

October 29, 2014

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

Dear Jeffrey:

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

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

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

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

#### **Cost-sharing**

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

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<sup>1</sup> NH DHHS, NH Health Protection Program Premium Assistance, §1115 Research and Demonstration Waiver, 1 (October 2014).

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

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

### *Prescription Co-pays*

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

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

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

<sup>3</sup> Waiver at 14.

<sup>4</sup> Waiver at 4.

<sup>5</sup> Waiver at 5.

<sup>6</sup> Waiver at 6.

<sup>7</sup> See Danny McCormick, Assaad Sayah, Hermione Lokko, et al., Access to Care After Massachusetts’ Health Care Reform: A safety Net Hospital Patient Survey, 1552 (July 2012).

<sup>8</sup> See National Health Law Program, Medicaid Premiums and Cost-sharing, 1 (March 2014).

<sup>9</sup> See *id.* at 5, 11.

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

<sup>11</sup> See McCormick at 1550.

<sup>12</sup> Plan; see National Health Law Program at 6, 9.

<sup>13</sup> National Health Law Program at 3, 6.

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

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

### *Cost Shifting*

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

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<sup>14</sup> See Waiver at 6.

<sup>15</sup> National Health Law Program at 9.

<sup>16</sup> *Id.* at 5.

<sup>17</sup> See Plan.

<sup>18</sup> See Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, 1 (February 2013).

<sup>19</sup> See National Health Law Program at 8; see also Kaiser Commission on Medicaid and the Uninsured at 6.

<sup>20</sup> See Plan.

<sup>21</sup> National Health Law Program at 8.

<sup>22</sup> See *id.* at 8, 9.

<sup>23</sup> See Plan.

<sup>24</sup> See National Health Law Program at 3.

<sup>25</sup> Waiver at 14.

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

#### *Alternatives to cost-sharing*

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

#### *Calculating and Collecting Cost-sharing*

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

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<sup>26</sup> See Kaiser Commission on Medicaid and the Uninsured at 1.

<sup>27</sup> See McCormick at 1553.

<sup>28</sup> See Jaan Sidorov, Robert Shull, Janet Tomcavage, et al., Does Diabetes Disease Management Save Money and Improve Outcomes?, 684 (April 2002).

<sup>29</sup> See National Health Law Program at 4.

<sup>30</sup> Waiver at 14.

<sup>31</sup> N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014).

<sup>32</sup> Waiver at 14.

<sup>33</sup> *Id.*

<sup>34</sup> See Fact Sheet: Impact of Medicaid Expansion by Industry, <http://www.nhfpi.org/research/fact-sheet-impact-medicare-expansion-industry.html> (October 2013).

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

### **Grievance and Appeals Process**

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

### **Auto-Assignment of PAP Program Enrollees to QHPs**

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

### **Network Adequacy**

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

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<sup>35</sup> Kaiser Commission on Medicaid and the Uninsured at 6.

<sup>36</sup> Waiver at 11.

<sup>37</sup> Waiver at 23.

<sup>38</sup> *Id.* at 24.

<sup>39</sup> *Id.* at 20.

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

### **Waiver of 90-day Retroactivity**

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

### **Waiver of Medicaid’s 24-hour Prior Authorization Requirement for Prescription Drugs**

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

### **340B Drug Pricing Program**

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<sup>40</sup> Waiver at 28.

<sup>41</sup> *See id.* at 2.

<sup>42</sup> Karen Pollitz and Cynthia Cox, *Medical Debt Among People with Health Insurance*, 18 (January 2014).

<sup>43</sup> Waiver at 28.

<sup>44</sup> *Id.*

<sup>45</sup> *See id.*

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

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

#### **Proposed Timeframe for the Waiver**

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

#### **Conclusion**

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

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

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<sup>46</sup> HRSA <http://www.hrsa.gov/OPA/> (last accessed in October 2014).

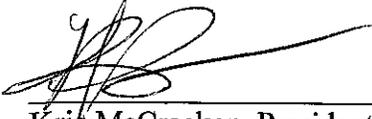
<sup>47</sup> *Id.*

<sup>48</sup> HRSA <http://www.hrsa.gov/OPA/>.

<sup>49</sup> *Id.*

<sup>50</sup> N.H. Rev. Stat. Ann. § 126-A:5(XXV)(e)(1) (2014); *see* Waiver at 6.

Sincerely,

A handwritten signature in black ink, appearing to be 'Kris McCracken', written over a horizontal line.

Kris McCracken, President/CEO

EMAIL: [kmccracken@mehc-nh.org](mailto:kmccracken@mehc-nh.org)

PHONE: 603-935-5210