Committee Report

REGULAR CALENDAR

March 29, 2018

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on Health, Human Services and Elderly Affairs to which was referred SB 313-FN,

AN ACT (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. William Marsh

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**Health, Human Services and Elderly Affairs**
Bill Number:	**SB 313-FN**
Title:	**(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**
Date:	**March 29, 2018**
Consent Calendar:	**REGULAR**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT 2018-1282h**

STATEMENT OF INTENT

The committee recommends that medicaid expansion should be continued as a managed care program. Actuarial information demonstrates this will be substantially less expensive to NH than the current program. It is critically important to maintain coverage for the 50,000 people currently covered by this program. It would be prohibitively expensive to alternatively fund necessary programs, such as those to address the opioid problem, with general fund dollars instead of this program. Amendments address self-employment as a means to satisfy the work requirement, seasonal employment, membership of the commission set up to review the program, and the items to be evaluated by that commission.

Vote 21-0.

Rep. William Marsh
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Health, Human Services and Elderly Affairs

SB 313-FN, (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds. **OUGHT TO PASS WITH AMENDMENT.**

Rep. William Marsh for Health, Human Services and Elderly Affairs. The committee recommends that medicaid expansion should be continued as a managed care program. Actuarial information demonstrates this will be substantially less expensive to NH than the current program. It is critically important to maintain coverage for the 50,000 people currently covered by this program. It would be prohibitively expensive to alternatively fund necessary programs, such as those to address the opioid problem, with general fund dollars instead of this program. Amendments address self-employment as a means to satisfy the work requirement, seasonal employment, membership of the commission set up to review the program, and the items to be evaluated by that commission. **Vote 21-0.**

Original: House Clerk
Cc: Committee Bill File

SB 313 reforming NH's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

OTP/A 2018-1282h 21-0 Regular Calendar

The committee recommends that Medicaid Expansion should be continued as a managed care program. Actuarial information demonstrates this will be substantially less expensive to NH than the current program. It is critically important to maintain coverage for the 50,000 people currently covered by this program. It would be prohibitively expensive to alternatively fund necessary programs, such as those to address the opioid problem, with general fund dollars instead of this program. Amendments address self-employment as a means to satisfy the work requirement, seasonal employers, membership of the Commission set up to review the program, and the items to be evaluated by the Commission.

Rep. William Marsh for the Committee

COMMITTEE REPORT

COMMITTEE: HHS & EA

BILL NUMBER: SB #313-FN

TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: 3/28/18 **CONSENT CALENDAR:** YES ~~X~~ NO X

- ☐ OUGHT TO PASS
- ☒ OUGHT TO PASS W/ AMENDMENT
- ☐ INEXPEDIENT TO LEGISLATE
- ☐ INTERIM STUDY (Available only 2nd year of biennium)

Amendment No. 1213, 1221, 1222, 1226, 1273

STATEMENT OF INTENT:

HHS & EA recommends ~~finds~~ that Medicaid ~~should~~ Expansion should be continued as a managed care program. Actuarial information demonstrates this will be substantially less expensive to NH than the current program. It is critically important to maintain coverage for the 50,000 people currently covered by this Program. It would be prohibitively expensive to alternatively fund necessary programs, such as those to address the opioid problem, with general fund dollars instead of this program. Amendments address self-employment as a means to satisfy the work requirement, seasonal employers, membership of the Commission set up to review the program, and the items to be evaluated by the Commission.

COMMITTEE VOTE: 21-0

- Copy to Committee Bill File
- Use Another Report for Minority Report

RESPECTFULLY SUBMITTED,

Rep. William Marsh WILLIAM MARSH

For the Committee

Rev. 02/01/07 - Yellow

Health, Human Services and Elderly Affairs
March 29, 2018
2018-1282h
01/03

Amendment to SB 313-FN

Amend the introductory paragraph and subparagraphs (1) and (2) of RSA 126-AA:2, III(a) as inserted by section 1 of the bill by replacing them with the following:

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month, or an average of 600 hours over 6 months, based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment, including self-employment, including by nonprofit organizations.

(2) Subsidized private sector employment, including self-employment.

Amend RSA 126-AA:2, VII as inserted by section 1 of the bill by replacing it with the following:

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

Amend RSA 126-AA:4, I(a)(6)-(13) as inserted by section 1 of the bill by replacing them with the following:

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health

and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

Amend RSA 126-AA:5, I(c) as inserted by section 1 of the bill by replacing it with the following:

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

Rep. W. Marsh, Carr. 8
Sen. Bradley, Dist 3
March 28, 2018
2018-1273h
01/03

Amendment to SB 313-FN

Amend RSA 126-AA:2, III(a)(1) and(2) as inserted by section 1 of the bill by replacing them with the following:

(1) Unsubsidized employment, including self-employment, including by nonprofit organizations.

(2) Subsidized private sector employment, including self-employment.

Rep. Knirk, Carr. 3
March 23, 2018
2018-1222h
01/10

Amendment to SB 313-FN

Amend RSA 126-AA:4, I(a)(6)-(13) as inserted by section 1 of the bill by replacing them with the following:

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

Rep. Knirk, Carr. 3
Rep. W. Marsh, Carr. 8
March 23, 2018
2018-1221h
01/05

Amendment to SB 313-FN

Amend RSA 126-AA:5, I(c) as inserted by section 1 of the bill by replacing it with the following:

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

Rep. Knirk, Carr. 3
Rep. W. Marsh, Carr. 8
Rep. J. Edwards, Rock. 4
March 23, 2018
2018-1213h
01/03

Amendment to SB 313-FN

Amend the introductory paragraph of RSA 126-AA:2, III(a) as inserted by section 1 of the bill by replacing it with the following:

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month, or an average of 600 hours over 6 months, based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

Rep. Knirk, Carr. 3
March 26, 2018
2018-1226h
01/03

Amendment to SB 313-FN

Amend RSA 126-AA:2, VII as inserted by section 1 of the bill by replacing it with the following:

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

Voting Sheets

Health, Human Services and Elderly Affairs
March 29, 2018
2018-1282h
01/03

Amendment to SB 313-FN

Amend the introductory paragraph and subparagraphs (1) and (2) of RSA 126-AA:2, III(a) as inserted by section 1 of the bill by replacing them with the following:

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month, or an average of 600 hours over 6 months, based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment, including self-employment, including by nonprofit organizations.

(2) Subsidized private sector employment, including self-employment.

Amend RSA 126-AA:2, VII as inserted by section 1 of the bill by replacing it with the following:

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

Amend RSA 126-AA:4, I(a)(6)-(13) as inserted by section 1 of the bill by replacing them with the following:

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health

and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

Amend RSA 126-AA:5, I(c) as inserted by section 1 of the bill by replacing it with the following:

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

Rep. W. Marsh, Carr. 8
Sen. Bradley, Dist 3
March 28, 2018
2018-1273h
01/03

Amendment to SB 313-FN

Amend RSA 126-AA:2, III(a)(1) and(2) as inserted by section 1 of the bill by replacing them with the following:

(1) Unsubsidized employment, including self-employment, including by nonprofit organizations.

(2) Subsidized private sector employment, including self-employment.

Rep. Knirk, Carr. 3
March 23, 2018
2018-1222h
01/10

Amendment to SB 313-FN

Amend RSA 126-AA:4, I(a)(6)-(13) as inserted by section 1 of the bill by replacing them with the following:

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

Rep. Knirk, Carr. 3
Rep. W. Marsh, Carr. 8
March 23, 2018
2018-1221h
01/05

Amendment to SB 313-FN

Amend RSA 126-AA:5, I(c) as inserted by section 1 of the bill by replacing it with the following:

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

Rep. Knirk, Carr. 3
Rep. W. Marsh, Carr. 8
Rep. J. Edwards, Rock. 4
March 23, 2018
2018-1213h
01/03

Amendment to SB 313-FN

Amend the introductory paragraph of RSA 126-AA:2, III(a) as inserted by section 1 of the bill by replacing it with the following:

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month, or an average of 600 hours over 6 months, based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

Rep. Knirk, Carr. 3
March 26, 2018
2018-1226h
01/03

Amendment to SB 313-FN

Amend RSA 126-AA:2, VII as inserted by section 1 of the bill by replacing it with the following:

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: March 28, 2018

LOB ROOM: 205

MOTIONS: **ADOPTION OF AMENDMENT**

Moved by Rep. Knirk | Seconded by Rep. Freitas | AM Vote: 12-10

Amendment # 2018-1226h

MOTIONS: **ADOPTION OF AMENDMENT**

Moved by Rep. Knirk | Seconded by Rep. Spagnuolo | AM Vote: 10-12

Amendment # 2018-1216h

MOTIONS: **ADOPTION OF AMENDMENT**

Moved by Rep. Knirk | Seconded by Rep. Weber | AM Vote: 12-10

Amendment # 2018-1213h

MOTIONS: **ADOPTION OF AMENDMENT**

Moved by Rep. Knirk | Seconded by Rep. Weber | AM Vote: 13-9

Amendment # 2018-1221h

MOTIONS: **ADOPTION OF AMENDMENT**

Moved by Rep. Knirk | Seconded by Rep. Weber | AM Vote: 20-2

Amendment # 2018-1222h

MOTIONS: **ADOPTION OF AMENDMENT**

Moved by Rep. W. Marsh Seconded by Rep. M. MacKay AM Vote: 20-2

Amendment # 2018-1273h

MOTIONS: **OUGHT TO PASS WITH AMENDMENTS**

Moved by Rep. W. Marsh Seconded by Rep. LeBrun and M. MacKay AM Vote: 21-0

Amendment # 2018-1226h, 2018-1213h, 2018-1221h, 2018-1222h, and 2018-1273h

MOTIONS: **OUGHT TO PASS WITH AMENDMENT**

Moved by Rep. W. Marsh Seconded by Rep. LeBrun and M. MacKay AM Vote: 21-0

Amendment # 2018-1282h (Combined Amendment)

CONSENT CALENDAR: NO

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep Bill Nelson, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: 3/28/18

LOB ROOM: 205

MOTION: (Please check one box)

☐ OTP ☐ ITL ☐ Retain (1st year) ☑ Adoption of Amendment # 1222 ✓

(5) ☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. Kwirk Seconded by Rep. Weber Vote: 20-2

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # 1273 ✓

(6) ☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. MARSH Seconded by Rep. M. MACKAY Vote: 20-2

MOTION: (Please check one box)

☐ OTP ☒ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # _____

(7) ☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. MARSH Seconded by Rep. LeBrun M. MACKAY Vote: 21-0

1226 1213 1221 1222 1273

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # _____

☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

CONSENT CALENDAR: ~~☒~~ YES X NO

Minority Report? _____ Yes _____ No If yes, author, Rep: _____ Motion_____

Respectfully submitted: Bill Nelson

Rep Bill Nelson, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: March 28, 2018

LOB ROOM: 205

MOTION: (Please check one box)

1

☐ OTP ☐ ITL ☐ Retain (1st year) ☒ Adoption of Amendment # 1226 ✓

☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. Knirk Seconded by Rep. Freitas Vote: 12-10

MOTION: (Please check one box)

2

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☒ Adoption of Amendment # 1216 ✓

☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. Knirk Seconded by Rep. Spagnuolo Vote: 10-12

MOTION: (Please check one box)

3

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☒ Adoption of Amendment # 1213 ✓

☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. Knirk Seconded by Rep. Weber Vote: 12-10

MOTION: (Please check one box)

4

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☒ Adoption of Amendment # 1221 ✓

☐ Interim Study (2nd year) *(if offered)*

Moved by Rep. Knirk Seconded by Rep. Weber Vote: 13-9

CONSENT CALENDAR: ____ YES X NO

Minority Report? ____ Yes ____ No If yes, author, Rep: ____ Motion____

Respectfully submitted: Bill Nelson

Rep Bill Nelson, Clerk

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

3/14/2018 12:12:24 PM
Roll Call Committee Registers Report

2018 SESSION

HHS&EA

Bill #: SB 313 Title: Reform NH Medicaid & Premium Assistance Program, establishing the granite workforce pilot programs, and relative to certain liquor funds

PH Date: 3/20/18 Exec Session Date: 3/28/18

Motion: OTP/A (see below) Amendment #: see below

1226 1213 1221 1222 1273

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman	21	
LeBrun, Donald L. Vice Chairman	1	
McMahon, Charles E.	2	
Nelson, Bill G. Clerk	3	
Guthrie, Joseph A.	4	
Donovan, Daniel A.	5	
Fothergill, John	6	
Bove, Martin N.	7	
MacKay, Mariellen J.	8	
Edwards, Jess	—	—
Fedolfi, Jim	—	—
Marsh, William M.	9	
Pearson, Mark	10	
MacKay, James R.	11	
Freitas, Mary C.	12	
Weber, Lucy M.	13	
Gordon, Pamela S.	14	
Knirk, Jerry	15	
Messmer, Mindi F.	16	
Salloway, Jeffrey C.	17	
Campion, Polly Kent	18	
Ayala, Jessica	19	
Spagnuolo, Philip	20	
TOTAL VOTE:	21	0

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

3/14/2018 12:12:24 PM
Roll Call Committee Registers Report

2018 SESSION

(4)

HHS&EA

Bill #: SB 317 Title: _____

PH Date: 3 / 20 / 18 Exec Session Date: ___/___/___

Motion: Adoption of Amendment Amendment #: 1273

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman	20	
LeBrun, Donald L. Vice Chairman		1
McMahon, Charles E.	1	
Nelson, Bill G. Clerk	2	
Guthrie, Joseph A.	3	
Donovan, Daniel A.	4	
Fothergill, John	5	
Bove, Martin N.	6	
MacKay, Mariellen J.	7	
Edwards, Jess	—	—
Fedolfi, Jim		2
Marsh, William M.	8	
Pearson, Mark	9	
MacKay, James R.	10	
Freitas, Mary C.	11	
Weber, Lucy M.	12	
Gordon, Pamela S.	13	
Knirk, Jerry	14	
Messmer, Mindi F.	15	
Salloway, Jeffrey C.	16	
Campion, Polly Kent	17	
Ayala, Jessica	18	
Spagnuolo, Philip	19	
TOTAL VOTE:	20	5

