

December 31, 2014

Cindy Mann
Deputy Administrator
Center for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, MD 21244

VIA ELECTRONIC SUBMISSION

Dear Deputy Administrator Mann,

Planned Parenthood of Northern New England (“Planned Parenthood”) is pleased to submit comments on the New Hampshire Health Protection Premium Assistance Program Premium Assistance Section 1115 Research and Demonstration Waiver draft application (“draft application”). As a trusted women’s health care provider and advocate, Planned Parenthood appreciates the opportunity to provide the Center for Medicaid and CHIP Services (“CMCS”) 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 are their primary source of medical care. We serve New Hampshire residents through 6 health centers located in Claremont, Derry, Exeter, Keene, Manchester and White River Junction, VT. Last year we saw nearly 16,000 patients at these sites.

We strongly support the purpose of the draft application to provide Medicaid coverage to individuals with incomes up to 138 percent of the federal poverty level (FPL). 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 CMCS works with the State of New Hampshire to finalize this proposal, we strongly urge CMCS to ensure the Health Protection Premium Assistance Program meets the unique health needs of women. Specifically, we urge CMCS to make sure the program will provide women coverage of comprehensive health care services, including family planning and pregnancy-related services, and ensure patient access to the providers they trust. Properly implemented, the Health Protection Premium Assistance Program will enable women to access the services they need, resulting in better health outcomes for women and their families.

I. CMCS Should Explicitly Clarify that Individuals Eligible for Limited-Scope Medicaid Coverage, such as Family Planning-Only Coverage, Remain Eligible for the Health Protection Premium Assistance Program.

We appreciate the state’s efforts to expand Medicaid coverage to more low-income individuals. It is clear from the context of the draft application, and the public information released by state officials on the draft application, that the Health Protection Premium Assistance Program intends to provide coverage to individuals who have incomes up to 138 percent FPL, barring medically needy individuals

and individuals who have access to cost-effective employer-sponsored insurance. However, because the draft application explicitly confers eligibility to the new adult group defined in Social Security Act § 1902(a)(10)(A)(i)(VIII), it is unclear whether individuals with incomes up to 138 percent FPL who are also eligible for limited-scope Medicaid coverage will be able to concurrently enroll in coverage through the Health Protection Premium Assistance Program.

To ensure the Health Protection Premium Assistance Program reflects the state's intent to expand Medicaid coverage, we ask CMCS to explicitly clarify that individuals who have access to limited-scope Medicaid coverage and have incomes at or below 138 percent FPL also be eligible for the Health Protection Premium Assistance Program. This clarification is particularly important with respect to New Hampshire's Family Planning Program, which provides limited-scope Medicaid coverage for family planning and family planning-related services. Since the Family Planning Program does not provide comprehensive coverage, it is important that Family Planning Program enrollees be able to access coverage via the Health Protection Premium Assistance Program.

II. CMCS Should Explicitly Clarify that Health Protection Premium Assistance Program Enrollees Retain Freedom of Choice for Family Planning Providers.

The draft application seeks to waive Social Security Act § 1902(a)(23) (freedom of choice) so that the state can implement mandatory enrollment in qualified health plans (QHPs) and limit access to in-network providers. Yet Social Security Act § 1902(a)(23)(B) and its implementing guidance 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

We understand that the draft application does not intend to undermine access to family planning providers. As noted in the draft application, individuals will be able to access out-of-network providers for family planning services, and out-of-network providers who furnish family planning care will be reimbursed at fee-for-service rates. Nevertheless, to solidify this intent, we ask CMCS to explicitly clarify that the state must preserve family planning freedom of choice and that the state cannot waive Social Security Act § 1902(a)(23)(B) in seeking to waive § 1902(a)(23).

III. CMCS Should Clarify that Enrollees are Entitled to the Full Range of Family Planning Services and Supplies Without Delay or Burden.

We strongly urge CMCS to clarify that qualified health plans (QHPs) participating in the Health Protection Premium Assistance Program may not impose prior authorization or step therapy on family

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).

planning services and supplies, as well as reinforce that enrollees must receive access to the full range of family planning services and supplies covered both by the state's Medicaid program and the participating Qualified Health Plans (QHPs). Imposing prior authorization or step therapy on contraceptive services limits access to contraception (a benefit conferred under federal law), and undermines the important public health goals tied to family planning such as reducing the rate of unintended pregnancy and increasing healthy birth spacing.

The draft application notes that Health Protection Premium Assistance Program enrollees will have access to QHP covered services as well as benefits provided under the Alternative Benefit Plan (ABP). Under § 2713(a)(4) of the Public Health Service Act (PHSA), QHPs must cover the full range of FDA-approved contraceptives; additionally, Social Security Act § 1937(b)(7) requires benchmark or benchmark-equivalent coverage to include family planning services. Moreover, Social Security Act § 1937(b)(5) requires benchmark or benchmark-equivalent coverage to include the Essential Health Benefits (EHB), which includes the women's preventive health services required under PHSA § 2713(a)(4). Notably, there are two separate legal standards at play – one that applies to QHPs and one that applies to Medicaid programs. The Health Protection Premium Assistance Program must meet both, meaning that enrollees must be able to access the full range of FDA-approved contraceptive methods via their QHP coverage as well as the family planning services and supplies outlined in the ABP.

