates using generally accepted actuarial standards and practices. Wraparound services costs were assumed to be complete. Therefore, no IBNR adjustment was used for those services.

Comparison Group Cost Development

Milliman used the same comparison group for both approaches, which consists of the medical cost component of the hypothetical Bridge program capitation rate as if the program had continued beyond 2015.

Table D-3 shows the development of the projected medical costs for the comparison group. The following sections provide additional details related to the adjustments shown in Table D-3.

Table D-3: Comparison Group Cost Development Base Data CY 2015

Benefits	CY 2015 Per Capita Monthly Paid Cost	Acuity Adjustment	IBNR Adjustment	Utilization Trend Factors	Unit Cost Trend Factors	Expanded Mental Health Services	Projected Per Capita Monthly Paid Cost
Hospital Inpatient	\$62.22	1.0000	1.0049	1.0000	1.0200	\$0.21	\$63.98
Hospital Outpatient	\$134.95	1.0000	1.0049	1.0200	1.0400	\$0.00	\$143.86
Professional and Other Services	\$136.93	1.0000	1.0049	1.0300	1.0050	\$0.00	\$142.43
Mental Health Center	\$12.49	1.0000	1.0049	1.0300	1.0050	\$2.68	\$15.67
Prescription Drugs	\$76.56	1.0000	1.0049	0.9989	1.1114	\$0.00	\$85.41
All Services	\$423.15	1.0000	1.0049	1.0168	1.0373	\$2.89	\$451.35

Base Data

To develop the hypothetical capitation rate, Milliman used CY 2015 encounter data from the New Hampshire Health Protection Program (NHHP) and excluded all Medically Frail individuals since they are ineligible to enroll in a Qualified Health Plan (QHP) under the PAP. The MCO encounter data and sub-capitated expenditures were obtained directly from the participating MCOs. Milliman did not identify any material concerns with the quality or availability of the data with respect to total claims in aggregate or by major service category. The data reconciliation efforts are consistent with Actuarial Standard of Practice #23. Milliman believes the encounter data is of appropriate quality and completeness to use as the primary basis for developing hypothetical capitation rates.

Milliman summarized detailed MCO encounter claims data with dates of service between January 2015 and December 2015 with dates of payment through November 2016 with the following specifications:

- The cost and utilization data reflect the claim header information for claims paid at the header level and line item detail for claims paid at the detail level.
- Claims for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers reflect their normal prospective per encounter rates.
- Prescription drug claims reflect gross ingredient cost and dispensing fees prior to any pharmacy rebates.

The base experience data covers over 380,000 member months generating more than \$160 million in claims for a base experience period PMPM cost of \$423.15.

Acuity Adjustment

Milliman did not apply an acuity adjustment to reflect health differences between the Bridge program population and the PAP population over concerns about the CHIS data quality. In fact, it appears there may be under-reporting of International Classification of Disease (ICD) codes in the CHIS data based on risk scores developed from this data. Since 80 percent of the PAP population was previously enrolled in the Bridge program, Milliman would expect similar risk scores for these two populations. However, the resulting CHIS risk scores implied that the 20 percent of the PAP population new to Medicaid had acuity levels less than half of those previously in the Bridge program.

Since the member identification numbers used in each database does not crossover, Milliman was unable to perform a side-by-side member comparison to determine if former Bridge program enrollees had a consistent risk score using the CHIS data. The Bridge program population had, on average, over 30 percent more diagnosis codes and 20 percent more prescription drug codes per member in total and by carrier. Due to these concerns, Milliman did not include an acuity adjustment in the analysis.

Using an acuity adjustment as calculated would decrease the projected medical cost for the hypothetical Bridge program capitation rates and increase the cost neutrality factor.

IBNR Adjustment

Milliman made a 1.0049 IBNR claims adjustment to capture outstanding claims liability past the November 2016 paid through date. Milliman's *Claim Reserve Estimation Workbook (CREW)* was used to calculate the 1.0049 completion factor. CREW calculates IBNR reserve estimates using generally accepted actuarial standards and practices.

Utilization and Unit Cost Trends from CY 2015 to CY 2016

Milliman applied utilization and unit cost trends from the CY 2015 base period to CY 2016 by type of service using experience with similar populations in other states and CMS projected trends. The annual trend rates used are consistent with those used to develop the initial NHHP capitation rates.

Table D-4 below shows the annual utilization and unit cost trend rates used.