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

3/14/2018 12:12:24 PM
Roll Call Committee Registers Report

2018 SESSION

(5)

HHS&EA

Bill #: SB 313 FN Title: _____

PH Date: 3/20/18 Exec Session Date: 3/28/18

Motion: Adoption of Amendment Amendment #: 1122

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman		2
LeBrun, Donald L. Vice Chairman	1	
McMahon, Charles E.	2	
Nelson, Bill G. Clerk	3	
Guthrie, Joseph A.	4	
Donovan, Daniel A.	5	
Fothergill, John	6	
Bove, Martin N.	7	
MacKay, Mariellen J.	8	
Edwards, Jess	—	—
Fedolfi, Jim		1
Marsh, William M.	9	
Pearson, Mark	10	
MacKay, James R.	11	
Freitas, Mary C.	12	
Weber, Lucy M.	13	
Gordon, Pamela S.	14	
Knirk, Jerry	15	
Messmer, Mindi F.	16	
Salloway, Jeffrey C.	17	
Campion, Polly Kent	18	
Ayala, Jessica	19	
Spagnuolo, Philip	20	
TOTAL VOTE:	20	2

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

3/14/2018 12:12:24 PM
Roll Call Committee Registers Report

2018 SESSION

(4)

HHS&EA

Bill #: SB 313 Title: _____

PH Date: 3/20/18 Exec Session Date: 3/28/18

Motion: Adoption of Amendment Amendment #: 1221

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman		9
LeBrun, Donald L. Vice Chairman		1
McMahon, Charles E.		2
Nelson, Bill G. Clerk		3
Guthrie, Joseph A.	1	
Donovan, Daniel A.	2	
Fothergill, John		4
Bove, Martin N.		5
MacKay, Mariellen J.		6
Edwards, Jess		
Fedolfi, Jim		7
Marsh, William M.	3	
Pearson, Mark		8
MacKay, James R.	4	
Freitas, Mary C.	5	
Weber, Lucy M.	6	
Gordon, Pamela S.	7	
Knirk, Jerry	8	
Messmer, Mindi F.	9	
Salloway, Jeffrey C.	10	
Campion, Polly Kent	11	
Ayala, Jessica	12	
Spagnuolo, Philip	13	
TOTAL VOTE:	13	9

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

2018 SESSION

3/14/2018 12:12:24 PM
Roll Call Committee Registers Report

3

HHS&EA

Bill #: SB 313 Title: _____

PH Date: 3/20/18 Adoption of Amendment

Exec Session Date: 3/28/18

Motion: OTP - Knirk ~~Voice~~

Amendment #: 1213

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman		10
LeBrun, Donald L. Vice Chairman		1
McMahon, Charles E.		2
Nelson, Bill G. Clerk		3
Guthrie, Joseph A.	1	
Donovan, Daniel A.		4
Fothergill, John		5
Bove, Martin N.		6
MacKay, Mariellen J.		7
Edwards, Jess	—	—
Fedolfi, Jim		8
Marsh, William M.	2	
Pearson, Mark		9
MacKay, James R.	3	
Freitas, Mary C.	4	
Weber, Lucy M.	5	
Gordon, Pamela S.	6	
Knirk, Jerry	7	
Messmer, Mindi F.	8	
Salloway, Jeffrey C.	9	
Campion, Polly Kent	10	
Ayala, Jessica	11	
Spagnuolo, Philip	12	
TOTAL VOTE:	12	10

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

3/14/2018 12:12:24 PM
Roll Call Committee Registers Report

2018 SESSION

(2)

HHS&EA

Bill #: SB 313 Title: Reforming NH's Medicaid & Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

PH Date: 3/20/18 Exec Session Date: 3/28/18

Motion: OTP ~~Kwik/Espinelo~~ Adoption of Amendment Amendment #: 1216

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman		12
LeBrun, Donald L. Vice Chairman		1
McMahon, Charles E.		2
Nelson, Bill G. Clerk		3
Guthrie, Joseph A.		4
Donovan, Daniel A.		5
Fothergill, John		6
Bove, Martin N.		7
MacKay, Mariellen J.		8
Edwards, Jess	—	—
Fedolfi, Jim		9
Marsh, William M.		10
Pearson, Mark		11
MacKay, James R.	1	
Freitas, Mary C.	2	
Weber, Lucy M.	3	
Gordon, Pamela S.	4	
Knirk, Jerry	5	
Messmer, Mindi F.	6	
Salloway, Jeffrey C.	7	
Campion, Polly Kent	8	
Ayala, Jessica	9	
Spagnuolo, Philip	10	
TOTAL VOTE:	10	12

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

3/14/2018 12:12:24 PM
Roll Call Committee Registers Report

2018 SESSION

(1)

HHS&EA

Bill #: SB 313 Title: Reforming NH's Medicaid + Premium Assistance Programs, establishing the granite workforce pilot program, and relative to certain liquor funds

PH Date: 3/20/18 Exec Session Date: 3/28/18

Motion: ~~OTP Amend~~ Adoption of Amendment Amendment #: 1226

MEMBER	YEAS	NAYS
Kotowski, Frank R. Chariman		10
LeBrun, Donald L. Vice Chairman		1
McMahon, Charles E.		2
Nelson, Bill G. Clerk		3
Guthrie, Joseph A.		4
Donovan, Daniel A.		5
Fothergill, John	1	
Bove, Martin N.		6
MacKay, Mariellen J.		7
Edwards, Jess	~~~~	~~~~
Fedolfi, Jim		8
Marsh, William M.		9
Pearson, Mark	2	
MacKay, James R.	3	
Freitas, Mary C.	4	
Weber, Lucy M.	5	
Gordon, Pamela S.	6	
Knirk, Jerry	7	
Messmer, Mindi F.	8	
Salloway, Jeffrey C.	9	
Campion, Polly Kent	10	
Ayala, Jessica	11	
Spagnuolo, Philip	12	
TOTAL VOTE:	12	10

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **March 20, 2018**

LOB ROOM: **Reps. Hall** Time Public Hearing Called to Order: **10:00 a.m.**

Time Adjourned: **4:40 p.m.**

Committee Members: **Reps. Kotowski, LeBrun, M. Pearson, McMahon, Nelson, Guthrie, Donovan, Fothergill, Bove, M. MacKay, J. Edwards, Fedolfi, W. Marsh, J. MacKay, Freitas, Weber, P. Gordon, Knirk, Messmer, Salloway, Campion, Ayala and Spagnuolo**

Bill Sponsors:

Sen. Bradley	Sen. Morse	Rep. S. Schmidt
Rep. Umberger	Rep. Danielson	Rep. Kotowski

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Sen. Jeb Bradley introduced the bill. He discussed what stayed the same and what has been done via changes. This bill moves to a managed care system. This is a taxpayer savings, better conditions, takes away uncertainties - inflation, price increase. This managed care system benefits those in private care and those in managed care.

Incentives for participants to stay healthy. Use of wellness clinics rather than emergency rooms. This will be looked at favorably by insurance companies. Why the change: 51,000 are eligible for Medicaid. This has helped individuals.

Uncompensated care - If people fall between the cracks as far as coverage. People use emergency room care which is the most expensive care. To qualify there is a work requirement: 25 hours per week or 100 per month. Many exemptions - care for someone sick, furthering their education, etc. These count toward the required hours. 130,000 people have been in the current program at some point, 15,000 full time. Work program gives people opportunity. Portions of this bill mirror this system--will be a benefit to Medicare and mental health services. This system uses federal funds as promised - 100%, then 93%, then 90%. The state portion will use 5% of liquor profit funds. Any unused funds will be put in a "lock box" and will not be able to be used for other purposes.

The Senator was questioned on makeup of the commission. He mentioned it has been the tradition to use Governor, Senate President, Speaker of the House and others not in elected positions. He introduced many of the committee. Sen. Feltes is not present at this time but supports bill.

Lisa Guertin, President, Anthem BC/ BS - supports bill.

*Dawn McKinney, Policy Director, NH Legal Assistance - opposes bill as presented. See testimony. Work requirements, asset requirements, 90-day transition period.

*Niambi Mercado - See testimony. She gave a personal experience and how she benefited by Medicaid expansion.

*Michelle Merritt, Esq, President, New Futures - supports reauthorization of NH Medicaid expansion. See testimony.

*Todd Fahey, AARP - supports bill. See testimony.

Commissioner Meyers, DHHS - supports.

- 52,000 currently in program
- 15,000 have been receiving coverage since program began in 2014
- 130,000 have been enrolled in program at any one time
- As of Feb. 2018, 12,700 have received services for substance abuse
- Numerous committee questions centered around the work requirement
- Commissioner Meyers said TANF recipients are exempt

Carrie Martin Duran - parent, caregiver for father, part-time teacher. Daycare expenses used up money she earned. Expanded Medicaid has allowed her to receive medical services.

*Gary Woods, MD, NH Medical Society/Cancer Association - supports Medicaid expansion. He lists in testimony his concern with SB 313.

*Ken Norton, NAMI-NH, supports bill with exception of 122:AA2, section VI. Suggested recommendations and edits given. See testimony.

Dr. Stephanie Wolfe Rosenblum, So. NH Health- many experiences and memberships mentioned. Bill has its good and bad parts.

Dr. Cheryl Wilkie - works for 140 bed treatment facility - supports bill. Expressed concern over reimbursement rates, Part B, page 2.

- The exchange $300-500 per day
- Medicaid $162 per day
- If you don't have private insurance $140 per day

Mike Apfelberg, United Way of Greater NH - supports bill. Concerned over use of alcohol funds. Does this put in place an example of raiding the alcohol funds.

Monica Nagle - business owner from Dover. Shared publications to look at. Explained her background and issues she faced. Expressed concern over those with mental issues. Does much volunteer work in the Dover area.

*Kenneth Gordon, CEO, Coos County Family Health - See testimony.

*Karen M. Trudel - Written testimony provided. Did not testify.

*Edward Shanshala, Ammonoosuc Community Health - supports bill. Testimony presented with petition attached.

Lisa Beaudoin, ABLE NH - page 5, lines 23, 5, 6 and 7: please retain wordage for people with disabilities.

Elizabeth Atwood, Rochester

***Kristine Stoddard, Esq, Bi-State Primary Care** - supports bill. See testimony. Concerned that alcohol funds could be diverted. Mentioned how the current system has been.

***Joan Widmer, NH Nurses Association** - supports bill. See testimony.

Carrie Martin - supports bill.

***Sarah Freeman, The NH Providers Assoc.** - See testimony. Reauthorization is crucial. Rates are an issue - too low. Alcohol dollars need to be protected.

Louise Spencer - supports bill. Not present when called upon.

***Steve Ahnen, President, NH Hospital Association** - supports. Hospital has been a long-term supporter of expansion. Right thing to do. Dropped uncompensated costs to hospitals more than $67 million ($131.2 million in FY 2016 to $64.1 million in FY 2018).

***Nikki Casey** - opposes bill. See testimony

Chris Kozak, Community Mental Health Centers - supports. Critical to pass. Provided a continuity of care. Five year extension especially critical and necessary. Rates need to be increased; 275 positions open - 200 are clinical. Rates need adjustments. Bill not perfect but better than nothing. Necessary.

***Susan Stearns, Sanbornton** - supports. See testimony. Employed by NAMI. On Board of Mental Health at Strafford. Parent of a child with mental health issues. One in five individuals have a mental health disorder here in NH.

***Sandra May**, parent - supports bill. See testimony.

***Norma MacKinley Smith,** Nashua - supports bill. See testimony. She is an individual with a mental health condition. Need the support this legislation will provide. We can't afford to lose it. Protect the exclusion option on work regulation. Raise the rates.

Greg Moore - opposes bill. Not present when called.

J.J. Smith, M.D.,MPH, NH Public Health Association - supports. This bill is important to support. Former Medical Director of Harbor Homes. Community mental health center need the enhanced reimbursement rates. Work requirements not helpful.

***Kevin Irwin, Governor's Commission on Alcohol, Drug Abuse Prevention, Intervention and Treatment** - supports bill. See testimony.

Becky Whitley, NH Children's Behavioral Health Collaborative - supports bill. Medicaid is an important vehicle to reach uninsured children in NH. NH needs to do all it can to protect its children.

***Paula Mattis, Director of Medical Services, Department of Corrections** - supports with suggested change. See testimony. Amend the 90-day waiver of retroactive coverage or allow DOC a waiver. They currently can defer dollars to the Feds. With this 90-day

requirement, they would not be able to do this. Saved $7 million so far this year this way.

*Richard Wiggins - supports bill. See testimony.

Kathy Staub, Rights and Democracy - supports. Held a rally yesterday. People won't be able to get treatment without expansion.

Seth Brunelle - supports. No present when called.

Tim Guidish, Cystic Fibrosis Foundation - supports. People with cystic fibrosis (CF) need this program. People with CF not considered disabled. Work regulation will be tough to adhere to.

*Cameron Ford, E.D. Headrest - supports. See testimony. On suicide hotline. Medicaid expansion has been a gift to their program. Gives clients coverage to continue rehab after 90-day has ended.

Alex Casall, Drug Courts - supports. These courts would go away without expansion or be greatly reduced. When a person leaves jail, it is the most critical time. They need insurance to be in place immediately in order to be served and take part in his/her needed services. Over 400 individuals treat in 2017.

Respectfully submitted,

Rep. Bill Nelson, Clerk

Respectfully submitted,

Rep. Mariellen MacKay, Acting Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: March 20, 2018

ROOM: Reps. Hall Time Public Hearing Called to Order: 10:00

Time Adjourned: 4:40 pm. ?

(please circle if present)

Committee Members: Reps. Kotowski, LeBrun, Nelson, McMahon, Guthrie, Donovan, Fothergill, Bove, M. MacKay, J. Edwards, Fedolfi, W. Marsh, M. Pearson, J. MacKay, Freitas, Weber, P. Gordon, Knirk, Messmer, Salloway, Campion, Ayala and Spagnuolo

Bill Sponsors:

Sen. Bradley	Sen. Morse	Rep. S. Schmidt
Rep. Umberger	Rep. Danielson	Rep. Kotowski

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Sen Bradley introduced the bill

He discussed what stays the same + what has been done via changes

This bill moves To a managed Care system. This is A tax payer saving, better conditions, takes away uncertainties - inflation, price increased

this managed care system benefits those in private care + those in managed care.