However, in response to public comments asking the state to withhold prior authorization or step therapy from family planning services and supplies to ensure enrollees' access to contraceptive care, the state responded that "QHP carriers are permitted to establish their own prior authorization requirements, and the State does not intend to limit which drugs may be subject to prior authorization."³ This response ignores the fact that there is an additional legal standard that applies to Medicaid coverage of family planning, and fails to recognize that permitting QHPs to impose prior authorization or step therapy for contraception may undermine the accompanying legal standards for Medicaid coverage of family planning services and supplies. We ask CMCS to correct this misinterpretation of the law and ensure the approved Health Protection Premium Assistance Program provides each enrollee access to the full range of contraceptive services without barrier or delay.

Step therapy and prior authorization requirements are particularly harmful when it comes to women's access to contraception. Delaying access to birth control could potentially lead to reduced use of contraception, which in turn, could result in unintended pregnancy. Indeed, step therapy requires a woman to try and fail with one or more contraceptive products, meaning that she could have to experience an unintended pregnancy before being able to access the contraceptive product that fits her needs.

A woman must have timely access to the type of birth control she needs and has chosen in consultation with her health care provider without onerous protocols. The side-effect profile of birth control medications and devices, difference in permanence and reversibility of contraceptives, and a woman's personal preferences necessitate that each woman have access to a complete range of contraceptive choices. Unfortunately, step therapy and prior authorization requirements overlook these important considerations, undermining both the efficacy of the method a woman chooses and the intent of law to ensure access to family planning services and supplies.

IV. CMCS Should Ensure Participating QHPs Provide Women Sufficient Access to Women's Health Providers.

³ Draft application, Appendix C, pg. 118 (response to comment 39).

To ensure that the Medicaid expansion population has meaningful coverage to quality care, we ask CMCS to work with the state to make sure that the Health Protection Premium Assistance Program-participating QHPs have a sufficient number of women's health providers in their networks. Additionally, we strongly urge CMCS to require the state to implement an exceptions process that will enable an enrollee to obtain care out-of-network without penalty if she is unable to access a covered service from an in-network provider.

When health insurance is significantly expanded, women's health providers are the first to be overwhelmed with increased demand. For example, 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 in Massachusetts had the longest wait time of any health care provider primarily because there were not enough women's health providers in provider networks. Since the Health Protection Premium Assistance Program will expand health care access via private plans, it is important that the state ensure the participating QHPs are equipped to meet increases in patient demand.

Moreover, safeguarding access to women's health providers will also help ensure that the Health Protection Premium Assistance Program reflects the unique ways low-income women access health care. According to a recent survey, 41 percent of low-income women report relying on their OB/GYN providers as their main source of care.⁴ Therefore, requiring QHPs to have a sufficient number of in-network women's health care providers will help improve women's access to the broader health care system and ensure their access to the other critical primary and preventive health services they need to stay healthy.

In addition to examining participating QHPs' provider networks, we encourage the CMCS to implement an exceptions process so that individuals can go out-of-network without penalty if a provider is not geographically accessible or cannot provide a covered service in a reasonable time. This exceptions process for QHP-covered services would be in addition to other access provisions related to wrap-around coverage, and would help ensure that the Health Protection Premium Assistance Program provides meaningful coverage.

V. CMCS Should Make Sure Enrollees are Informed of Wrap-Around Coverage and Have Timely Access to Providers that Can Furnish Wrap-Around Services.

We support the proposal to provide wrap-around coverage for State plan benefits not provided by the participating QHPs. This proposal is consistent with federal law and policy to ensure that individuals who receive premium assistance remain entitled to Medicaid benefits and other Medicaid protections. Specifically, we appreciate the state's decisions to provide Health Protection Premium Assistance Program enrollees a Medicaid card in addition to their QHP card so that they will be able to access wrap-around benefits and to educate Medicaid call center staff about wrap-around coverage so they can assist enrollees in obtaining coverage.

To strengthen the proposal, we urge CMCS to require the state to inform Health Protection Premium Assistance Program enrollees about wrap-around coverage. Notices should be in clear, plain language and should also include the appropriate Medicaid call center number for follow-up questions. In addition, we recommend that participating QHPs and other consumer assisters, such as Navigators and Certified Application Counselors, receive training in the wrap-around benefits and refer enrollees to the

⁴ PerryUndem Research & Communication. "Women & OB/GYN providers". Research conducted for Planned Parenthood Federation of America (November 2013). Available at http://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.

Medicaid call center. Greater collaboration between the Medicaid agency, consumer assisters, and participating QHPs will better enable enrollees to receive accurate information about their benefits regardless of the entity they contact.

