BI-STATE PRIMARY CARE ASSOCIATION
SERVING VERMONT & NEW HAMPSHIRE
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August 28, 2018

Andrea J. Casart
Director, Division of Medicaid Expansion Demonstrations
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

Submitted electronically to:
https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1897891

Re: Granite Advantage 1115 Waiver Extension Application; Amendment to Project #11-W-00298/1

Dear Ms. Casart:

Thank you for the opportunity to submit comments on the 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' (Department) 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 on beneficiaries and providers, will reduce low-income individuals' access to health insurance coverage, and will have unintended financial implications for federally qualified health centers.

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 disorders, 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.

[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).

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 reimbursement for services provided to Medicaid enrollees, and the auto-assignment of enrollees to providers who 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 who they have an established relationship with, and health centers were not reimbursed in a timely fashion. We respectfully request that the Department be required to 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 that the Department 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

[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).

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 remained in poverty, 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 engagement requirement. If self-employment were excluded, independent contractors, such as construction workers, home-health workers, hair stylists, and more could 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 asked the Department to clarify its stance on this important issue and seek an administrative or legislative resolution if necessary. Ultimately, we fundamentally disagree that a work and community engagement requirement furthers the purpose of the Medicaid program, which is to provide health care services.

We are also concerned that the Special Terms and Conditions issued by CMS on May 7th and any future STCs that contain a work and community engagement requirement will have unintended consequences on the health centers. According to the STCs, a beneficiary will be suspended for failure to meet the required community engagement hours.[7] However, a beneficiary's eligibility will only be terminated for failure to meet the community engagement requirement at her annual redetermination period, meaning the beneficiary is still considered a Medicaid enrollee until her eligibility is terminated at her annual redetermination period.[8] It is our understanding that once a Medicaid beneficiary's eligibility is suspended, the MCOs will not receive a per member per month payment for a beneficiary, and health care providers will not receive any reimbursement from Medicaid for services provided to that Medicaid enrollee.

As you know, federally qualified health centers receive federal grants under §330 of the Public Health Services Act, and the Medicaid Act stipulates that federally qualified health centers must be reimbursed appropriately to ensure that §330 grants are not used to subsidize the cost of treating Medicaid patients.[9] Therefore, federally qualified health centers cannot use §330 grants to supplant any losses incurred by providing services to Medicaid enrollees who are deemed "suspended." This issue will undoubtedly and unfairly increase the uncompensated care provided by the health centers if left unaddressed. How does CMS propose that the health centers pay for these services if they cannot use §330 funding? Will CMS create special grants to cover any losses incurred by the health centers? We respectfully request that you clarify in the next STCs whether a Medicaid beneficiary whose eligibility is suspended remains a "Medicaid enrollee" or specify that the federally qualified health centers will receive their Medicaid reimbursement rate for services provided to beneficiaries whose eligibility is deemed "suspended."

Bi-State and our members are also concerned with the requirement that, in order for enrollment at a college to qualify as a community engagement activity, the enrollment must be in a New Hampshire school. The STCs do not specify that the enrollment in a college-level program be at a New Hampshire school. We respectfully request that any future STCs exclude any requirement that the college be located in New Hampshire. This provision seems arbitrary, especially given the number of online colleges. We also take issue with the wording of the waiver application with regards to how the credit hours are counted for purposes of a qualifying activity. In order for a student to meet the community engagement requirement, she would have to fulfill almost 50 additional hours in another qualifying activity. The state should encourage students to focus on their studies, not further burdening them. We ask that CMS define full-time student

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[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.

[7] *See* Special Terms and Conditions, 20, 22 (May 7, 2018).

[8] *See id* at 22.

[9] *See Three Lower Counties Community Health Services, Inc. v. The State of Maryland* 498 F.3d 294, 303 (4th Cir. 2007); *Community Health Assoc. v. Shah,* 770 F.3d 129, 150 (2nd Cir. 2014); *New Jersey Primary Care Ass'n Inc. v. New Jersey Dep't of Human Servs.,* 722 F.3d 527, 529, 540-541 (3d Cir. 2013).

using the Tax Benefits for Education definition and deem a full-time student having fulfilled 100-hour community engagement requirement.

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.[10] 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 requires the Department to establish "behavioral health rates sufficient to ensure access to, and provider capacity for, all behavioral health services."[11] 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 to Medicaid enrollees in good faith.

Again, Bi-State and our members support the expansion of Medicaid. We look forward to working with CMS and the New Hampshire Department of Health and Human Services on this next iteration of such a critical program.

Sincerely,

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[10] Karen Pollitz and Cynthia Cox, "Medical Debt Among People with Health Insurance," 18 (January 2014).
[11] NH Senate Bill 313, 2 (2018).