Incentive for participants To stay healthy. Use of wellness clinics rather than Emer. Rooms. This will be looked at favorably by Ins. Companies

Why the change

51,000 are eligible for medicaid. this has helped individuals to be able

UN compensated care — IS people Still become the cracks as Soon as coverage, - people use Emergency Room Care. the most expensive care.

To qualify there is a work requirement. 25 hrs week / 100 per month many exemptions - Care for some sick, furthering their education etc. these count Toward the required hours

130,000 people have been on the current program at some point. 15,000 Full Time.

Work program gives people opportunity

Portions of this bill mirrors

this system will be a benefit To medicare, mental health services

This system uses Fed Funds as promised - 100%, then 93%, 90%. the state portion will use 5% of liquor profit funds. Any unused funds will be put in a "lock box" + will not be able To be used for other purposes.

The sen. was questioned on makeup of the commission He mentioned has been the tradition used. (Gov., senate President, Speaker of the House + members ~~other non-public~~ others not in elected positions. He introduced many on the committee

Sen Feltes is not present ~~but~~ at this Time but Supports bill

Lisa ~~Goertin~~ Quentin Pres Bc/Bs — supports bill

✓ ~~Donna~~ Dawn Mckinney - policy Director — NH Legal Assistance
— see testimony - opposes bill as presented. Work requirements. Asset requirements. 90 day transition period

✓ Niambi Mercado — See Testimony. She gave personal experience + how she benefited by medicaid Expansion

✓ Michele Merritt, Esq — Pres. New Futures — supports reauthorization of NH medicaid Expansion
See Testimony

✓ Todd Fahey AARP — supports Bill

✓ Commissioner ~~Meyers~~ meyers — HHS — supports
52,000 currently in Program
15,000 have been ~~in since~~ receiving coverage since program began in 2014
130,000 have been ~~in program~~ enrolled in program at any one time
As of Feb 2018 — 12,700 have received services ~~for~~ for substance abuse

(numerous committee questions centered around the work requirement.)

Comm. ~~Meyers~~ Meyers said TANF recepies are exempt

? (First Name) ~~Bonny~~ Martin Derand - Parent, Caregiver for Father, part-Time Teacher. Daycare expenses used up ~~##~~ she earned.

Expanded medicaid ~~has~~ has allowed her to receive medical services

✓ Gary Wood MD. NH medical Society / Cancer Association supports medicaid Expansion. He lists in Testimony concern with SB ~~###~~ 313.

✓ Ken Norton - ~~NAME~~ NH NAME — supports bill with exception of 122:AA2 Section VI. Suggested recommendations + edits given.

✓ Dr. Stephanie Wolfe Rosenwald — MAN, experience + memberships medical — Bill has ~~pluses + minus~~ its good + bad parts.

✓ Dr. Cheryl Wilkie Recommends works for — 140 bed Treatment ~~Facilities~~ facilities ~~140 beds~~. — supports bill ~~For first~~ Expressed concerns over reimbursement rates. The Exchange Rate $ 300-500 per day

Part B - Page 2

~~Non Medicaid~~ → 162 per day

If you done have privates or medicaid → 140 per day

(5)

✓ Mike ~~Hattenberg~~ Apfelberg - Greater Nashua United Way

Concerned over use of Alcohol funds.
Does this put in place ~~an~~ an example of vanding the Alcohol funds

✓ Monica Nagle - Business owner from Dover
shared publications to look at.
Explained her background + issues she faced.
Expressed concern over those with mental issues
Does much volunteer work in the Dover Area

✓ ~~Ken~~ Kenneth Gordon CEO COOs ~~County~~ County Family Health
See testimony

Karen M. Trudel - Testimony provided - did not ~~Test~~ Testify

✓ ~~Edw~~ Edward Shanshala - Ammonoosuc Community Health - supports
Testimony Presented - Petition attached
~~Eliz~~ Elizabeth Edwards -

✓ Lisa Bowden - ABLE-NH
- Page 5 Line 23 5.6+7 - Please
re-Tain wordage for people with disabilities

(6)

Eliz. ATwood - Rochester

Kristine Stoddard Esq — B. State Primary Care — ~~Supports~~
See Testimony — supports Bill —
Concern that Funds of Alch./ Funds could
be deverted. mentioned how the current
system has bo

~~Joan~~ Joan Widmer NH Nurses Association
see testimony — supports Bill

Carrie MARTIN — supports Bill

~~Lisa Guertin~~ A

1:50 pm Cont

Hand-out ↑ Supports — Sarah Freeman ~~Friedman~~ - NH Providers assn - Reauth is crucial. Rates are an issue TO low. Alcohol $'s need protected

Louise Spencer - NOT Here

Hand-out ↑ Supports — Steve Ahnen - NH Hosp Pres. Assn - Hosp's long Ter Supporters of Expansion - Right thing To do. Dropped uncomp. costs To hospitals more than $67 million ($131.2 mil in FY 2016 T $64.1 million in FY 2018

Nicky Casey - NOT Here

↑ Supports — Chris Kovacs - m/H CTRS of NH - Critical TO pass. Provided a continuity of Car 5yr extension esp critical a necessa Rates need to be increased. 275 positions open - 200 are clinical Rates need adjustments. Bill not perfe but better than nothing. Necessar

Supports ↑ handout — Susan Stern - Bus. of Sanbornton - emp. by NAMI Board of m/H @ Strafford. paren of a child w/ m/H issues. 1 in 5 has a m/H disorder here in NH

Karin Trudel - NOT Here

Sandra May - parent - hand-out ↑ Supports

Norma McKinley Smith - Nashua - indiv w/ m/H condition ↑ Supports
need the support this lig will hand-out
provide. We can't afford to lose it.
Protect the exclusion apt on work req.
Raise the rates

Greg moore - NOT Here

[redacted]

TJ Smith, MD - important to support. former ↑ Supports
med. Dir of Harbor Homes
Comm. m/H CTRS need the
enhanced reimbursement rates
wk requirements not helpful

Kevin Irwin - NOT Here - testimony handed in ↑ supports
Jake Berry (New Futures)

Becky Whitley - NH Childs B.b. Health Collab ↑ Supports
medicaid important vehicle to reach hand-out
uninsured children in NH. NH needs
to do all it can to protect its
children

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # SB 313 Date 3/20/18

Committee HHS

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Jim Masay	28 Sagebush Rd, Hooksett NH	321-1199	Self	X	
Viola Kahsilime			Self	✓	
MARY ANN AMARAL	53 KIMBERLY ST	340-0551	SELF	✓	
Roger Desrosiers	22 Tenii Road Concord	225-7395	AARP	✓	
Alyssa Walker	2 Quincey Street Nashua, NH		NSKS	X	
Michele Watson	21 Whittier Rd Merrimack NH		self	X	
Karen Daum	5 Westgate Rd, Mont Vernon NH		Self	✓	
Catherine Gruette	72 Ridge Rd Barnstead	CT 03225	self	X	
Elizabeth Hodgkins	241 Stonington Dr. Manchester		self	X	
New Hampshire Medical Society				✓	
Dennis Jakubowski			Self	✓	
GAIL T. BROWN	N.H Oral Health Coalition	603-415-5550		✓	
Francis Hayes	Canterbury NH	783-9262		✓	
Susan Paschell	NH Community Behavioral Health Assn			✓	
Jayne Wagner	11000 Optum Circle MN		Optum	✓	
Anthony Provitola	Manchester	(949) 641-7600	RAD	✓	
Roger Blaney	3 W. Everett ST Derry NH			✓	
Judith Ryotar	5 Edendale Ln, Durham			✓	
Janet A. Thompson	Hampton NH			✓	
Deb Smith	15 Prince Lock Raymond			✓	
Emily Ricards	63 pennacook manch			✓	
Rep Penny Cushing	Rock 21			✓	

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # SB 313 Date 3/20/18

Committee Health

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Kendall Swan	200 Alliance Way 669-1075		self	✓	
Rep Timothy Horrigan	Strafford 6			✓	
Rep. Skip Berrien			ROCK-18	✓	
Stephanie Myers	NJ	856-786-1652	AmeriHealth Caritas	✓	
Patricia Rogers	52 Sun Bonnet RD, Concord	603-225-5359	self	✓	
Lenny Litalien (Holderness)	Canterbury	783-4016	self	✓	
Shanna Large			Riverbend CMHC	✓	
Lynn Stanley	Penacook NH	496.0994	NASW NH	✓	
Maureen Ettermann	Concord		self	✓	
Keith Klenning	Bow		CFS	✓	
Martha La Fleur	Greenland		self	✓	
Kathie Kaluzynski	Manchester		AARP	✓	
Kathy Cahill	Concord NH			✓	
Pat Wallace	Concord		AARP	✓	
Donna Marston	Families sharing without shame			✓	
Rep. Tamara Le - Rock #31 - North Hampton				✓	
Rep Dennis H. Fields	Belknap #4 Sanbornton Tilton			✓	
Jen Thompson	NH Nurse Practitioner Assn			✓	

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # SB 313 Date 3/7/18

Committee H. Jud

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Doug McNutt	45 S. Main Concord	858-4640	AARP	✓	
Richard Moore	21 Fred Wood Chichester NH	798-3695	AARP Volunteer	X	
Karen Ulmer Dorsch	403 Hale Rd Sanborn ton			X	
Dee Perrotta	15 Prince, Raymond	244-9629	AARP	X	
Gary Woods	38 Evangelyn Bow	228-3827	NHMS ESC	X	
& Mike Skelton	54 Hanover Street	792-4102	Manchester Chamber of Commerce	X	
Will Anderson	Concord	self			✓
Cordell Johnston			NH Municipal Ass'n	✓	
Louise Spencer	Concoud	491-1795		✓	
Doris Hampton	Canterbury	783 4418		X	
Audrey Clairmont				X	
Senator Chuck Morse	x8472 SD-22			X	
DAN WARD	2 MANCHESTER ST #2			✓	
Steve Wade	Brain Injury Association of NH			X	
Rev. John M. Gregg-Davis	Meriden, NH	469-3235	NHCUCC	X	
Alex Casale	842 Smcook Valley Rd	988-1857	Drug Courts	✓	

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # SB313 Date 3/20/18

Committee Hall

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Neal Byles	Concord		Self	✓	
ROBERT MULLIGAN	GOFFSTOWN		AARP (VOL)	✓	
Mike Bradley	Box 68 Hillsboro	464-4033	Self	X	
Faith Sillars	Dowboro Rd Pittsfield	435-8103		X	
Rev. Gael Kinney	Canaan	NH-United Church of Christ		X	
GAIL SMUDA	CONCORD		AARP	✓	
Brittany Porter	Strafford		NAMI NH	✓	
Barbara Publicover	Merrimack		Self	✓	
Diane GEDNEY	225-5359		NAMI NH	✓	
Dick Chevrefils	224-9077		NAMI NH	✓	
Fran Chevrefils	491-3783		Self	✓	
Elizabeth Carell	Concord		self	✓	
Nancy Brennan	Weare		Self	✓	
Cathy Arnault	Nottingham		AARP	✓	
Timothy Burdick MD	Bedford NH		self	✓	
Heather Donnell	Community Support Network (CSNI)			✓	
Kevin Flynn	Business + Industry Association			✓	
GUY CHAPDELAINE	83 HITCHING POST LN BEDFORD		AARP	✓	
Dick Wiggins	262 Hale Rd, Sanbornton		NAMI NH	✓	
Gale Taylor	16 Sagamore Ct Concord, NH			✓	
Rep DAVE DAWIELSON	9 Derby Lane Bed Bedford Hills #7			✓	
REGINA BLANEY	3 W. Everett ST Derry, NH			✓	
SUSAN COVERT	31 COTTAGE CONTOOCOOK NH			✓	

Testimony

MEDICAID EXPANSION:

my VIEWS ON THE

IMPORTANCE OF PASSING THIS BILL

I currently live with mental health issues in Penacook independently. I am responible for everything I do and say so, I feel I need to be heard. People that live with the issues I do can't speak out this so I am here today for them.

Like Ms. Joyce Craig, the Mayor of Machester stated at the hearing of the Senate for this bill: over 50,000 thousands of people who rely on Medicaid Expansion in NH. Can you imagine what our cities will look like with time??? We think we have a mental health crisis now. There will be many more people who will flood our ER's. There have been an average about 40 adults and 3 childern waiting days in the ER's, up to sometimes 21 days and beyond. What happened to due process? If we pull insurance from the people that need this most, we will end up with many more homeless, addicts, and a higher crime rate. Our most vulnerable population will be in more danger than ever. People might go off their meds. I know when I go off my meds, I become pyschotic. Nothing is clear. I may forget to pay rent, bills, or other things. I might then lose my apartment. I would NOT be able to survive without insurance.

I am aware that there is a requirement for the individual to work 20 to 30 hours per week! Have you thought of what this would do to the disabled population? 30 hours - full time??? Really? That is a lot to ask people who have been trying to find word, or even work 5 hours a week? I am current working 5 hours a week. I am not sure I could increase my hours. I also volunteer for NAMI NH on the Public Policy Board and the Board of the Directors. I understand most people feel that there needs to be a wrok reuirement, but HOW ABOUT ACCESSING THE INDIVIDUAL AND LOOK AT EVERYONE CASE BY CASE. There should NEVER be a threat: Do this or I take your health insurance away!!!!

PLEASE take every precaution to move this bill forward. I am overwhelmed by 25 hours per week! That is 5X what I am doing now! Setting up for failure!

EVERYONE IS AN INDIVIDUAL AND DESERVES TO BE TREATED AS SUCH. PLEASE HEAR THE NEED FOR THIS.

