NICHOLAS A. TOUMPAS
COMMISSIONER

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
~~XXXXXXXX~~ FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

New Number: 603-271-9200

FIS 14 130

July 22, 2014

The Honorable Mary Jane Wallner
and Members of the Fiscal Committee of the General Court
107 North Main Street
Concord, NH 03301

Re: Request For Approval – State Plan Amendment

Dear Chairman Wallner and Members of the Committee:

REQUESTED ACTION

Pursuant to Chapter 3:2 laws of 2014 (SB 413) the Department is requesting the Committee's approval of various state plan amendments for the New Hampshire Health Protection Program.

1. The Department is submitting a state plan amendment to remove non-emergency services from coverage under the Alternative Benefit Plan for the new adult group, for action by the Committee and;
2. Pursuant to Chapter 3:2 laws of 2014 (SB 413) the Department is asking for approval to add coverage for hearing aids for the new adult group for those over age 21.

BACKGROUND

The Department advised the Fiscal Committee at the May 22, 2014 meeting that it was prepared to bring forward a further Medicaid state plan amendment to address concerns over the inefficient use of hospital emergency rooms for non-emergency services. The Department informed the Committee that non-emergency use of hospital emergency departments is not an essential health benefit that would apply to the new adult group to be covered under the New Hampshire Health Protection Program. As a result, the Department issued a public notice for the further change to the Alternative Benefit Plan (ABP) that will apply to the new adult group to remove non-emergency services performed in hospital emergency departments from coverage.

If approved by Fiscal and the Centers for Medicare and Medicaid Services (CMS), the Amended ABP SPA (on page 5 of 26 of the enclosed ABP SPA) would now provide coverage in emergency rooms for "treatment of an emergency medical condition." That is defined as:

> "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part."

The Department received a number of written comments in response to the public notice. Copies of these comments are also enclosed.

If approved by the Committee, the Department will submit the amended ABP SPA to CMS for approval.

The Amended ABP SPA makes one additional change that is reflected on page 25 of the document. The Department is also proposing to add coverage for hearing aids for the new adult group for those over age 21. Although hearing aids are not included in the essential health benefits and are not required to be covered for the new adult group for those over 21, they will be covered for those aged 19 and 20 (as part of the EPSDT benefit), and the Department believes that the hearing aid benefit should apply to the entire new adult group. The hearing aid benefit is limited and is described on page 25; the cost of the benefit is 100% federal funds through the period authorized for the New Hampshire Health Protection program.

The Department looks forward to addressing this SPA at the July 25, 2014 meeting.

Sincerely,

Nicholas A. Toumpas
Commissioner

Enclosures

LEGAL NOTICE

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Notice is hereby given that the New Hampshire Department of Health and Human Services (DHHS) intends to amend the NH Title XIX State Plan (SPA) to change the Alternative Benefit Plan (ABP) for the eligibility category created pursuant to section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to eliminate coverage for non-emergency use of the emergency room.

Under the amended SPA, emergency room services will be covered only for treatment of an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

DHHS proposes an effective date of October 1, 2014 for this amendment to the ABP.

The State will assure compliance with section CFR 440.345 to provide full access to Early Periodic Screening Diagnosis and Treatment (EPSDT) services for covered nineteen and twenty year olds by describing the process to access these benefits in notices sent to all individuals receiving the ABP. The State will assure compliance with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009 by continuing to engage in tribal consultations, to the extent required by federal law.

Copies of the draft state plan pages will be on file with the Department of Health and Human Services, Office of Medicaid Business and Policy, Legal and Policy Unit, 129 Pleasant Street-Thayer Building, Concord, NH 03301-3857. To request a copy of the draft SPA pages, please contact Diane Peterson at (603) 271-4367, or via e-mail at dpeterson@dhhs.state.nh.us. The draft SPA pages may undergo further revisions before and after submittal to CMS based upon public comment or CMS feedback. Comments are due by July 18, and should be e-mailed to Diane Peterson at the above e-mail address or to the Department of Health and Human Services, Office of Medicaid Business and Policy, Legal and Policy Unit, 129 Pleasant Street-Thayer Building, Concord, NH 03301-3857, ATT: Diane Peterson.

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Appeared in: ***The Union Leader*** on Thursday, 06/19/2014

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- [ ]

OMB Expiration date: 10/31/2014

Benefits Description **ABP5**

The state/territory proposes a "Benchmark-Equivalent" benefit package. [No]

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

The base benchmark plan is the Matthew Thornton Blue Health Plan.

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Visit to Treat an Injury of Illness

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Practitioner Office Visit (APRN, PA, etc.)

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Advance Practice Registered Nurse, Physician Assistant, Nurse Practitioner, and Certified Midwives, consistent with their scope of practice.

Remove

Benefit Provided:

Outpatient Facility Fee (e.g., Amb. Surgery Ctr.)

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided:

Hospice Services

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Urgent Care Centers or Facilities

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Coverage limited to treatment of an emergency medical condition.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Emergency room services covered only for treatment of an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Remove

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient Hospital Services
Source: Base Benchmark Small Group
Remove

Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prior authorization is required only for out-of-state inpatient hospitalization.