Furthermore, it is critical that enrollees have access to providers that can furnish wrap-around benefits in a timely manner. This is particularly important with respect to reproductive health services. For example, 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.⁵ However, QHPs have no legal obligation to cover abortion under any circumstances.⁶ Likewise, an enrollee may need to access other reproductive health care, such as miscarriage management, out-of-network because an in-network provider lacks the expertise to furnish care or because an in-network provider refuses on religious or moral objection to provide the care an enrollee needs.

VI. CMCS Should Ensure the State has Sufficient Coverage Mechanisms for Women who Become Pregnant after Enrolling in the Health Protection Premium Assistance Program.

We appreciate the state clarifying in its response to public comments that the Health Protection Premium Assistance Program will permit a woman who enrolls in coverage and later becomes pregnant to remain enrolled in QHP coverage and receive coverage without cost-sharing.⁷ Providing pregnant women the option to remain enrolled in QHP coverage or transfer to traditional Medicaid coverage is ideal because it empowers each pregnant woman to make decisions about her own pregnancy care. Moreover, withholding cost-sharing for pregnancy care is consistent with federal law.⁸

Yet we are confused by part of the state's response – in particular, that if a pregnant woman chooses to remain in the QHP, “she will be transferred to a zero cost-sharing plan.”⁹ We assume “transferred” refers to the administrative process by which the state communicates to the woman's QHP that she is free from cost-sharing obligations. However, to ensure there is no disruption in a woman's care and that she is not actually transferred to a different QHP, we ask CMCS to clarify that a Health Protection Premium Assistance Program enrollee who becomes pregnant may choose to stay in her current QHP, and that the QHP will freeze any cost-sharing obligations for the duration of her pregnancy and post-partum period.

In addition, we ask the CMCS to reinforce that pregnant women will receive all covered pregnancy-related services, including wrap-around services,¹⁰ without cost-sharing, regardless of whether they stay with their QHP or transfer to traditional Medicaid coverage. Moreover, we encourage CMCS to ensure that pregnancy-reporting mechanisms are sufficient to meet enrollees' needs. Efficient and effective mechanisms are necessary to ensure pregnant women receive the care they need in a timely manner.

⁵ CMS, Dear State Health Official Letter (Feb. 12, 1998).

⁶ ACA § 1303(b)(1); 45 C.F.R. § 156.280(c)(2).

⁷ Draft application, Appendix C, pg. 118-119 (response to comment 41).

⁸ 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)).

⁹ Appendix C, *supra* at note 7.

¹⁰ 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&faqlid=9602>.

VII. CMCS Should Deny the State's Request to Waive Retroactive Coverage.

We appreciate the state'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 proposal to auto-enroll individuals in QHP coverage if they fail to select a plan within a certain period of time so that eligible individuals are guaranteed access to coverage.

However, we are very concerned that the draft application seeks to waive retroactive coverage. We strongly urge CMCS to clarify that premium assistance enrollees, like all other Medicaid enrollees, will remain entitled to 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 as 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. Moreover, given that the state believes few will need retroactive coverage, as most enrollees are expected to be transferred from another source of coverage via the bridge program, maintaining retroactive coverage should not impose too much cost or burden on the state. Indeed, since this waived provision is expected to affect a small percentage of the Medicaid population, it is hard to justify it as a demonstration that will provide new or innovative ways to deliver care.

VIII. CMCS Should Clarify that Enrollment in the Health Protection Premium Assistance Program will Continue Year-Round.

The draft application indicates that enrollment will start at the same time as the Marketplace open enrollment period for 2016. However, it is unclear from the draft application whether the state intends to limit enrollment to the open enrollment period. While we assume the state intends to accept applications and assess eligibility for the Health Protection Premium Assistance Program year-round, as it does for Medicaid currently, we ask CMCS to clarify that enrollment in the Health Protection Premium Assistance Program will continue after the open enrollment period ends.

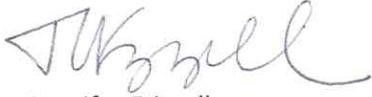
IX. CMCS Should Maintain Cost-Sharing Protections for Premium Assistance Enrollees.

We are grateful that the state incorporated stakeholders' concerns regarding cost-sharing and proposed to implement a premium assistance framework that will exempt individuals with incomes less than 100 percent FPL from premium obligations. Additionally, we appreciate that the draft application reinforces that pregnant women and family planning services and supplies will be exempt from cost-sharing. These limitations on cost-sharing are consistent with federal law and reflect the reality that even minimal co-pays or premium obligations can be an access barrier for low-income individuals and families. We strongly urge CMCS to maintain these cost-sharing protections as it works with the state to finalize the Health Protection Premium Assistance Program.

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.

We thank CMCS for the opportunity to submit these comments. If you have any questions, please do not hesitate to contact me at 603.513.5334 or jennifer.frizzell@ppnne.org.

Sincerely,

A handwritten signature in black ink, appearing to read "J Frizzell". The signature is fluid and cursive, with the first letter of the first name being a large, stylized capital "J".

Jennifer Frizzell

Vice President for Public Policy