THANK YOU FOR BEING HERE

Feel free to call me or email me.
603-494-2726
tktrudel1@gmail.com

Karen M. Trudel

coös county
Family Health

54 Willow Street
Berlin, NH 03570-1800
Ph: 1-603-752-3669
Fax: 1-603-752-3027

133 Pleasant Street
Berlin, NH 03570-2006
Ph: 1-603-752-2040
Fax: 1-603-752-7797

2 Broadway Street
Gorham, NH 03581-1597
Ph: 1-603-466-2741
Fax: 1-603-466-2953

59 Page Hill Road
Berlin, NH 03570-3568
Ph: 1-603-752-2900
Fax: 1-603-752-3727

March 20, 2018

Representative Kotowski
House Health, Human Services, and Elderly Affairs Committee
Legislative Office Building Room 205
33 N. State Street
Concord, NH 03301

RE: SB 313-FN reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds

Dear Chairman Kotowski and Committee Members:

My name is Ken Gordon. I have the privilege of serving as the Chief Executive Officer of Coos County Family Health Services. We are a Federally Qualified Community Health Center serving the Berlin-Gorham region of the North Country, and are the only primary care practice in the region. We provide primary care, behavioral health, dental, and substance use disorder treatment for approximately 12,000 patients at five clinical sites. More than half of our patients live at or below the federal poverty level. We also operate the RESPONSE Center for Domestic Violence and Sexual Assault, a social service program serving all of Coos County.

The New Hampshire Health Protection Program has changed the lives of hundreds of our patients, and has also had a positive impact upon the operations of our health center. According to the NH Department of Health and Human Services, as of last month more than 900 individuals in the Berlin-Gorham region were participating in the program. Before the Health Protection Program existed, many of the patients who have benefited from this program did not have health insurance because it was simply financially out of reach to them. The program has improved these patients' access to primary care, as well as to prescription medicines, lab work, radiology and other specialty services that would otherwise be unavailable to them.

One of the patients we serve who benefited from the Health Protection Program is a self-employed logger who required major orthopedic surgeries in order to continue to work and support his family. With access to the Health Protection Program, he was able to receive the orthopedic care he required, and has now returned to gainful employment. In addition, the program has helped hundreds of other people in our region to receive preventative care, treatment for chronic conditions, and has helped to reduce the unnecessary utilization of other, more costly forms of health care services.

The Health Protection Program has also been good for businesses in our region by supporting the development of a healthier and more productive workforce. Health care provider

organizations in the region have benefited, as well. In our experience, since the program began in 2014, the number of patients without health insurance or who rely upon our sliding fee discount program has dropped by roughly half, strengthening the financial position of our organization, and allowing us to expand the services we offer to the entire community. In recent years, and in partnership with other community providers, we've been able to expand our hours of operation to include nights and weekends, established a dental clinic, and now offer behavioral health and drug treatment services.

These behavioral health and drug treatment programs have been essential to our community's fight against the ravages of opioid abuse, and the Health Protection Program has been instrumental in both positioning our organization to be able to offer these services, and providing patients who qualify for the program with access to these forms of treatment.

Thank you for your work to ensure that all New Hampshire residents have access to affordable health care services. Please feel free to contact me should you have questions or we can be of service to you or your constituents.

Sincerely,

Ken Gordon

Kenneth E. Gordon
Chief Executive Officer
Coos County Family Health Services

Susan Allen-Samuel
23 Dianna Road
Londonderry, NH 03053
c-603-351-8356
Sallen@naminh.org

Honorable Members of the Health, Human Services and Elderly Affairs Committee, Thank you for allowing me to submit my testimony.

My name is Susan Allen-Samuel and I live in Londonderry. I am here in regards to SB 313, related to reauthorization of funding for Medicaid Expansion.

I have been a long-time advocate for New Futures. I teach Active Bystander trainings in NH communities. I am a proud and long standing staff member of the National Alliance on Mental Illness, NAMI NH. I advocate politically and personally on a daily basis to insure the quality of life for citizens of our state are offered a standard of living that is rational and humane.
I work one on one with families and can tell you how any back step in our funding impacts mental health supports and how lessening access to those services will adversely impact the families and the communities of our fine state. I can tell you clearly and independently how it will affect my own. Not only do I work with these families...I ***am one of these families*** impacted by having a loved one with a dual diagnosis and found hope with the initial authorization of Medicaid Expansion.

My young adult son has the co-occurring diagnosis of bipolar and substance use and other untreated medical conditions. He has/we have struggled with this since his early teens. He has been in the emergency room, in the hospital, he has lived on the streets, he has been in jail...he has been in prison, and back and forth. You get the picture. He has received little or no treatment. He was released with conditions to find a job and enter a 30 day treatment program. Those conditions offered no guidance to a young man...one who is now a convicted felon with no skills, no license, no income, no insurance and no idea how to pull any of this together.

Under prior standards, he was not eligible for Medicaid. Any plan he could get was cost prohibitive. We supported him the best that we could by paying for appts, programs and medications until we were totally depleted. Without consistent, stable supports, he struggled keeping his sobriety, his mental health and ongoing other medical treatment. His father and I continued to pay for his appts, his medications, his recommended treatments....and then his father was tragically killed. I now faced clearly my inability to fully fund the medical care that he needed.

As changes happened in the health protection qualifications, he became eligible for Medicaid coverage through Medicaid Expansion and was now able to maintain any and all recommended treatment through his own insurance. He was now able be consistent and fully engaged in his treatments and able to regain and maintain good health and sobriety.

My whole family suffered with his disease. When he wasn't well, my family wasn't well. I was less productive in the work force, unfocused, distracted, and less reliable. As misfortunes have a ripple effect, the changes in the system have had as well. My son has become a productive, tax paying, voting citizen. He not only holds a job but he owns his own business, pays his bills, creates and keeps good community and family relationships including being a husband and a great dad.

Consider the cost of his incarcerations, trips to emergency rooms, of supporting his family when he couldn't, the financial implications to his family, to the community and to the state. Those costs much surpass the cost of treatment i.e access to affordable health insurance. Please consider those costs or defunding or underfunding healthcare vs the costs of keeping your citizens stable, healthy, employed, and contributing to the stewardship of our beloved state and nation.

My story is not unique. How many more families have to lose a son, a daughter, a friend, a colleague because they do not have access to appropriate healthcare? Again, I ask you to please vote to regarding SB313 to reauthorize funding to Medicaid Expansion.

Lastly, if you hear nothing else, prevention and intervention, and those can only be addressed through our healthcare system not our judicial system, are more fiscally, medically and morally responsible than the cost of hospitalization or incarceration. We can't afford nor do we deserve less than we have...we are in dire need for more not less. Thank you for letting me to speak on behalf of my family and on behalf of the families of NH.

Respectfully submitted,

Susan Allen-Samuel

NAMI New Hampshire

National Alliance on Mental Illness

Honorable Chairman Frank Kotowski
Health, Human Services and Elderly Affairs Committee
Legislative Office Building Room 205
36 N. State Street
Concord, NH 03301

March 20, 2017

Honorable Chairman Kotowski

Thank you for the opportunity to testify today. My name is Kenneth Norton and I serve as Executive Director of NAMI NH, the National Alliance On Mental Illness. I also have a family member with a serious mental illness and co-occurring substance use disorder.

Although we are here today to testify in strong support of the need to reauthorize expansion of Medicaid in New Hampshire, this bill represents challenges for NAMI NH and the advocacy community. We have serious concerns about aspects of this bill, particularly those related to work requirements, however understanding the compromises that have already been made in crafting this bill and passing it through the Senate, and that the concept of reauthorizing Medicaid expansion, if not the bill itself, will face considerable opposition in the House it is difficult to offer anything other than enthusiastic support for SB 313. That said, my written testimony goes into great detail about specific parts of the bill and suggestions for changes and clarification. I encourage you to read it and I will limit my comments today to a few of those points.

NH's mental health system currently faces significant challenges. The most visible symptom of that this morning there were 42 adults and 3 children in a mental health crisis being boarded in our Emergency Departments throughout the state. This is wrong medically, legally, ethically, morally and economically. The New Hampshire Health Protection program has been successful in increasing individual's access to timely mental health and/or substance misuse treatment before it rises to a crisis or life threatening stage. It is our firm belief that without establishing the New Hampshire Granite Advantage Health Care Program, that those numbers of people seeking emergency mental health treatment in our emergency departments will rise significantly beyond the level where they are now, and will move us backwards from the positive steps the Legislature and Governor Sununu have been taking to improve the mental health service delivery system.

The National Institute on Health estimates that one in five people have mental illness. Yet despite the availability of effective treatment, only about 50% of people with mental illness ever seek help. Like other medical illness, delays in treatment mean progression of the seriousness of the illness and more difficulty and cost when the person does seek treatment. Providing over

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50,000 Granite State residents with health insurance through the NH Health Protection Program has encouraged early detection and treatment of mental as well as physical disorders such as heart disease, diabetes and cancer where there are high rates of co-occurring depression.

The state also faces a serious opioid and addiction crisis which is having a profound negative impact on the health and well-being of residents of all ages. Addiction disrupts the entire family and puts huge pressure on courts, corrections, child protective services, and other economically and socially costly services. By offering substance misuse and addiction treatment services, the New Hampshire Health Protection Program is part of the front line in our efforts to stem the current drug crisis. Offering a substance use disorder benefit is especially critical for individuals who have both a mental illness and co-occurring substance use disorder. They have poorer outcomes including increased rates of hospitalization, incarceration, homelessness, complicated medical conditions, suicide and drug overdoses. Providing a treatment benefit for substance use disorders will greatly improve the outcomes for these individuals as well as help reduce medical costs.

There are some specific comments I would like to make regarding the proposed legislation.

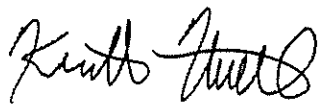
- In the amended version Section126-AA:2 I (e) page 2 (24-27) states the Department shall establish behavioral health rates sufficient to ensure access to and provider capacity for all behavioral health services.
    - With over 275 current vacancies in the Community Mental Health System, it is *imperative* that rates increase in order to address workforce capacity issues. NAMI NH recommends amending this to say "reimbursement rates to providers of treatment of substance use disorders and mental health services shall be higher than rates in existence under the former premium assistance program as of 12/31/2018, and shall be sufficient to ensure access to and provider capacity for all behavioral health services….."
- We strongly support the metrics identified in Section 126-AA:2 g (1) particularly inclusion of timeliness of follow up for mental illness or substance use disorders page 3 (D) line 6..
- Regarding the work requirement, we recognize that for this legislation to pass we all must make compromises. We are vey concerned about the costs and practical aspects of administering this program and at the lack of detail specifics regarding exemptions. At the outset we note that people with serious mental illness face severe barriers to employment and those receiving public mental health services have among the worst unemployment rates of any group in the US. NAMI's 2014 report *Road to Recovery: Employment and Mental Illness* contained both good and bad news for New Hampshire. The good news is that we ranked 3rd in the country in the lowest unemployment rates for people receiving public mental health services. The bad news is that rate, as determined by the Federal Substance Abuse and Mental Health Services Administration stood at 67%.
    - However, the study also pointed out that most people with serious mental illness want to work.
    - We are supportive of the Granite Workforce Pilot program and strongly advocate for it to be funded at a sufficient level to assist people with mental illness and

other disabilities to meet the workforce requirements to maintain eligibility for the Granite Health Care program. .
    - In section 126-AA:2 III (a) 12 page 4 (line 23) we recommend adding "or a mental health treatment program"
    - In section 126-AA:2 III (d) We support the exemptions in (1) page 5 (7-13)
        - In section 126-AA:2 III (d) (4) page 5 (line 21) we recommend adding "or a child with a severe emotional disturbance…" who is residing with the parent….
    - NAMI NH supports section 126-AA:5 7, I page 12 (lines 21-25) stating priority for job placement for health care safety positions
- **We strongly object to and ask that Section-126-AA:2 VI page 6 lines 30-34 regarding reporting of "mental defectives" to NICS be removed.** This section has nothing to do with Medicaid and has no place in this bill. Further, the lack of clarity of this exact language in the NH Health Protection Program legislation HB 1696 resulted in what NAMI NH believes was a complete misinterpretation of Legislative intent and subsequent legal wrangling between the Attorney General and the Supreme Court with the Supreme court declining to enforce the request from the Attorney General in a letter dated July 22, 2016. NAMI NH would be happy to provide copies of the correspondence between the Attorney General and NH Supreme Court.
- NAMI NH strongly supports and applauds the addition of section Section-126-AA:2, VII page 6/7 line 35-2. With drug overdoses and suicide being two of the top leading causes of death in our state, it is imperative that wellness visits including appropriate assessments and/or screenings of both physical health as well mental health and substance misuse.
- NAMI NH also supports Section 126-AA:4 to evaluate the effectiveness and future of the Granite Advantage Health Care Program.
    - We recommend adding a representative of the Medical Care Advisory Committee (MCAC) as appointed by the Chair. The MCAC is a public advisory group required under Federal rules to advise the state Medicaid Director on Medicaid policy and planning.
- Lastly, given the number of people with substance misuse or co-occurring mental illness and substance misuse, NAMI NH supports Section 12 III page 13 lines 32-37 to increase the Alcohol fund to 5% of gross liquor sales to be used to offset costs for the Granite Health Protection program, presuming that those funds will be replenished sufficient to fund critical substance misuse prevention and treatment programs. While the Granite Health Protection Program will insure access to needed treatment the original intent of the Alcohol fund was to promote prevention services with a goal of reducing future rates of substance misuse and addiction and this continues to be of primary importance for our future.

In conclusion, NAMI NH appreciates the thought and innovation that has gone into drafting this bill for the Granite Health Protection Program and strongly support this bill as proposed with the exception of 122:AA2 section VI and with our suggested recommendations and edits.

Thank you for your time and consideration. I am happy to answer any questions

Respectfully,



Kenneth Norton LICSW
Executive Director

HEARING--SB 313- AMENDED

March 20, 2018

Gary L. Woods, M.D.

I am here is support the continuation of Medicaid expansion. Does that mean I am in love with the entirety of SB 313 as amended? NO!!!

There are some problems i.e. some "warts on the toad" as it were. But first let's think about the basics. SB 313 ostensibly is a legislative exercise.

I submit it is more.

Legislation is by definition the mechanism or process by which society institutes and codifies our moral inclinations. The most basic legislative paradigm is to **care** for the public. At its roots, legislation is a moral obligation.