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided: Bariatric Surgery
Source: Base Benchmark Small Group

Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:

Transplant

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for all organ transplants, except kidney transplants.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Minimum stay of 48 hours

Add

Alternative Benefit Plan

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Mental/behavioral Health Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; and telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider.

Benefit Provided: Mental/behavioral health inpatient services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for inpatient hospital services or residential treatment center facility for mental health care; inpatient rehabilitation treatment for substance abuse care in a hospital or substance abuse treatment facility; partial hospitalizations; and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase

Alternative Benefit Plan

of a substance abuse condition.
Benefits exclude IMDs.

Remove

Benefit Provided:
Substance Abuse Disorder Outpatient Services

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for outpatient treatment for mental health care and substance abuse care, partial hospitalizations, and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; and telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider.

Benefit Provided:
Substance Abuse Disorder Inpatient Services

Source:
Base Benchmark Small Group

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for inpatient hospital services or residential treatment center facility for mental health care; inpatient rehabilitation treatment for substance abuse care in a hospital or substance abuse treatment facility; partial hospitalizations; and day/night visits.
No benefits are available for therapy, counseling or any non-surgical inpatient or outpatient service, care or program to treat obesity or for weight control; custodial care, convenience services, milieu therapy, marriage or couples counseling; therapy for sexual dysfunctions; recreational or play therapy; educational evaluation; career counseling; services for nicotine withdrawal or dependence; psychoanalysis; telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase

Alternative Benefit Plan

of a substance abuse condition.
Benefit excludes IMDs.

Remove

Add

Alternative Benefit Plan

☒ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☐ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of New Hampshire's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Home Health Care Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: No benefits are available for custodial care.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Skilled Nursing Facility
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: 100 days per year
Duration Limit: None
Scope Limit: No benefits are available for custodial care.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Rehabilitation Services
Source: Base Benchmark Small Group
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: 20 visits per year for each therapy type
Duration Limit: None.
Scope Limit: See below.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services.

No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational, or occupational reasons; or therapy for TMJ.

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Cardiac Rehabilitation

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Habilitation Services

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Remove

Amount Limit:
20 visits for each therapy type

Duration Limit:
None

Scope Limit:
See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

There is a separate 20 visit limit for each of the following types of therapies: physical therapy, occupational therapy, and speech therapy. Benefit limits are shared between outpatient rehabilitation and habilitation services.

No benefits are available for on-going or life-long exercise and education programs intended to maintain lifelong physical fitness; voice therapy or vocal retraining; preventive therapy or therapy provided in a group setting; therapy for educational reasons; therapy for sport, recreational, or occupational reasons; or therapy for TMJ.

Benefit Provided:
Chiropractic Care

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
12 vistis per year

Duration Limit:
None

Scope Limit:
Includes spinal manipulation and manual medical intervention services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Durable Medical Equipment

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits are available for durable medical equipment, medical supplies, and prosthetic devices. Prior authorization is required for durable medical equipment and adult incontinence supplies.

Remove

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services — Collapse All

Benefit Provided: Diagnostic Tests (X-Ray and Lab Work)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No benefits are available for diagnostic x-rays in connection with research or study.

Benefit Provided: Imaging (CT/PET scans/MRIs)

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for the following types of imaging: CT, PET, MRI, MRA, and nuclear cardiology.

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Preventive Care/Screening/Immunization

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The preventive care benefit includes the following: (1) all services listed on the USPSTF A and B lists; (2) Advisory Committee for Immunization Practices (ACIP) recommended vaccines; (3) preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and (4) additional preventive services for women recommended by the Institute of Medicine (IOM) and HRSA. This benefit includes family planning services and contraceptive coverage, consistent with the requirements of the additional preventive services for women recommended by the IOM and HRSA. Specifically, the preventive services benefit includes all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

Add

Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

EPSDT will apply for all 19 and 20 year olds. Prior authorization required for the following dental services: comprehensive and interceptive orthodontics, dental orthotic devices, surgical periodontal treatment, and extractions of asymptomatic teeth.

Add

Alternative Benefit Plan

☒ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Other Base Benefit Provided:
Routine Eye Exam (Adult)

Source:
Base Benchmark

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
1 exam every 2 years

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit:
No prior authorization

Add

Alternative Benefit Plan

☐ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Alternative Benefit Plan

☐ 13. Other Base Benchmark Benefits Not Covered

Collapse All ☐

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Non-Emergency Medical Transportation

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: Prior authorization is required for non-emergency medical transportation, including scheduled ambulance.

Other 1937 Benefit Provided: Eyeglasses for individuals 21 and over

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 1 pair per year single vision or bifocal glasses*

Duration Limit: None

Scope Limit: None

Other: One refraction is covered to determine the need for glasses, no more frequently than every 12 months. One pair single vision lenses with frames is covered, provided that the refractive error is at least plus or minus .50 diopter according to the type of refractive error, in each eye. One pair of glasses with bifocal corrective lenses or one pair of glasses with corrective lenses for close vision and one pair of glasses with corrective lenses for distant vision if there is a refractive error of at least .50 diopter for both close and distant vision Benefit is the same as described in the Medicaid State Plan. No authorization is required.

