Planned Parenthood
of Northern New England

Maine
New Hampshire
& Vermont

October 31, 2014

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

VIA ELECTRONIC SUBMISSION

Dear Mr. ~~Meyers~~, Jeff

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[5] 42 C.F.R. §438.206(b)(2).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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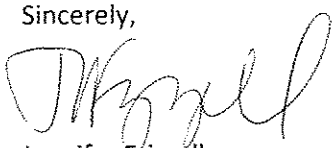
We thank the Department for the opportunity to submit these comments, and we look forward to working together toward our shared goal of improving health care access and coverage. If you have any questions, please do not hesitate to contact me at 603.513.5334 or jennifer.frizzell@ppnne.org .

Sincerely,



Jennifer Frizzell
Vice President for Public Policy

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

[14] 42 CFR § 441.20.