In considering those with inadequate means, providing Health care is one such moral obligation especially in the midst of a society which possesses such wealth. Not providing even the most fundamental access to Health care is an abrogation of our collective moral responsibility.

One can examine the specifics of SB 313:

1. The Work requirement----is this putative or supportive?
2. MCO---managed **cost** organization: cost shifting to providers and hospitals
3. Provider participation issues—lower reimbursement means fewer providers willing to participate in the Medicaid programs.
4. Available vs Accessible
5. Etc., etc., ...

The bottom line is----maintaining Medicaid expansion is crucial. Without it we have nothing with which to move forward and remove the "warts on the toad".

SB 313 amended 1022s

1. Page 3—line 36-37 .....engaging in at least 100 hours per month based on an average of 25 hrs per week.....

   A landscape worker as a lawn mower finishes about Oct and then is employed as worker for a snow removed firm in mid-Dec. ------will he qualify for the good cause exemption???

2. Page 7 ---line 1 .....screening for.....**unhealthy substance**...
   a. Are there legal foundations to mandating this testing?
   b. Unintended consequences of mandated testing-----e.g. prenatal care requiring HIV testing----the American Medical Assoc. experience. The same push back might exist with the putative sounding "Work Requirement"

3. Page 10 --- line14 replace the wording in (c) with: measure the impact of the use of incentives, the loss of incentives, cost transparency, and reference based pricing on costs and health parameters.

Rebecca B. MacKenzie, LICSW
PO Box 304, Claremont, NH 03743-0304
603-504-2851 rbmackenzie@myfairpoint.net

March 16, 2018

Dear NH House Health, Human Services, and Elderly Affairs Representative:

Please support NH Medicaid Expansion!

As a clinical social worker, I have many clients who depend on NH Medicaid to participate in obtaining mental health services. I have made it a goal to serve NH Medicaid clients because many healthcare providers do not. I believe we are all entitled to quality healthcare. According to the U.S. Census Bureau, NH is ranked 5th in the nation for per capita income. *We can provide healthcare for all if we have the will to do so.*

I have read the personal biographies and voting records of many of the members of the House Health, Human Services, and Elderly Affairs Committee and am very inspired by most of the humanitarian views of many of the members of this Committee. I appreciate your service, especially to the most vulnerable among us, as representatives of NH citizens. Again, I ask: Please support Medicaid Expansion.

More than 50,000 Granite Staters have the health care they need and deserve thanks to Medicaid Expansion.

Without reauthorizing Medicaid Expansion, New Hampshire will be taking significant steps backward in our fight against our addiction epidemic. Fifty-one percent of our state list the drug crisis as the state's most important problem, and Medicaid Expansion is our state's most important tool to fight the crisis.

Additionally, our workforce needs your voice! Access to health care is a critical support for Granite State workers in such necessary roles as child care providers, home health care workers, and restaurant workers.

Thank you for your support of NH Medicaid Expansion,

Rebecca MacKenzie, LICSW
Claremont, NH
603-504-2851

Judy silva

NHMA
NEW HAMPSHIRE MUNICIPAL ASSOCIATION
EST. 1941

March 19, 2018

Honorable Frank Kotowski, Chair
House Health, Human Services and Elderly Affairs Committee
LOB Room 205
Concord, New Hampshire 03301

Dear Chairman Kotowski and Members of the Committee:

The New Hampshire Municipal Association (NHMA) **supports** the reauthorization of Medicaid expansion in New Hampshire, currently contained in SB 313.

NHMA supports the reauthorization of Medicaid expansion because the benefits it provides to New Hampshire residents with health care issues have, in turn, resulted in significant benefits to local welfare clients resulting in savings in local welfare costs.

In New Hampshire, general assistance is provided by cities and towns through the local welfare program that every municipality is required by statute to operate—and it is paid for 100 percent with local property tax dollars. Unlike many jurisdictions, there is no state-run general assistance program in New Hampshire. Therefore, the continuation of Medicaid expansion is particularly important to municipalities.

Local welfare officials have reported that expanded Medicaid has provided access to medical coverage for individuals who are not otherwise able to afford the care they need to allow them to return to work. When their health problems are treated, these **workers** return to the workforce and no longer have a need for local welfare assistance. The resulting local welfare savings are often difficult to quantify due to the structure of local welfare, but local welfare officials know that these savings, due to Medicaid expansion, are real. Medicaid expansion has also helped to reduce local expenditures for prescriptions.

Expanded Medicaid has been critical in helping to address the state's severe substance abuse situation, which has placed increasing and grueling demands on municipal first responders dealing with addiction-related issues.

For these reasons, the NHMA Board of Directors voted unanimously to support reauthorization. We urge you to reauthorize Medicaid expansion in New Hampshire. Please do not hesitate to contact me if you have any questions or need further information.

Sincerely,

Judy A. Silva
Executive Director

C: House HHS&EA Committee Members
Senator Chuck Morse
Senator Jeb Bradley

NEW HAMPSHIRE MUNICIPAL ASSOCIATION
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Patrica murphy

NH Local Welfare Administrators Association
C/O Cornerstone Association Management
53 Regional Drive, Suite 1
Concord, NH 03301
Telephone: 603-228-1231

Towards self-sufficiency...

March 16, 2018

Honorable Frank Kotowski, Chair
House Health, Human Services and Elderly Affairs Committee
NH State House
Representative's Hall
Concord, NH 03301

Re: Support of NH Granite Advantage Health Care Program for Medicaid Expansion per SB 313

Dear Honorable Chairman Kotowski and Committee Members,

The NH Local Welfare Administrators Association (NHLWAA) is a professional non-profit organization that works to support our municipal members to insure that we are providing the basic needs assistance to our residents (mandated under NH RSA 165) while being cognizant to the delicate balance of spending municipal taxpayer dollars. NHLWAA is submitting this letter in support of extending the Medicaid Expansion through NH Granite Advantage Health Care Program.

We have a unique situation in NH, where residential tax payers are required to become the safety net of all basic needs of residents without a financial limit. No other state has this dependency on its' local municipalities. While municipal welfare does not pay for health care, we must pay for prescriptions, housing, utilities and food. When people cannot afford health care and they fail to get timely treatment, the results are a population disabled by mental health, addiction and other medical conditions that continue their dependency on local welfare and residential tax payers.

Under the Affordable Health Care Act and NH Health Protection Program, municipalities have seen financial impacts with residents having this basic need of health coverage. The first direct financial impact of local welfare expenditures is prescriptions costs which for just 13 cities and 20 towns have reduced expenditures by 67% totaling $195,990 in the first year and in the fourth year we are seeing almost 90 % savings. The second impact, but the more difficult to quantify, is that residents are able to get access to health treatment, especially to surgeons. Some residents are no longer permanently disabled as a result. They have been able to return to work and are no longer dependent on local welfare for the more expensive basic needs expenditures of housing and utilities. Access to Mental Health and Substance Misuse Health Care will continue to reduce the disabled numbers, if not deaths.

NHLWAA understands that the NH Legislature has a difficult choice to fund our State share of the cost of Medicaid Expansion. We have had three years to see the strong positive results of residents having access to medical care. This makes sense not only on a current and fiscal level but also on a basic human needs level.

We strongly urge you to consider these far reaching implications for the relief of the local taxpayers and residents and support SB 313 for continuing the Medicaid Expansion under NH Granite Advantage Health Care Program.

Respectfully yours,

Patricia A. Murphy

Patricia A. Murphy
NHLWAA President
603 423-8535
pmurphy@merrimacknh.gov

American Cancer Society
Cancer Action Network
2 Commerce Dr, STE 110
Bedford, NH 03110
603.471.4115
www.acscan.org/nh

March 20, 2018

Representative Frank Kotowski
Chair, House HHS&EA Committee
Legislative Office Building, Room 205
Concord, NH 03301

Dear Chairman Kotowski,

ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, and supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy that matters at all levels of government. We write to encourage you to reauthorize the state's Medicaid expansion, preserving eligibility for and access to health care coverage for 50,000 low-income Granite Staters. We also ask that you consider our concerns about the inclusion of the work and community engagement requirements, in SB 313, as a condition of eligibility for newly eligible adults and the impact that they could have on cancer patients, survivors and individuals who will be diagnosed with the disease and others with chronic conditions.

Over 8,600 NH residents are expected to be diagnosed with cancer this year – many of whom are receiving health care coverage through the NH Medicaid program.[1] Evidence demonstrates that individuals with lower socio-economic status (income, education and insurance status) have higher cancer incidence and higher death rates.[2] Overwhelmingly, these populations have less access to quality and comprehensive health care coverage, including prevention and early detection services and treatment. The coverage, benefits and services provided through our expanded Medicaid program helps to improve access and utilization of preventive care, leads to increased early detection of cancers, and results in better health outcomes and survival rates for patients and survivors.[3,4,5,6,7] The Medicaid program helps low-income cancer patients and survivors manage their disease, maintain a good quality of life, and improve their financial situation.[8] For these and many other reasons, Medicaid is a critical safety-net in the fight against cancer, especially for low-income cancer patients and survivors receiving health care coverage through the program.

ACS CAN believes that work and community engagement requirements, like those contained in SB 313, could negatively impact the adult Medicaid population, including cancer patients, survivors, and those who will be diagnosed with cancer in their lifetime. Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[9,10,11] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[12] Imposing a work or community engagement requirement, as a condition of eligibility, could result in a significant number of cancer patients, recent survivors, and many other individuals managing serious, chronic illnesses being denied access to the timely, appropriate and lifesaving health care and treatment services provided through the state's Medicaid program.

The preservation of eligibility and coverage through the state's Medicaid program remains critically important for many low-income Granite Stater who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. If the House passes SB313 in its current form, thousands of low-income state residents, including cancer patients, those with a history of cancer, those at risk for cancer, or other serious

diseases could find that they are unable to access their only safety net coverage option available. We ask you to weigh the impact that this legislation may have on low-income Granite Staters access to prevention and early detection services as well as lifesaving health care coverage, particularly for those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Based upon the evidence-based conclusions stated above, ACS CAN opposes tying access to affordable health care for low-income persons to work or community engagement requirements because cancer patients, survivors, and those who will be diagnosed with the disease - as well as those with other complex chronic conditions - could be seriously disadvantaged by such policies and find themselves ineligible for any affordable health care coverage.

We urge you to reauthorize the state's Medicaid expansion - preserving eligibility requirements for newly eligible adults and we ask you to reject any language that would condition eligibility for the program on participation in work or community engagement activities. Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors enrolled in the state's Medicaid program. We look forward to working with you and the members of the New Hampshire legislature to ensure that all state residents are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at mike.rollo@cancer.org or 603.471.4115

Sincerely,

Michael Rollo
New Hampshire Government Relations Director
American Cancer Society Cancer Action Network (ACS CAN)

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Improving Access to Medicaid Will Reduce Cancer Burden and Improve Health Outcomes

Cancer Action Network℠ American Cancer Society®

acscan.org

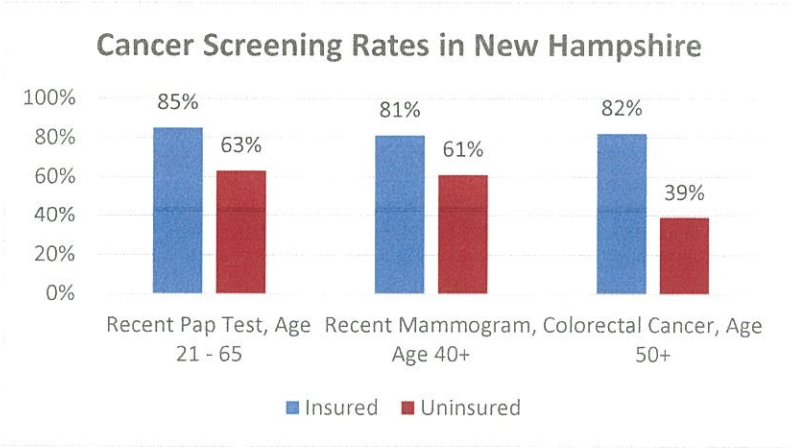
State Medicaid programs provide millions of low-income Americans access to quality, comprehensive, and affordable health care coverage, including those with cancer, those who will be diagnosed with cancer and cancer survivors. An estimated 2.3 million adults with a history of cancer rely on the health care coverage provided by their state Medicaid program to help them fight and prevent recurrence of this disease.[1] In 2013 alone, 32 percent of pediatric cancer patients ages 0-19 had Medicaid as the payer at diagnosis.[2] The benefits and services provided by Medicaid span the cancer continuum – from prevention and early detection to diagnostic and treatment services through cancer survivorship or end-of-life care, all of which are important in the fight against cancer.

- Since 2014, New Hampshire has provided low-income Granite Staters, earning less than 138 percent of the federal poverty level ($16,753/year for an individual; $34,638/year for a family of four), access to comprehensive and affordable health care coverage through the New Hampshire Health Protection Program (NHPPP).
- The federal government currently provides the state 94 cents for every dollar it spends to provide coverage to these state residents and no less than 90 cents for every dollar in 2020 and beyond.
- As a result of the state accepting these federal funds more than 50,000 state residents have gained access to health care coverage, including preventive and early detection services – such as mammograms and colonoscopies, diagnostic testing and cancer treatment therapies.

Reduce State's Cancer Burden

New Hampshire's Health Protection Program provides state residents access to primary care and preventive services such as tobacco cessation, nutrition counseling, Pap tests, mammograms, and colonoscopies, improving the likelihood that cancer will be prevented or detected earlier at a more curable and less expensive stage. Evidence demonstrates that individuals with lower socio-economic status (income, education and insurance status) have higher cancer incidence and higher death rates.[3] Overwhelmingly, these populations have less access to quality and comprehensive health care coverage, including prevention and early detection services and treatment.