Other 1937 Benefit Provided: Dental for individuals 21 and over

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Coverage is limited to treatment of acute pain or infection

Remove

Other:

Benefit is the same as described in the Medicaid State Plan. No authorization is required.

Other 1937 Benefit Provided:

Hearing aids for individuals age 21 and over

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below

Duration Limit:

None

Scope Limit:

See below

Other:

Hearing aid evaluation or a hearing aid consultation limited to one service every two years. Coverage includes ear molds; hearing aids/pocket talkers; dispensing or fitting of hearing aids/pocket talkers, follow up, and audiograms. Monaural hearing aids are covered when the audiogram indicates a bilateral hearing loss with an average threshold of 35 dBHL or poorer for 1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz. Binaural hearing aids are covered if the beneficiary meets the definition of statutory blindness or if the beneficiary qualifies for monaural hearing aids and the individual is either (1) attending post-secondary school for the purpose of obtaining employment or is receiving vocational training or (2) the beneficiary is employed and is likely to be determined as unable to meet the audiometric requirements of the job without the use of binaural hearing aids. Hearing aid batteries are covered for the lifespan of the hearing aids. Replacement hearing aids are covered only if (1) there is an increase in the beneficiary's hearing loss, which makes the existing hearing aid ineffective or (2) the hearing aid can no longer be repaired or it is not cost-effective to do so. Pocket talkers are covered only if the individual meets the criteria to receive a monaural hearing aid, but a hearing aid has not also been covered by Medicaid. Pocket talkers are replaced (1) with hearing aids or a more effective pocket talker if there is an increase in the beneficiary's hearing loss, which makes the existing pocket talker ineffective or (2) every five years. Replacement of a headset, earbuds, or neckloop for a pocket talker once every year if the accessories are malfunctioning. Binaural hearing aids are subject to prior authorization.

Add

Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219

New Hampshire Hospital Association

July 14, 2014

Diane Peterson
Legal and Policy Unit
Office of Medicaid Business and Policy
Department of Health & Human Services
129 Pleasant Street – Thayer Building
Concord NH 03301-3857

Re: NH Health Protection Program: Alternative Benefit Plan SPA

Dear Ms. Peterson

I am writing on behalf of the New Hampshire Hospital Association (NHHA) and our acute care member hospitals to comment on DHHS' proposed Title XIX State Plan Amendment under the Alternate Benefit Plan (ABP) for the eligibility category created pursuant to section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to eliminate coverage for non-emergency use of hospital emergency rooms.

We support the Department's goal of encouraging access to health care services in the most appropriate settings and in the most efficient manner possible. We absolutely do not want people to use hospital emergency room services who should be seeking care in more appropriate care settings. It is therefore vitally important that we – DHHS, providers and the Medicaid MCOs – all work together to identify ways to ensure that beneficiaries receive the right care in the right place at the right time. We believe that the most effective way to deter inappropriate use of emergency room services is to continuously educate beneficiaries from the moment they are enrolled in the program on how to properly access the health care system.

PRUDENT LAYPERSON: How to define a medical emergency.
One of the more challenging aspects of the state's proposal regarding non-coverage of non-emergency services in hospital EDs is the determination as to whether or not a medical emergency condition exists. That is where the federal government's "Prudent Layperson" standard comes in to play.

DHHS articulates the "Prudent Layperson" standard in its proposed SPA as an emergency medical condition ...

"... manifesting itself by acute symptoms of sufficient severity so that a *prudent layperson*, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual ... in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part."

Therefore, the determination of whether the Prudent Layperson standard has been met must be focused on the presenting symptoms (and not on the final diagnosis nor on the health plan's evaluation afterward), and must take into account that the patient's decision to seek emergency care was made by a *prudent layperson* (versus a medical professional).

Naturally, hospitals are concerned that the MCOs might consider the subjective nature of the Prudent Layperson standard as a reason to deny payment for services. As stated above, we believe it will be more effective to have all parties – providers, DHHS and the MCOs – collaborate to identify the best way to educate beneficiaries in the use of hospital emergency services, as well as to work out processes by which disputes or disagreements can be moderated.

FEDERAL EMTALA REQUIREMENTS

It is also vitally important that DHHS and the MCOs understand the legal framework under which hospitals must operate relative to the provision of emergency services. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) regulations[1] specify the responsibilities of hospitals for emergency cases. EMTALA governs when and how a patient must be (1) examined and offered treatment or (2) transferred from one hospital to another when the patient is in an unstable medical condition. Under Sec. 1867 [42 U.S.C. 1395dd][2], hospitals *must* provide an appropriate medical screening examination for every individual who requests treatment at a hospital emergency room to determine whether or not an emergency medical condition exists.

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[1] EMTALA is Section 1867(a) of the Social Security Act, and is codified within the section of the U.S. Code which governs the Medicare program, 42 CFR 489.24, Special responsibilities of Medicare hospitals in emergency cases. See http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec489-24.pdf

[2] Medical Screening Requirement: In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for an examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

Further, if an emergency medical condition does exist, the hospital must provide necessary stabilizing treatment.