Table D-4: Annual Trends from CY 2015 to CY 2016

Service Category	Utilization Trend	Unit Cost Trend
Hospital Inpatient	0.0%	2.0%
Hospital Outpatient	2.0%	4.0%

Service Category	Utilization Trend	Unit Cost Trend
Professional and Other State Plan Services	3.0%	0.5%
Prescription Drugs	-0.1%	11.1%
Community Mental Health Center	3.0%	0.5%

Expanded Mental Health Services Adjustment

Milliman made an adjustment to reflect DHHS' continuing expansion of the mental health service capacity consistent with the Community Mental Health Agreement (CMHA). The \$2.89 PMPM add-on reflects the incremental increase in funding between 2015 and 2016 through the CMHA and Community Mental Health Center workforce expansion implemented in state fiscal year (SFY) 2017.

Measure 14-3 Additional Results

Study Group

For the study group, administrative expense levels are derived from the CY 2016 PAP rate filing information. The CY 2016 PAP rate filings were obtained from the System for Electronic Rates & Forms Filing (SERFF) for the five carriers offering plans to the PAP population on the Federally Facilitated Health Insurance Marketplace (the "exchange"). The five carriers include Celtic Insurance Company, Harvard Pilgrim Health Care of New England, Maine Community Health Options, Matthew Thornton Health Plan, Inc., and Minuteman Health, Inc.

The reported administrative expense load, profit & risk load, and taxes & fees allocations were applied to the PAP plan premiums to calculate the estimated administrative costs PMPM. Carriers included the following costs in each category:

General Administrative Expenses:

- Acquisition Costs
- Maintenance Costs (i.e., overhead, operations, sales, distribution, and marketing)
- Quality Improvement Expenses

Profit & Risk Margin:

- Target post-tax profit

Taxes & Fees:

- Patient-Centered Outcomes Research Institute (PCORI) fee
- Health Insurer Provider Fee
- Federally Facilitated Exchange fee
- Premium taxes
- Income taxes
- New Hampshire Vaccine Program Assessment
- New Hampshire Insurance Department (NHID) Administration Assessment
- Risk Adjustment Fee

Table D-5 below shows a high-level summary of the information collected from the 2016 rate filings.

Table D-5: Summary of CY 2016 Administrative Expenses from Rate Filings

Administrative Cost Components	Administrative Cost PMPM	Administrative Cost Load as a Percent of Premium Only	Administrative Cost as Percent of Total PAP Cost
General Administrative Expenses	\$44.06	10.8%	7.6%
Profit and Risk Margin	\$10.40	2.5%	1.8%
Taxes and Fees	\$37.69	9.2%	6.5%
Total	\$92.14	22.6%	15.9%

Comparison Group

For the comparison group, administrative cost levels are defined as the administrative cost allowance included in the hypothetical Bridge program capitation rate had the program continued into CY 2016. Three categories of administrative costs are included in the hypothetical Bridge capitation rate.

- **General administrative expenses:** The general administrative allowance is consistent with the average CY 2016 percentage administrative allowance under the New Hampshire Medicaid Care Management program for current Medicaid beneficiaries that is set based on managed care industry experience and MCO administrative cost data. The administration / margin allowance provides for a 7.4 percent load for administrative expenses. The general administrative expense allowance is consistent with that used in the September 2014 – December 2015 NHHPP Bridge program capitation rates.
- **Profit and risk margin:** The September 2014 – December 2015 NHHPP Bridge program capitation rates included a 2.0 percent load for profit and risk margin.
- **Premium tax:** The premium tax is 2.0 percent in the state of New Hampshire.
- **Health Insurance Providers Fee:** The average health insurer providers fee was calculated as 1.57 percent of premium. The health insurance providers fee is imposed on the health insurance industry under Section 9010 of the Affordable Care Act (ACA) and Section 1406 of the Reconciliation Act. One current Medicaid MCOs is subject to the fee while the other MCO is exempt. The included allowance reflects the fee being imposed on one MCO only.

Table D-6 below shows a high-level summary of the comparison group administrative cost development.

Table D-6: Summary of CY 2016 Administrative Expenses for Comparison Group

Administrative Cost Components	Administrative Cost PMPM	Administrative Cost Load
General Administrative Expenses	\$37.15	7.2%
Profit and Risk Margin	\$10.04	1.9%
Premium Tax	\$10.04	1.9%
Health Insurance Providers Fee	\$7.88	1.5%
Total	\$65.11	12.6%