- In New Hampshire, uninsured individuals have lower cancer screening rates when compared to insured individuals[4]:
  - Pap test = 85% insured / 63% uninsured
  - Mammogram = 81% insured / 61% uninsured
  - Colonoscopy/FOBT = 82% insured / 39% uninsured
- Uninsured individuals are more likely to have their cancer detected at later stages, when cancer treatments are more costly and less effective.[5] Without coverage, some cancer patients would be forced to delay or forego potentially lifesaving treatment.
- Uninsured women diagnosed with breast cancer are 3 times more likely to have a late stage diagnosis than women enrolled in private health insurance.[6]
- Americans are up to three times more likely to receive preventive care for potentially fatal chronic diseases if they have health insurance.[7] Having insurance was one of the most important factors in determining if an individual received preventive services. For example, women were nearly 2.5 times



more likely to have had a mammogram to detect breast cancer if they were insured versus those not insured. People with insurance were three times more likely to have received colon cancer screening than people without coverage.[8] Screening for colorectal cancer with colonoscopy is one of only a few tests that can screen, detect and remove precancerous polyps, effectively preventing cancer altogether.[9]

Improve Health Outcomes

- States providing health care coverage to the childless adult population, through Medicaid expansion have increased early detection of cancers, leading to fewer cancer deaths and better outcomes for patients.[10]
- Low-income women in states that expanded their Medicaid programs were 25 percent more likely to adhere to screening than they were in 2008.[11]
- For cancer patients, there is evidence that individuals who enroll in Medicaid prior to their diagnosis have better survival rates than those who enroll after their diagnosis.[12]
- After increasing access to Medicaid, KY saw significant improvement in the use of preventive care. In state fiscal year 2014, compared with 2013, breast cancer screenings increased 111 percent, cervical cancer screenings by 88 percent, colon cancer screenings by 108 percent, and physical exams increased 187 percent.[13]

ACS CAN's Recommendations

Every American deserves access to quality, affordable health care. From cancer screenings like mammograms and colonoscopies to the latest breakthroughs in treatment, everyone should have access to the care that could prevent cancer and save their life. **ACS CAN recommends that New Hampshire lawmakers reauthorize the NHPPP maintaining eligibility requirements and preserving access to health care coverage for 50,000 low-income individuals and families through the state's Medicaid program.** By supporting policy proposals that would preserve eligibility for the NHPPP, we can save lives from cancer, improve health outcomes and save money on health care costs. Going to the doctor is much cheaper than going to the emergency room and preventing cancer is much less expensive than treating it. Ensuring that low-income individuals and families in New Hampshire have continued access to comprehensive, affordable health care coverage – is critical in the fight to reduce cancer incidence and mortality.

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Niambi Mercado

March 20, 2018

Representative Frank Kotowski, Chairman
Health, Human Services and Elderly Affairs
33 North State Street.
Concord, NH 03301

Via Hand Delivery

Re Medicaid Expansion

Dear Chairman Kotowski and Honorable Members of the Committee,

My name is Niambi Mercado and I'm here today because Medicaid Expansion saved my life. In 2016, I fell ill due to an infection caused by tooth decay. I had not been able to go to a dentist on a regular basis for some time because I did not have health insurance. Meanwhile I was a full time Graduate student at Antioch University in Keene. On top of my course load I worked part time as a dishwasher as well as heading the compost program at the University. Neither of these jobs provided health insurance and my parents were uninsured.

Luckily the dentist I saw when my tooth got infected told me to apply for Medicaid. However Medicaid doesn't cover dental care for adults, so the only thing that could be done was an emergency extraction. Unfortunately the infection had worsened to the point where I ended up in the hospital for 7 days. During this ordeal, I had to rely on the generosity of others to help me pay for taxis to get back and forth from the orthodontist and hospital, because I only had $20 in my bank account.

Thanks to Medicaid Expansion I was not burdened with medical bills that I could not afford. I was able to focus on my course work and finish my degree at Antioch. I am now working full time at a non-profit and have private health insurance.

I consider myself a Medicaid expansion success story. The program assisted me when I needed it most – allowing me to get healthy, finish my degree, and get a full-time job here in NH with private insurance. Please continue Medicaid expansion for the hard-working people of NH like me.

Thank you for your time,

Niambi Mercado
Assis Fellow
(918) 344-5848

March 20, 2018

The Honorable Frank Kotowski, Chair
House Health, Human Services and Elderly Affairs Committee
Legislative Office Building, Room 205
33 North State Street
Concord, NH 03301

Re: New Futures' support for reauthorization of the Medicaid expansion program

Dear Chairman Kotowski and Members of the Committee:

New Futures strongly supports reauthorization of New Hampshire's Medicaid expansion program, which has provided critical health insurance coverage to more than 130,000 Granite Staters. New Futures agrees with Senator Bradley, Senator Morse and the cosponsors of this bill that Medicaid Expansion has been *the* most important tool at New Hampshire's disposal to help combat the opiate epidemic. We simply cannot allow this crucial program to end.

Impact on the Opiate Epidemic

It is well established that addiction touches individuals across incomes; however, adults living between 0-138% of the federal poverty level are particularly sensitive to the epidemic. Rates of addiction among those living in this income bracket ($0-$16,000 per year for a single individual) in New Hampshire are 19.4%, double the statewide average. Prior to expanding Medicaid, the state had the capacity to treat between 4,000-6,000 individuals annually; placing New Hampshire second to last in the nation.

On average, 7,500 unique individuals have used their newfound coverage to access addiction treatment services *each quarter*, with 82% of those individuals accessing opiate-specific treatment. Considering these statistics, there is no doubt that the rapid growth witnessed in New Hampshire's addiction treatment field is a direct result of the state's decision to expand Medicaid. The expansive and robust substance use disorder service array provided through Medicaid expansion has allowed providers to increase capacity and, in turn, has allowed the state to reallocate Alcohol Fund dollars previously used for treatment toward other important service areas, such as prevention programming, recovery housing, diversion programs and building up the state's recovery support network.

The impact of Medicaid expansion on the opiate epidemic cannot be overstated. More than 90% of New Hampshire's Drug Court participants rely on health coverage through Medicaid expansion. It may not be well known that, to even participate in Drug Court, an individual must be able to pay for their treatment. For many, paying for treatment would be impossible without coverage through expanded Medicaid. To put it bluntly, without Medicaid expansion the state's Drug Court programs would cease to exist due to lack of eligible participants.

While access to Substance Use Disorder treatment services are a critical component of the Medicaid expansion, it is also worth noting the important role the program plays in connecting individuals to basic healthcare services. At New Futures, we have heard numerous stories of individuals self-

medicating with opiates to address pain and/or undiagnosed mental illness. Medicaid expansion allows individuals to access care and treatment for such health issues before their condition worsens to the point that they might turn to illicit substances. The robust service array offered through Medicaid expansion includes coverage for comprehensive screening in primary care and emergency setting; this builds upstream opportunities to identify individuals at-risk of developing a substance use disorder or mental illness and diverting them to lower-cost, clinically appropriate treatment options.

Medicaid Managed Care

New Futures is not opposed to the concept of shifting the Medicaid expansion population from private health plans to Medicaid managed care organizations (MCOs), as proposed in this bill. We believe that such a change may help to guarantee better care coordination, connections to treatment and reduce barriers to care for Medicaid expansion beneficiaries. That said, we believe strongly that a shift to MCOs, without additional considerations, will result in unintended hardships for several healthcare providers, including those at the forefront of the mental health and addiction crises.

Reimbursement rates for behavioral health providers vary significantly between the private market and Medicaid managed care organizations. Behavioral health providers have reported reimbursements by MCOs are, in some cases, 40% less than rates offered for the same service by private carriers. The Commission to Evaluate the Effectiveness of the Premium Assistance Program (PAP Commission) acknowledged this issue, recommending in their final report that a shift to an MCO model must also include enhanced behavioral health reimbursement rates. Reference to this goal can be found in this proposal and must be preserved if we are to continue expanding the addiction treatment capacity of New Hampshire providers.

In addition to addressing the discrepancy in provider rates, the PAP Commission also recommended the reauthorization of Medicaid expansion include: incentives for preventative care; enhanced screenings and well-checks for beneficiaries; short-term suspensions of prior authorizations; and protections to ensure smooth care transitions for impacted beneficiaries. New Futures believes each of these recommendations are critical and supports their inclusion in this legislation. Current language requires all MCOs to honor "pre-existing authorizations for care plans and treatments." Although, it appears this language is intended to cover prior authorizations for medications, this section could be clarified to assure the MCOs honor *all* prior authorizations for a period of 90 days.

As a final note, and for sole purpose of clarifying misinformation, there is no evidence that the Medicaid expansion population has higher health care costs when compared to all others in the individual market. Per a Gorman Actuarial, Inc. presentation for the PAP Commission on September 27, 2017, the Medicaid expansion population in the individual market has costs that were comparable to individuals whose incomes were between 138% and 250%of the Federal Poverty Level (FPL) who receive cost sharing reductions. It is *only* those with incomes above 250 percent of FPL who have lower costs. We share this information not to push back against the shift to MCOs, but to provide a more accurate picture of this population.

Work Requirements

While New Futures remains suspect of work requirements generally, we believe those outlined in this legislation represent a substantial improvement over existing requirements. To streamline this section and eliminate confusion, reference to "substance use disorder treatment" as a qualifying

community engagement activity should be amended to read "recovery community engagement activities." An individual with a substance use disorder is "medically frail" under 42 C.F.R. 440.315(f), an exemption from the work requirement articulated in latter sections of this bill. New Futures believes inclusion of "substance use disorder treatment," without greater clarification, will lead to unnecessary confusion about whether individuals with active substance use disorder are, or are not, subject to the 100-hour monthly requirement.

We also suggest clarifying that an individual participating in the Granite Workforce program, or who is deemed a "full-time" student by an institution of higher education, satisfies the 100-hour monthly requirement. As most know, the time commitment of pursuing post-secondary education far exceeds time spent physically in a classroom, the benchmark for most academic hours. Very few full-time students will have 25 "academic hours" per week to meet this requirement. Program beneficiaries seeking to advance their education should not have to choose between studying for a test or maintaining their health insurance. The stated purpose of the work and community engagement requirements are to make individuals "workforce ready." Imposing such additional requirements on full-time students is counter to this stated goal, especially considering the health care workforce shortage that primarily includes bachelor's and master's level clinicians.

Commission to Evaluate the Effectiveness and Future of the NH Granite Advantage Health Care Program

New Futures fully supports the creation of a second study commission to monitor the transition from the private market plans to an MCO model. The stated goals of this commission are appropriate, and the report produced will be valuable for assessing needed modifications to the program.

Funding Mechanism

In 2000, Senate Bill 153 (Chapter 328, Laws of 2000, effective July 1, 2001) created the Alcohol Abuse Prevention and Treatment Fund (Alcohol Fund) through RSA 176–A:1, a non-lapsing and continually appropriated fund to support alcohol education, abuse prevention and treatment programs. The intent of the law was to ensure that 5% of the gross profits from the sale of alcohol be dedicated to combating drug and alcohol problems in New Hampshire. However, every year but one since establishing the Alcohol Fund, either the governor or the legislature has suspended the 5% funding formula and transferred revenue to the General Fund. Subsequently, the legislature would appropriate only a small amount of general funds, equivalent to a fraction of mandated Alcohol Fund support, for prevention and treatment.

Beginning in 2016, the legislature, under the leadership of the Senate, began utilizing liquor revenues to fund the Alcohol Fund. While not funded at the intended 5% level, this marked a significant step forward. Since then, the percent allocated has increased from 1.7% in the 2016-17 operating budget to 3.4% in 2018-19 operating budget.

When funded, the Alcohol Fund has proved to be a crucial source of support for prevention, treatment and recovery programs. New Futures whole-heartedly supports the provision of this bill to increase the allocation of liquor revenues to 5%. However, protecting the integrity of the Alcohol Fund and the autonomy of the Governor's Commission remain one of New Futures' top priorities.

We understand the sponsors of this bill intend to use federal and other funds to replace, dollar for dollar, the liquor revenues used from the Alcohol Fund for Medicaid expansion. It is also the intention that the replacement dollars will continue to have the same flexibility as liquor revenues. This is important. One of the benefits of liquor revenues in the Alcohol Fund is that they are unrestricted and can be used for any Commission-approved purpose. Federal funds often do not have this same flexibility. For example, the Alcohol Fund has been previously used to support bricks and mortar modifications to treatment and recovery facilities for fire-code compliance; something federal dollars cannot support. They have also been used to support recovery housing, drug court program infrastructure and dedicated staff positions in the Governor's office to address the addiction crisis; again, all traditionally impermissible uses for federal funds. It is this flexibility that has made the Alcohol Fund such a critical tool in fighting the addiction epidemic. Any replacement federal funds must include this same flexibility for Alcohol Fund-funded programs to be maintained.

Finally, New Futures believes amendments could be made to this bill to strengthen and protect the integrity of the Governor's Commission on Alcohol and Other Drug Abuse Prevention, Treatment and Recovery. Any and all replacement dollars should go through the Governor's Commission and allocated to support Commission approved programs. This modification will ensure the protection of these funds and the continued support for critical prevention, treatment and recovery programs.

While questions remain regarding the use of the Alcohol Fund and its potential impacts, we are committed to working with leadership from both bodies and the Governor's office to address any outstanding concerns. We are confident that we can, together, find workable solutions to advance our shared goal of continuing New Hampshire's Medicaid expansion program.

Respectfully submitted,

Michele D Merritt

Michele D. Merritt, Esq.
President/CEO
New Futures

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Working for Equal Justice Since 1971

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March 20, 2018

House Health, Human Services and Elderly Affairs
State House
107 North Main Street
Concord NH 03301

Dear Honorable Members of the House Health, Human Services and Elderly Affairs Committee:

I'm here today on behalf of New Hampshire Legal Assistance (NHLA) and the low-income and elderly clients we represent in civil cases impacting their basic needs, including healthcare. Many of our clients have benefited from Medicaid expansion both in physical and financial health, and NHLA is committed to reauthorizing the Medicaid expansion program. However, today I would like to address some of our concerns.

This bill directs the Department of Health and Human Services (DHHS) to seek permission from the Centers for Medicare and Medicaid Services (CMS) for any necessary Medicaid waivers and amendments. Under 42 U.S.C. § 1315(a), such demonstration projects may only be approved if they promote the objective of the Medicaid program. The objective of the Medicaid program is to provide healthcare services. Provisions contained in this legislation are in conflict with that objective and therefore impermissible under federal law. In fact, a lawsuit has been filed against the federal government over the Kentucky waiver that CMS recently approved. NHLA will be monitoring this litigation closely for any potential implications for New Hampshire.