However, the State Plan Amendment is silent on the federal EMTALA requirement that obligates hospitals to conduct a medical screening examination on any individual who requests treatment at an emergency room. At issue is the fact that this mandatory medical screening exam requires a physical examination conducted by a clinician and usually several diagnostic tests (lab, radiology). These tests and exams must be carried out to determine **whether or not** the patient's condition is an emergency in compliance with 42 CFR 489.24(c), Use of dedicated emergency department for nonemergency services.[3]

It follows, therefore, that the MCOs must pay for the federally mandated screening examination, including diagnostic tests, required under EMTALA, **whether or not the condition is determined to be an emergency**. And the MCOs must pay for the treatment necessary to stabilize the emergency medical condition.

FURTHER DISCUSSION ON PAYMENT FOR NON-EMERGENCY SERVICES

DHHS' proposed non-coverage of non-emergency services presumes that individuals' health services seeking behaviors will change once they're informed that they will be responsible for the payment for non-emergency services. Again, we believe that a more effective means of changing behavior is to work with the Medicaid MCOs to assure that Medicaid beneficiaries are educated about appropriate ED use.

We must also work with DHHS and the MCOs to ensure reasonable payment for medically necessary services that are provided to ameliorate a condition that, though found not to be an emergency medical condition, requires treatment in accordance with the clinical judgment of the ED physician.

EDUCATION OF BENEFICIARIES

If we're going to be successful at changing patient behaviors, we have to employ methods that will have the greatest potential to achieve the desired goals. We believe the MCOs have an obligation to make sure that their members know how to access the services they need in the most appropriate settings. It is the role of the MCOs, therefore, to use a variety of tools to educate their members. We also believe DHHS can

[3] If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

use this opportunity to bring the MCOs and providers together to work on solutions to the problem of inappropriate use of hospital ED services.

An excellent model has been developed by Washington State to reduce inappropriate use of hospital emergency room services. "ER is for Emergencies" is a partnership of physicians, hospitals and state Medicaid representatives and has resulted in savings of over $33 million in Medicid fee-for-service emergency care costs. The Washington State Health Care Authority published a report[4], ***Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation***, that describes seven best practices to redirect care to the most appropriate setting, reduce low acuity and reduce preventable Medicaid emergency room visits. The program addresses the root of the problem, i.e. high users with chronic medical conditions, substance abuse issues, and lack of primary care access. Best practices include:

1. Tracking ED visits to reduce "ED shopping";
2. Implementing patient education efforts to re-direct care to the most appropriate setting;
3. Instituting an extensive case management program to reduce inappropriate emergency department utilization by frequent users;
4. Reducing inappropriate ED visits by collaborative use of prompt (72 hour) visits to primary care providers and improving access to care;
5. Implementing narcotic guidelines that will discourage narcotic-seeking behavior
6. Tracking data on patients prescribed controlled substances by widespread participation in the state's Prescription Monitoring Program; and
7. Tracking progress of the plan to make sure steps are working.

Finally, the most important concern for us all is that patients receive the right care in the right place at the right time. We should therefore work together to find a more effective way to promote appropriate use of health care services *and* to encourage this new group of beneficiaries to better manage their health care. These efforts should be incorporated into the Managed Care program to be more consistent with the goals of the program.

The New Hampshire Hospital Association would be very happy to work with DHHS and the MCOs to research the types of programs that have worked elsewhere, and assist the Department to implement a truly effective program to impact patients' behavior.

Thank you for the opportunity to comment.

Sincerely,

Steve Ahnen

Steve Ahnen
President

[4] http://www.hca.wa.gov/Documents/EmergencyDeptUtilization.pdf

Elliot Hospital

One Elliot Way
Manchester, NH 03103
P. (603) 669-5300

July 16, 2014

Department of Health and Human Services
Office of Medicaid Business and Policy, Legal and Policy Unit
129 Pleasant Street – Thayer Building
Concord, NH 03301-3857
Attn: Diane Peterson

Dear Ms. Peterson:

I am writing on behalf of Elliot Hospital (EH) to raise concerns about the proposed SPA Amendment that would apply the prudent layperson standard for paying for emergency room services for the New Hampshire Health Protection Program (NHHPP) population. EH is the largest provider of comprehensive healthcare services in Southern New Hampshire. EH is a 296-bed acute care facility located in Manchester, New Hampshire. EH is home to Manchester's designated Regional Trauma Center, two Urgent Care Centers, a Level 3 Newborn Intensive Care Unit, Elliot Regional Cancer Center, Elliot Senior Health Center, Elliot at River's Edge and the New Hampshire's Hospital for Children. EH is an affiliate of Elliot Health System that also includes Elliot Physician Network, Elliot Professional Services, Elliot 1-Day Surgery Center, and the Visiting Nurse Association of Manchester and Southern New Hampshire.

We share the Department of Health and Human Services' goal of reducing inappropriate utilization of emergency room services (ED). However, we are concerned that the proposed SPA Amendment is the wrong tool for making that change. The problem with using the billed claim is that the claim has the final diagnosis and not the reason that the patient came to the ED in the first place. By way of example, an individual may come to the ED with a headache and the claim may end up as a headache diagnosis, but the reason that the person came to the ED was because the individual thought that he/she was having a stroke or had an aneurysm. The billing claim will not say that, rather it may say headache or migraine. So under the State's revision, the claim would be denied as "not an emergency" and yet the reason the patient came to the ED does meet the definition of the prudent person law. The prudent person law was passed to protect the consumer and, under both state and federal law, it is the individual who is experiencing the medical onset who determines whether or not he/she is in serious jeopardy to health, impairment to bodily functions or organ or body part – in other words, the meaning of the law is meant to be subjective. If the State removes the subjectivity and applies 20/20 hindsight by looking at the final diagnosis versus the presenting symptoms or complaints, the provider has expended resources to care for the patient that may not be reimbursed. The State may say

that the "patient is responsible to pay"; however, the reality is that the particular population for whom the state wants to implement this proposed change cannot afford to pay (otherwise they would be on a plan other than the Medicaid Expansion Plan). This means that hospitals and providers absorb the costs without corresponding reimbursement forcing hospitals to seek higher reimbursement rates from commercial payors.

Under EMTALA, we are obligated to accept and, at minimum, screen patients who come to the ED – to send them away without screening could be viewed as "dumping" because of the Medicaid recipient's inability to pay. It is the provider, not the State, who is subject to the complaint.

In response to the inappropriate use of emergency services, EH's efforts include operating two urgent care centers while simultaneously educating the public around when to go to the ED, e.g., chest pain, and when to go to urgent care, e.g., cold, fever, sore throat.

We urge that the proposed SPA Amendment not be approved and implemented.

Sincerely,

Richard A Elwell

Richard A. Elwell
Senior Vice President & CFO

July 17, 2014

Diane Peterson
Legal and Policy Unit
Office of Medicaid Business and Policy
Department of Health & Human Services
129 Pleasant Street – Thayer Building
Concord NH 03301-3857

Re: NH Health Protection Program: Alternative Benefit Plan SPA

Dear Ms. Peterson

I am writing on behalf Frisbe Memorial Hospital to comment on DHHS' proposed Title XIX State Plan Amendment under the Alternate Benefit Plan (ABP) for the eligibility category created pursuant to section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to eliminate coverage for non-emergency use of hospital emergency rooms.

The elimination of coverage of non-emergency services provided in hospital EDs for the new adult coverage group eligible for health insurance coverage under the New Hampshire Health Protection Program will negatively impact emergency departments across the state. In order to be compliant with EMTALA hospitals will have to change the triage process of their patients and now accommodate medical screening exams in space that was designed to triage patients. It is not practical to bring patients into the emergency department, to then medically screen them and tell them their problem is a non-emergency and will not be covered. Not only will this force hospital to develop a process to ensure the medical screening exam is completed; the hospitals will also need to have a mechanism in place to refer these patients for care. In order for this to be successful there needs to be sufficient capacity in clinics, primary care offices and urgent cares across the state. In our area we have limited access to resources that provide same day medical evaluation and care.

This also creates significant medical-legal risk for the hospital; as providers will now worry if they missed a possible life or limb treating condition during the medical screening exam. There will be not protection for the facility and the provider if the condition is deemed a non-emergency and an untoward event occurs because the patient's condition could not be adequately evaluated during a medical screening exam. The difficulty with this proposal is the emergency department still has to evaluate every patient that comes in; so provider staffing and nursing staffing will have to remain the same, despite the decrease in the number of patients that are treated. Financially this places the hospitals in a difficult position, because the patients can

ultimately refuse to get care elsewhere and demand the ED treat them. In this situation the treatment would not be reimbursed and the hospital would have to absorb the bad debt.

Thank you for the opportunity to comment.

Sincerely,

John A Marzinzik

July 17, 2014

Ms. Diane Peterson
New Hampshire Department of Health and Human Services
Office of Medicaid Business and Policy
Legal and Policy Unit
129 Pleasant Street, Concord, NH 03301

Via e-mail: dpeterson@dhhs.state.nh.us

RE: Proposed State Plan Amendment ending reimbursement for non-emergency use of a hospital emergency department.

Dear Ms. Peterson:

Thank you for the opportunity to comment on the proposed State Plan Amendment. The comments below reflect the concerns of a multi-stakeholder group that includes provider and consumer advocates.

We are very concerned about the proposal to make non-emergent use of the emergency department a non-covered service for the enrollees in the New Hampshire Health Protection Program (NHHPP). First and foremost, we disagree that this is a distinction that can be made. Physician visits are a covered service for NHHPP enrollees. While the state can, under the law, impose a copayment, it does not follow that a service that is otherwise described as an element of an EHB/ABP (e.g., physician visit) is not a covered service because an individual accessed it through an ED. In the proposed amendment, New Hampshire has improperly equated the *service* (which is a covered service) with a policy for the *preferred site* for delivering the service. If the recipient chooses the improper site, Congress has established that the permissible penalty is a copayment. New Hampshire rejected such a penalty earlier this year.