We oppose work requirements outright. The work requirements in this bill go further than those in the original Medicaid expansion law that New Hampshire passed. Most notably, it extends work requirements to parents with children over the age of twelve. Research shows a negative impact on children's insurance rates when parents are uninsured. In March 2017, one study found the uninsurance rate among children was 21.6 percent with uninsured parents and 0.9 percent uninsurance rate among children with insured parents.[1]

Much of the implementation is left to DHHS to determine, but on the surface it fails to address the fluctuation inherent in low-wage jobs, such as seasonal work, varying hours, insufficient hours, and short notice of shifts. It provides no phase-in or flexibility with calculating hours over the course of the year. It requires 100 hours per month which is more than CMS approved in Kentucky, Indiana, and Arkansas earlier this year. This program supports hardworking granite staters like child care workers, home health aides, landscapers, and others who are juggling multiple low-wage jobs. There is no doubt that some portion of these individuals who we rely on will lose coverage due to the work requirement.

Currently, receipt of medical assistance under New Hampshire Health Protection Program (NHHPP) requires the recipient to contact NH Employment Security for the purpose of finding employment and filing for unemployment. These

[1] http://hrms.urban.org/quicktakes/health-insurance-coverage-children-parents-march-2017.html

additional requirements and verification will be administratively burdensome, and the staff and technology changes required to implement this will be costly. In addition, the time beneficiaries will have to put in to verify work and the complexity of the processes will result in improper terminations.

Work requirements for Medicaid are unnecessary, as New Hampshire has one of the lowest unemployment rates in the nation and the majority of NHHPP adult enrollees who are not disabled or elderly are already working. An issue brief by the Kaiser Foundation shows that, without a work requirement in place, in New Hampshire 60% of healthy (not on federal disability programs) and non-elderly adults are working and that 74% are in working families.[2] Even when excluding SSI, most Medicaid adults not working report major impediments to work such as illness/disability, going to school, and taking care of family.[3]

As employers will tell you, good health is a pre-condition to work. Without access to medical care, untreated medical conditions, chronic pain, and dental needs are additional barriers to work. One study of adults on Medicaid reported that having that coverage made it easier to look for employment, continue working, pay their rent/mortgage, and buy food.[4]

Making Medicaid eligibility contingent on work fails to address the barriers to work that exist, such as access to and cost of childcare and transportation. The Granite Workforce provision that is in the current draft, does not truly address barriers. It creates a 6 month pilot program for a small segment of the population, but for the rest of beneficiaries it simply refers to existing programs, without providing additional funding for these programs.

Beyond the work requirement and lack of resources to address significant barriers to work, there are several other provisions that raise significant concerns for us. First, federal law directs state Medicaid programs to cover (and provides federal matching funds for) medical bills incurred up to 3 months prior to a beneficiary's application date.[2] Ending this 90 day retroactive eligibility will only drive up uncompensated care, medical debt, and bankruptcies. Second, an asset test will force those who have managed to save a little money for retirement into poverty in order to secure health coverage. Third, a 90 day transition period does not provide consumers the protections necessary to ensure continuity of coverage. Finally, much of the details are delegated to DHHS and the managed care organizations (MCOs) via RFPs, contracts, and rule-making. It is critical that the public has the opportunity to monitor and provide input into this process, so as to ensure adequate protections for Medicaid beneficiaries. As currently drafted, this legislation is fraught with problems and ambiguity that will undoubtedly lead to loss of coverage for eligible adults.

Sincerely,

Dawn McKinney
Policy Director

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[2] http://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/
[3] http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/
[4] http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf

Headrest
14 Church St.
Lebanon, NH 03766

NH House Testimony on SB 313 Reforming NH's Medicaid and Premium Assistance Program
Submitted by: Cameron Ford, Executive Director and Laurie Harding, Board Chair
Date: March 20, 2018

Thank you for this opportunity to speak. For the record, my name is Cameron Ford and I am here to support SB313 on behalf of the Headrest Board including our Board Chair, Laurie Harding who could not be here today as well as our Staff and clients.

Headrest is a small transitional living treatment organization located in Lebanon, NH. We currently have 10 beds but because of our constant wait list, we are in the process of adding four more. We are licensed by the state as a low intensity treatment facility. We also have a 24/7 crisis hotline which is credentialed by the National Suicide Association and funded through our annual giving program. We have provided services to New Hampshire since 1971 and take about 8,000-10,000 calls a year. Headrest also has an outpatient program that includes Intensive Outpatient Services.

Thanks to Medicaid Expansion, we became approved to receive Medicaid reimbursement in 2015/2016. Prior to this point in time and in keeping with our mission, Headrest provided services mostly to individuals who were uninsured, supported by funding from the NH Bureau of Drug and Alcohol Services (BDAS). However, because of Medicaid Expansion, we are no longer as dependent on BDAS and neither are our clients. Billing Medicaid has challenged our organization. It was a very steep learning curve and a radical culture change for the staff.

The end of 2016, beginning of 2017 found us struggling to change our business practices so we could appropriately bill in an efficient manner. At that time, the majority of our clients were still supported by BDAS. We are proud to say that this year, as we write, only one of our ten clients is being funded by BDAS. Our staff is now aggressive about moving clients onto Medicaid because they recognize the many more options for treatment become available including Medication Assistance. The other important aspect of Medicaid Expansion is that it has enabled our clients to continue with treatment after they leave our 90 day program giving them more chance for lasting sobriety. Medicaid Expansion has been a gift. Thank you.

Relative to the amended version of SB 313:
We support the idea of work for those enrolled in Medicaid Expansion. A job provides structure and an opportunity to gain a sense of self-worth. There are many studies that demonstrate that work, a good job, is one of the most important aspects of maintaining sobriety. Headrest is in the process of developing a vocational program for our clients and the community. Area businesses are very interested in this endeavor because we desperately need to add to our workforce in the Upper Valley. With support, coaching, understanding and

education people suffering from Behavioral Health diagnoses have the capacity to make a significant contribution to the economy. However, the programs encouraged by the state need to be diverse in nature, readily available and adequately funded. Vocational Rehab. is not just a one-time commitment. Find someone a job and saying "good-bye" is not going to work. In addition, communities like Lebanon no longer have an employment security office. The office is now in Claremont and there is no public transportation. The other consideration is that not everyone can work even though we think they should be able to do so. We need to be careful not to put undue pressure on those who are already suffering from PTSD or Adverse Childhood Events. That determination needs to be figured out by people who are professionals so we don't end up further traumatizing those who are already traumatized. The language in III, d (1) is very helpful and needs to be preserved. Together we can work through the details of this program. We would strongly suggest that the program not be too prescribed.

The asset testing described in SB 313, II(a) & (b) is going to be a challenge especially for smaller organizations. We are told that applying for Medicaid under the Expansion program has been a reasonably efficient process. But many of our clients still have trouble getting the necessary documentation. When people need treatment, they are often in a condition where their ability to follow through with detailed requests is very limited. We are hopeful that we will be able to continue to bring people on to Medicaid in a timely fashion.

We would also like to mention that we believe that managed care especially with effective care management services, can expand the support system for people with Behavioral Health challenges. However, the goal needs to be appropriate funding for services that generate promising results. We cannot do this work on a shoe string. We need to encourage people to seek out a career in Behavioral Health not discourage them which our state has been known to do. We cannot afford to starve our counselors. Managed Care needs to be about providing necessary services and paying for them in a fair and equitable fashion so we can attract more people into the Behavioral Health workforce.

And then there is the alcohol fund. We are well aware that we, as a state have never used this fund for what it was intended. It is a perfect source of revenue for the state's contribution to Medicaid Expansion if we can use it appropriately.

We think that SB 313 has the potential of serving our Behavioral Health clients well. There are many aspects of the bill that offer promise of expanding the supports to those suffering from SUD and Mental Health illnesses. It offers a chance to build a strong community around our clients. It is important to remember that the opposite of addiction is community. Many people with Behavioral Health concerns do not have a community. If SB 313 is passed and implemented thoughtfully, we have a chance of saving money as a state, expanding our workforce and building an effective system of care that includes the entire health care system.

Headrest is prepared to do its part to make this program successful.
On behalf of the Headrest Board;
Sincerely, Cameron Ford, Executive Director & Laurie Harding, Board Chair, Headrest

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Helen E. Hanks
Commissioner

Paula Mattis, MSW, FACHE
Director

SB 313-FN as Amended 2018-0700s

An act reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Testimony of Paula Mattis, Director of Medical and Forensic Services, Department of Corrections
March 20, 2018

The Department of Corrections (DOC) is in support of maintaining Medicaid Expansion. It is a critical point of removing historical barriers of access post release for men and women returning to NH communities. Many of those under our care and custody did not qualify for historical federal or state aid programs until NH adopted the Medicaid Expansion definition. Currently, 90% or more of our clients leave with Medicaid as their primary insurance tool to continue their treatment for substance use, mental health needs and other medical care.

Our Department is seeking on request to amend this bill, which is to either remove the request to seek a waiver of the 90 day retroactive coverage or allow for an exception for correctional facilities. Our Department has deferred several million dollars since the inception of Medicaid expansion of medical claims to be paid through this Federal program rather than through general fund dollars. The following information further speaks to our concerns and request for this change.

I. 90 Day Retroactive coverage

On the first page of the amendment, Line 29 through Line 3, requires the commissioner of health and human services to seek a waiver of the requirement to provide 90-day retroactive coverage. This is the only way that correctional facilities can seek Medicaid to review and to cover costs of Medicaid eligible inpatient stays. Medicaid expansion began in NH on August 15, 2014. The attached chart shows the amount that has been deferred (in yellow). Clearly, since Medicaid expansion went into effect, the amount of money deferred to be paid through Medicaid rather than the State General funds has significantly increased. (The amounts in blue are what are being expended from general fund dollars allocated to the NH DOC.)

The PEW Charitable Trust writes (August 2, 2016):
http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision

Limited coverage of inmates

To be considered an inmate, a person must be in the lawful custody of a state or locality and held involuntarily in a correctional facility. States may not provide Medicaid coverage for health care services delivered to these individuals, with one exception: for care delivered outside the institution, such as at a hospital or nursing home,

when the person has been admitted for 24 hours or more. Under these circumstances, states can obtain federal reimbursement that covers at least 50 percent—and much more, if the person is newly Medicaid-eligible—of prisoners' off-site inpatient costs as long as they are eligible and enrolled in the program.

In the new guidance, CMS clarified that in instances where an inmate is eligible but not enrolled at the time that covered inpatient services are delivered, states may secure retroactive Medicaid coverage and therefore federal reimbursement so long as the person applies for the program within three months of receiving treatment. For example, if an inmate is hospitalized from March 1 to 4, federal assistance may be sought if the inmate was Medicaid-eligible at the time of the hospital stay and submits an application for enrollment—often with assistance from public officials—to the state Medicaid agency by June 30.

States that expand their Medicaid eligibility under the ACA will generally realize the largest savings from this option because most inmates, as nondisabled adults without dependent children, are eligible for Medicaid coverage only under the expansion. Moreover, payments for these newly eligible individuals will trigger the enhanced federal match of at least 90 percent.

States have begun to report realized and projected savings. For example, Arkansas, Colorado, Kentucky, and Michigan detail combined fiscal years 2014 and 2015 savings of $2.8 million, $10 million, $16.4 million, and $19 million, respectively.[7]

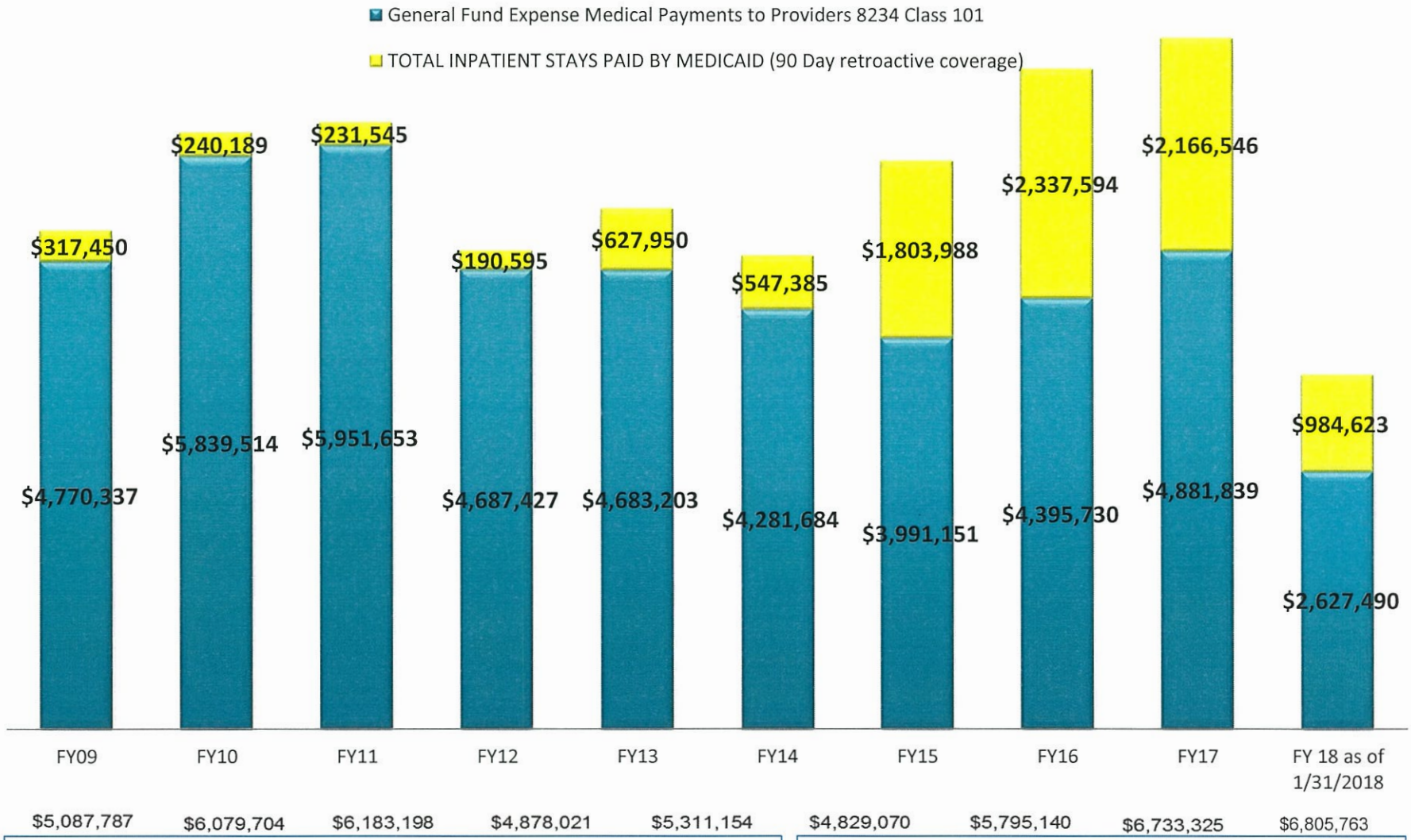
Since Medicaid expansion became fully realized (FY2015 to January 31, 2018) we have deferred $7,292,751 to date for expenses incurred for Medicaid eligible inpatient hospitalization stays. The DOC does not receive those dollars; Medicaid pays community hospitals directly. Nonetheless, it means that general fund dollars were not expended. This is a direct result of Medicaid expansion.