Moreover, a determination that non-emergent use of the ED is a non-covered service will likely mean that NHHPP enrollees will be charged $100 or more for non-emergent use of the ED. Enrollees will not learn how and/or where to access physician services appropriately by receiving a hefty bill from a hospital. They may, however, begin to mistrust that they can use their NHHPP coverage to access health care affordably. Consequently, they may ration their care without regard to whether they *should* put off seeking medical care or in what context. In fact, prior research has shown that low-income populations are sensitive to even modest copayments; the implication is that enrollees will be extremely sensitive to a much higher financial obligation. Research also indicates that instituting higher copayments on ED use in the Medicaid context does not effectively reduce expenditures.[i]

It should be noted that non-urgent use of the ED is uncommon among Medicaid enrollees. Only 10 percent of Medicaid ED visits are for non-urgent use and that rate roughly mirrors non-urgent use of the ED among the privately insured population.[ii] It is certainly true that Medicaid

enrollees use the ED overall at an almost two fold higher rate than the privately insured, but again, non-urgent visits comprise only about 10 percent of all ED visits by Medicaid enrollees. High utilization of the ED overall by Medicaid enrollees is likely a reflection that Medicaid enrollees are in poorer health than the privately insured population. Moreover, frequent ED use may also reflect access to care issues. If there is limited capacity for patients to be seen in an appropriate setting, there may be nowhere for the patient to go, or to be redirected, to avoid non-emergency ED use. If a recipient goes to an emergency department and there is no non-emergency service setting accessible and available in a timely way, they should not be penalized for seeking medical care, especially if the enrollee was directed there by a health care provider.

CMS issued guidance earlier this year outlining strategies to reduce non-emergent use of an ED, including broadening access to primary care services, addressing the needs of those who are high-utilizers of the ED, and addressing substance use disorder issues among high utilizers.[iii] We support these strategies and urge the state to adopt them. Below we explore two of these concepts in more detail.

Broadening Access to and Awareness of Primary Care Sites

Access to care is a threshold issue related to emergency department use. An effort must be made to identify and advertise alternate primary care sites, especially those available after business hours. Two-thirds of emergency visits occur after business hours[iv] and providing access to care after business hours may be a very practical first step in the effort to encourage appropriate use of the ED. The state could require managed care organizations (MCOs) to have a minimum percentage of providers in each network that offer after-business-hours care.

The state could also partner with MCOs to produce educational materials for providers and recipients to encourage recipients to use the most appropriate care settings and to make recipients aware of available, alternate primary care sites. Adoption of a system to educate patients about the most appropriate settings for health care (through brochures and instructions) and training ED providers to explain to patients where to receive care for non-emergent issues, may be a more effective method of teaching enrollees about appropriate use of health care resources than the financial penalties likely associated with the proposed SPA.

Deploying Managed Care Tools to Focus on High-Utilizers of the ED

High ED utilizers (those with 4 or more ED visits in a year) comprise 4.5 percent to 8 percent of all ED patients across payors but account for 21-28 percent of all visits.[v] High utilizers of the ED are more likely to have poor health and lack a usual source of care.[vi] In other words, a person who frequently uses the ED may be struggling to manage a chronic condition and/or to find a successful relationship with a provider.

The state should deploy the care coordination tools the MCOs are charged with having to address these issues. MCO care coordinators could be charged with flagging enrollees with a certain number of ED visits each year as being potential participants in Health Homes or Special Needs Plans or Patient Centered Medical Homes. The care

coordinators could be charged with also identifying any barriers to care that these enrollees are experiencing and working to address them, including screening high utilizers for behavioral health conditions.

Larger reforms may be needed as well. Since 2012, Washington State has worked with its 90+ hospitals to establish 7 best practices around reducing unnecessary ED use by Medicaid clients, in lieu of ending Medicaid reimbursement for non-emergent use of the ED. Washington has achieved 100 percent participation by all of its hospital EDs and has enjoyed some initial successes. As of June 2013, overall ED use had declined by 9.9 percent, the rate of visits by high-utilizers decreased by 10.7 percent, and the rate of visits with a low-acuity diagnosis fell by 14.2 percent.[vii]

One of the hallmark best practices in Washington was the adoption of an Emergency Department Information Exchange, which allows EDs to see all of the presenting patient's emergency room visits in the state over the prior 12 months and to see the diagnosis and treatment given during those prior visits. Consequently, ED physicians have been able to more accurately determine whether a patient is exhibiting narcotic-seeking behavior or has a chronic condition and respond accordingly.[viii] New Hampshire should explore broad-based reforms like those Washington has initiated prior to taking the drastic step of ending reimbursement for non-emergent services provided in the ED.

In conclusion, the state has better tools with which to encourage appropriate use of health care resources at its disposal than financial penalties likely to be associated with the proposed SPA. Broadening access to, and awareness of, primary care and deploying managed care tools for those enrollees who are high utilizers of EDs is far more likely to be effective than the proposed option. Larger reforms, including expanding the capacity for emergency departments to exchange data with one another, may be needed as well.

We appreciate the opportunity to provide our comments on this proposed SPA and remain committed to working with New Hampshire to develop effective, appropriate policies for the New Hampshire Health Protection Program.

Sincerely,

Deborah H. Fournier, Esq.
Policy Analyst
N.H. Fiscal Policy Institute

Stuart J. Glassman, MD
President
N.H. Medical Society

Sarah Mattson, Esq.
Policy Director
N.H. Legal Assistance

MaryLou Beaver
New England Director
Every Child Matters

Borja Alvarez de Toledo, President & CEO
Child and Family Services of N.H.

Susan Smith, Executive Director
N.H. Voices for Health

Ken Norton, LICSW
Executive Director
National Alliance on Mental Illness, N.H.

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[i] While reductions in ED use were evident in response to implementation of copayments, those reductions were counterbalanced by increased expenditures per user such that expenditures per person remained unchanged. The policy did reduce overall use of services, but in some cases shifted overall treatment patterns, such as the relative increase in inpatient care, in ways that are not inherently aligned with more cost-efficient or cost effective care. Wallace et al. 2008. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Research and Educational Trust.

[ii] Sommers et al. 2012 Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms. Center for Studying Health Systems Change.

[iii] CMCS Informational Bulletin. January 16, 2014.

[iv] Pitts et al. 2010. Where Americans Get Acute Care: Increasingly, it's not in their doctor's office. Health Affairs. 29(9):1620-1629.

[v] LaCalI et al. 2010. Frequent users of the emergency departments: The myths, the data and the policy implications. Ann Emerg Med. 56:42-48.

[vi] Hunt et al. 2006. Characteristics of frequent users of emergency departments. Annals of Emergency Medicine. Vol 48: 1-8.

[vii] Washington State Health Care Authority Report to the Legislature, Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation. January 30, 2014.

[viii] Washington State Health Care Authority Report to the Legislature, Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation. January 30, 2014.

NEW HAMPSHIRE
MEDICAL CARE ADVISORY COMMITTEE

Department of Health & Human Services ♦ Office of Medicaid Business and Policy
129 Pleasant Street ♦ Concord, NH 03301
(603) 271-9422 ♦ Fax (603) 271-8431

July 17, 2014

Ms. Diane Peterson, Medicaid Policy Administrator
Legal and Policy Unit
Office of Medicaid Business and Policy
NH Department of Health and Human Services
129 Pleasant Street – Thayer Building
Concord, NH 03301

Via e-mail: dpeterson@dhhs.state.nh.us

RE: Proposed Medicaid State Plan Amendment ending coverage and reimbursement for non-emergency use of a hospital emergency department

Dear Ms. Peterson:

Thank you for the opportunity to comment on the newly-proposed State Plan Amendment (SPA) that, in the context of the NH Health Protection Program (NHHPP), would end Medicaid coverage and reimbursement for non-emergency use of a hospital emergency department (ED).

This letter is being submitted on behalf of New Hampshire's Medical Care (Medicaid) Advisory Committee (MCAC). Established by federal regulation, the MCAC is an appointed multi-stakeholder group of consumer, provider, and advocate members that has regular and periodic meetings with NH Department of Health and Human Services (Department) leaders.

Pursuant to federal regulation, the Department's Medicaid Director provides the MCAC with the opportunity to review and provide input into proposed Medicaid policy changes for New Hampshire, including proposed State Plan Amendments. These comments reflect the input and concerns of New Hampshire's MCAC.

The MCAC strongly supports and shares the Department's goal of encouraging access to health care services in the most appropriate settings and in the most efficient manner possible. We do not want people to use hospital emergency room services who can and should be seeking care in available and more appropriate settings. However, we do not believe that the proposed SPA is an effective means of accomplishing this shared and extremely important goal.

As a preliminary matter, there is evidence that designating non-emergent use of the ED as a non-covered / non-reimbursable service for NHHPP / Medicaid enrollees is a distinction that cannot actually be made under federal law.

Physician visits are a covered service for NHHPP and Medicaid enrollees. While our state can, under the law, impose a co-payment, it does not follow that a service that is otherwise described as an element of the Essential Health Benefit / Alternative Benefit Program (e.g., a physician visit) is not a covered service because an individual accessed that service through an ED.

The draft SPA appears to mistakenly equate the *service* itself (a covered service) with a *policy for the preferred site for delivering the service*. If a Medicaid enrollee chooses the improper site, federal law provides that the permissible penalty is a co-payment. We understand that New Hampshire decided not to move forward with a proposed co-payment earlier this year.

While there are available and best-practice policy means of helping to ensure that patients access services in preferred and appropriate care settings (see below), there is little if any evidence that removing coverage and reimbursement – and having enrollees be subject to a hefty charge – for non-emergent services in the ED is one of them, or that doing so actually addresses any underlying cause of ED usage for such services.

There are better and more effective tools at New Hampshire's disposal to help address this shared and important challenge, and that merit the Department's timely and meaningful consideration.

CMS issued guidance earlier this year outlining recommended strategies to reduce non-emergent use of an ED, including: broadening access to primary care services; addressing the needs of those who are high-utilizers of the ED; and addressing substance use disorder issues among high utilizers.[i] The MCAC supports these strategies and urges New Hampshire to adopt and employ them. Two of these concepts are explored in a bit more detail here.

Broadening Access to and Awareness of Primary Care Sites

Access to care is a threshold issue related to ED use. An effort needs to be made to identify and advertise alternate primary care sites, especially those available after business hours. Two-thirds of emergency visits occur after business hours[ii] and providing access to care after business hours may be a very practical first step in the effort to encourage appropriate use of the ED. The state could require New Hampshire's managed care organizations (MCOs) to have a minimum percentage of providers in each network that offer after-business-hours care.

New Hampshire could also partner with MCOs to produce educational materials for providers and enrollees to encourage recipients to use the most appropriate care settings and to make enrollees aware of available, alternate primary care sites. Adoption of a system to educate patients about the most appropriate settings for health care (through brochures and instructions) and training ED providers to explain to patients where to receive care for non-emergent issues, may be a more effective method of teaching enrollees about appropriate use of health care resources than the financial penalties likely associated with the proposed SPA.

Deploying Managed Care Tools to Focus on High-Utilizers of the ED

High ED utilizers (those with 4 or more ED visits in a year) comprise 4.5 percent to 8 percent of all ED patients across payors but account for 21-28 percent of all visits.[iii] High utilizers of the ED are more likely to have poor health and lack a usual source of care.[iv] In other words, a person who frequently uses the ED may be struggling to manage a chronic condition and/or to find a successful relationship with a provider.

New Hampshire can and should deploy the care coordination tools that the MCOs are charged with having to address these issues. MCO care coordinators could be charged with flagging enrollees with a certain number of ED visits each year as being potential participants in Health Homes or Special Needs Plans or Patient Centered Medical Homes. The care coordinators also could be charged with identifying any barriers to care that these enrollees are experiencing and working to address them, including screening high utilizers for behavioral health conditions.

An impressive model has recently been developed by the State of Washington. Since 2012, Washington has worked with its 90-plus hospitals to establish 7 best practices around reducing unnecessary ED use by Medicaid clients, in lieu of ending Medicaid reimbursement for non-emergent use of the ED. The best practices are:

- Tracking ED visits to reduce frequent user "ED shopping";
- Implementing patient education efforts to re-direct care to the most appropriate setting;
- Instituting a case management program to reduce non-urgent emergency department utilization by frequent users;
- Reducing non-emergent ED visits by collaborative use of prompt visits (within 72 hours) to primary care providers, and improving access to care;
- Implementing narcotic guidelines that will discourage narcotic-seeking behavior;
- Tracking data on patients prescribed controlled substances by widespread participation in the state's Prescription Monitoring Program; and
- Tracking progress of the overall program to make sure that the steps are working.

Washington has achieved full participation by all of its hospital emergency departments and, even at this early stage, is enjoying impressive success. As of June 2013, overall ED use had declined by 9.9 percent, the rate of visits by high-utilizers decreased by 10.7 percent, and the rate of visits with a low-acuity diagnosis fell by 14.2 percent.[v]

New Hampshire has access to better and more effective tools with which to encourage and incentivize the use of appropriate care settings than the proposed SPA, along with the opportunity to work with providers and stakeholders on exploring the implementation of a Washington-like initiative in our state. Broadening access to and awareness of primary care, and deploying managed care tools for those enrollees who are high utilizers of EDs, are best practice policy options far more likely to be effective than the draft SPA proposal.

Thank you for the opportunity to submit these comments on the newly proposed State Plan Amendment. The MCAC is pleased to continue working with you on efforts to ensure the successful implementation of the NH Health Protection Program.

Sincerely,

Doug McNutt (RC)

Douglas McNutt, Chair
NH Medical Care Advisory Committee

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[i] CMCS Informational Bulletin. January 16, 2014.

[ii] Pitts et al. 2010. Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office

[iii] LaCall et al. 2010. Frequent users of the emergency departments: The myths, the data and the policy implications. Ann Emerg Med. 56:42-48.

[iv] Hunt et al. 2006. Characteristics of frequent users of emergency departments. Annals of Emergency Medicine. Vol 48: 1-8.

[v] Washington State Health Care Authority Report to the Legislature, Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation. January 30, 2014.

NH Community
Behavioral Health
ASSOCIATION

1 Pillsbury Street, Suite 200 Concord, NH 03301-3570 603-225-6633 FAX 603-225-4739

Ms. Diane Peterson
NH Department of Health and Human Services
Office of Medicaid Business and Policy
129 Pleasant Street
Concord NH 03301

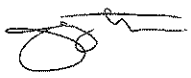
July 18, 2014

RE: Proposed SPA ending coverage and reimbursement for non-emergency use of a hospital emergency department

Dear Ms. Peterson:
The NH Community Behavioral Health Association, representing the state's ten community mental health centers, wishes to echo the comments about the proposed State Plan Amendment submitted to you by the NH Fiscal Policy Institute and the NH Medical Care Advisory Committee. We agree with the concerns stated by both NHFPI and MCAC in their July 17th letters, and we wish to emphasize that the populations we serve will be inordinately impacted by this proposal.

Both NHFPI and MCAC suggest that there are better and more effective tools available to encourage the use of appropriate healthcare settings. We agree. The inappropriate use of hospital emergency departments by individuals in a psychiatric crisis will not be solved through the use of financial penalties. We are already working with your Department and policymakers to address this problem with additional beds at NH Hospital, through additional support for community based mental health services, and through implementation of the state's Ten-Year Mental Health Plan by the MCOs as part of their care coordination efforts.

Thank you for the opportunity to comment. Very truly yours,



Jay Couture, President
NH Community Behavioral Health Association