Thank you for considering this testimony.

Respectfully submitted,

Paula Mattis

NH DOC Medicaid Paid Inpatient Stays & General Fund Paid Community Healthcare Costs (8234 -101) for services to People Incarcerated



NH Children's
Behavioral Health
Collaborative

March 20, 2018

The Honorable Frank Kotowski, Chair
House Health, Human Services and Elderly Affairs
Legislative Office Building, Room 205
33 North State Street
Concord, NH 03301

Re: CBHC's Support of SB 313, reforming New Hampshire's Medicaid and Premium Assistance Program

Dear Chairman Kotowski and Honorable Members of the Committee:

The New Hampshire Children's Behavioral Health Collaborative ("CBHC") strongly supports SB 313, reforming New Hampshire's Medicaid and Premium Assistance Program.

The CBHC is a collaboration of over 60 organizations and hundreds of families and youth dedicated to transforming the way we support children with behavioral health needs. In 2014, New Futures was selected to serve as the backbone organization for the CBHC. New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to improve the health and wellness of all Granite Staters. In my role as Children's Behavioral Health Policy Coordinator for New Futures, I provide strategic support and expertise to advance CBHC's policy priorities. In that capacity, I offer the comments below.

The CBHC supports state-level policy changes to transform New Hampshire's children's mental health and substance use disorder system into an integrated, comprehensive system of care that is family driven and youth guided, culturally and linguistically competent, and community-based.

Medicaid is the primary funder of behavioral health services to children, youth, and young adults in New Hampshire. Ensuring access to the program is critical to maintain a robust system of care for our most vulnerable Granite Staters and to provide services when needed and not just in a crisis, at a much higher cost. Our state is grappling with several crises related to the health and well-being of our children, including the emergency room boarding crisis, long waitlists for services at our local Community Mental Health Centers, impacts of the opioid crisis, and reform in our child welfare system. We cannot afford to move backwards.

Medicaid expansion is an important vehicle to reach uninsured children who may be eligible for Medicaid and the Children's Health Insurance Program (CHIP), which already provide a strong base of insurance coverage for children in New Hampshire. The evidence is strong that investing in Medicaid

coverage for parents leads to coverage increases and improved health outcomes for children.[1] One of the most effective strategies to reach eligible but uninsured children is to extend Medicaid coverage to parents and other low-income adults.[2] Parents are more likely to sign up their children for coverage when the whole family can get coverage.[3]

As a matter of public policy, New Hampshire should be doing whatever necessary to ensure health coverage for all children and Medicaid expansion helps reach uninsured children. Access to insurance makes a real difference in the health of children. There is also robust research and data to support that insurance coverage for children is a solid and sound public investment.[4] Returns include higher educational attainment and greater economic opportunities for children, and the creation of a more skilled workforce.[5] Lastly, health coverage provides financial security for the whole family. Children need healthy parents and health coverage improves parents' health and access to care.[6]

Because health coverage for parents and caregivers helps children, the CBHC urges the Committee to vote SB 313 Ought to Pass.

Respectfully,

Rebecca G. Whitley, Esq.
Children's Behavioral Health Policy Coordinator
New Futures, Inc.

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[1] See "Research Update: How Medicaid Coverage for Parents Benefits Children" from Georgetown University Health Policy Institute Center for Children and Families for a review of studies about the links between health coverage for parents and children. (Available at https://ccf.georgetown.edu/2018/01/12/research-update-how-medicaid-coverage-for-parents-benefits-children/) (2018)

[2] DeVoe, MD, DPhil, Jennifer E., et al., "Effect of Expanding Medicaid for Parents on Children's Health Insurance CoverageLessons From the Oregon Experiment," JAMA Pediatr. (Available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2086457) (2015)

[3] Ku, Leighton and Matt Broaddus, "Coverage of Parents Helps Children, Too" Center on Budget and Policy Priorities. (Available at https://www.cbpp.org/research/coverage-of-parents-helps-children-too?fa=view&id=754) (2006)

[4] Brown, David W. Amanda E. Kowalski and Ithai Z. Lurie "Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?" National Bureau of Economic Research(Available at http://www.nber.org/papers/w20835.pdf) (2015)

[5] Cohodes, Sarah, et all "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions" National Bureau of Economic Research (Available at http://www.nber.org/papers/w20178) (2014)

[6] "Health Coverage for Parents and Caregivers Helps Children." Center for Children & Families, Georgetown University Health Policy Institute. Available at https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf.

The Honorable Frank Kotowski, Chairman
House Health, Human Services and Elderly Affairs Committee NH State House, Representatives Hall, 107 North Main Street
Concord, NH 03301

RE: SB 313, reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Dear Chairman Kotowski and Honorable Members of the House Health, Human Services and Elderly Affairs Committee:

As a public member, and on behalf of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery, I wish to thank you for the opportunity to speak to you regarding SB 313, reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

The mission of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery is to significantly reduce alcohol and drug problems and their behavioral, health and social consequences for the citizens of New Hampshire by advising the Governor regarding the delivery of effective and coordinated alcohol and drug abuse prevention, treatment and recovery services throughout the state. Commission duties include:

1) Developing and revising, as necessary, a statewide plan for the effective prevention of alcohol and drug abuse, particularly among youth; and a comprehensive system of treatment and recovery services for individuals and families affected by alcohol and drug abuse;
2) Promoting collaboration between and among state agencies and communities to foster the development of effective community-based alcohol and drug abuse prevention, treatment and recovery programs;
3) To authorize dispersement of moneys from the alcohol abuse prevention and treatment fund.

The Commission's current state plan, "Collective Action – Collective Impact", prioritizes continued support of Medicaid Expansion as a vital tool to significantly reduce the negative behavioral, health and social consequences of substance misuse in our communities.

The services covered through Medicaid expansion support our efforts across the entire continuum of prevention, treatment and recovery. Healthy people are less likely to require substance use services in the first place. Comprehensive health care coverage is also key to early screening and interventions that can prevent the exacerbation of negative consequences of substance use, and whole health coverage is vital to supporting recovery.

For those for whom treatment is indication, Department of Health and Human Services Commissioner Jeff Myers has shared data with the Governor's Commission regarding the breadth and depth of programming that has been enabled through Medicaid expansion, including the coverage of approximately 7,400 individuals in treatment for substance use disorders in any given quarter.

Yet Medicaid expansion has not only greatly expanded our treatment capacity. Taken together, these services help to increase family stability, participation in the workforce, reduce the costly utilization of emergency services, and support people to adopt meaningful roles in our communities, and promote an overall stronger New Hampshire. All of these objectives are aligned with the Mission of the Governor's Commission.

While the Commission supports SB313, we do remain in conversation regarding the implications of utilizing the Alcohol Abuse Prevention and Treatment Fund as a means of supporting the state's match requirement. As you know the Alcohol Fund has not been funded to the full 5% level originally intended by the Legislature. SB313 does that, then transfers the total fund balance to the Granite Health Trust. Both the Department of Health and Human Services and the Office of the Governor have assured the Commission that other resources will be given to the Commission to maintain its financing of the critical prevention, treatment and recovery services supported by the Alcohol Fund. We look forward to understanding further the Executive branch's plan to bring those resources to sustain, stabilize and grow our ability to bring critical non-Medicaid services to communities. We would also hope to see efforts to protect the integrity and authority of the Commission to allocate those new resources, in pursuit of

our statutory charge. Therefore, at this time we take no position on the utilization of the existing Alcohol Fund for this purpose, and strongly encourage passage of SB313.

Thank you for your consideration of the Commission's support for to SB 313. If there is any information or additional assistance you need from the Commission, please do not hesitate to contact me or our Chairperson and Executive Director, Annette Escalante.

Respectfully,

Kevin Irwin

Testimony on SB 313 March 20, 2018

Good Morning Chairman Kotowski, and committee Representatives. Thank you for your service to the Granite State. My name is Norma MacKinley-Smith. I am a resident and a taxpayer from Nashua. I am here in support of SB 313.

You have the difficult task ahead of you to determine the most cost effective way to reauthorize what we currently know as "Medicaid Expansion". We know you are up to the task, as many of you have demonstrated a willingness to right the wrongs which resulted from 'skimping' in past legislative sessions. That short-sightedness has cost us dearly in lost lives and suffering. New Hampshire is on the right track; we are undergoing a painful correction, and we can't fight this battle again. We must commit ourselves to gaining back all the ground we have lost.

As one of the co-facilitators of the NAMI Nashua support and education group I am privileged to assist families in navigating the public health system. Many of our loved ones are excluded from treatment based on the type of insurance they have. Exclusion from effective treatment in the community can have a profound effect on someone struggling with mental a health condition, sometimes resulting in exorbitant hospitalization bills (which they cannot pay), as Involuntary Emergency Admissions and Emergency Department boarding is the psychiatric equivalent of getting care in the ICU. Lack of appropriate community care often results in individuals developing a substance use disorder, becoming homeless, incarcerated, or even losing their life.

Our loved ones want to be well; they want to work and succeed in life. Many people who experience mental health challenges do in fact recover, however it takes investment. While a work requirement is an honorable goal, we must protect the exclusion option for the unfortunate few who are truly unable to work. We must also empower the providers and clinicians who choose to work in the mental health field. How long can we expect the Community Mental Health Centers to serve the population they do, while being reimbursed at 2006 rates? How many of us drove here today on tires we bought in 2006, or work on 2006 computers?

Substance Use Disorder benefits are critical at this time as NH continues to struggle w/ the opiod addiction crisis. Continuing to provide insurance coverage to the 50K currently insured through Medicaid Expansion will enable families to remain strong, and provide protective factors to our vulnerable youth. As with other disorders, early detection and treatment saves personal distress as well as dollars.

Thank you for tackling this complex and crucial issue.

Norma MacKinley-Smith
Nashua

SB313 March 20, 2018

Thank you for the opportunity to tell you about my son, Mason. Because he was born the day after Christmas, I've tried hard over the years to make his birthday special. To make food everyone was excited to eat despite yesterday's excesses. To try and give memorable birthday gifts, instead of providing a thrilling bicycle helmet to match the bike from the day before. But now, birthdays have taken on a tone of dread. My son's future will be dramatically impacted by his access to medical care, but in just three years he will tumble out of our health care policy into an uncertain future.

I wish I could introduce you to Mason as he was in high school. He was one of those rare children that are universally liked. He didn't judge. He was simply comfortable and comforting to be around. As team captain of a previously obscure swim team and the best butterflier ever to stand on their deck, Mason led his team to back to back Division championships and won several medals at States. What I remember even more fondly was his singing the national anthem before the crowd at the YMCA Long Course National Meet in Atlanta, Georgia. Because he was such a skilled athlete, we sometimes overlooked that he was also a strong student who had a choice of academic scholarships and won a coveted physician's assistant slot in Kings College's five year program. That he turned this down should have been an early warning sign that we were heading in a completely unexpected direction.

As I stand here talking to you, my 23 year old son is at home in his bedroom talking out loud and sometimes yelling at voices only he hears. He might be wearing the ski mask he glued razor blades to or perhaps today he is only wearing an oddly knotted string or the dog's dish on his head. He tells me it would be not just a waste of time but a threat to humanity if he took a part time job or went back to school, because he needs to concentrate on the soldiers of ISIS which he can destroy with his mind. If you know someone with schizophrenia these delusions and odd behaviors probably sound very familiar. Perhaps you also know the shocking statistic that 1% of the population has this disease that robs you of friendships, self-esteem, and sanity. Because the disease has hit him in the same lobes of the brain where sensory input is processed and logical thought takes place, he doesn't realize anything is wrong with him. He has responded before to treatment, but was discharged from the hospital on the dubious expectation that he would continue taking pills for an illness he does not believe he has. Using the skills I have learned from the wonderful folks at NAMI, I have tried to nudge him into voluntarily seeking help. But I live in constant dread that the life changing treatment that is currently available even to the jobless will evaporate like a mirage we never could grasp.

If high-school Mason could have seen a future vision of the senior year college dropout he became, he might well have wanted to kill himself. I know he was a hard worker, because I often ran into his boss in the local 5K runners circuit. He never failed to come up to me in the scrum and tell me what a hard worker my son was, how polite, diligent, and willing to learn. Past Mason would be mortified to know he fell down before achieving a job with opportunities for promotion, a 401K plan, and a health benefits package. But he can still have a future. There are several medications that do work for many people. I do not want to be greedy or overly optimistic and tell you my son would finish college and hold down a high pressure office job. But in fact, some schizophrenia sufferers with similar arcs to my son's DO go back to college and finish. Some even obtain advanced degrees, and become psychiatrists themselves. My more modest wish for my son is that he return to the swim deck and share his enthusiasm and skill with the next generation of athletes, and with special populations, and with people who just want to improve their stamina and range of motion. Perhaps he could combine this with working at one of our many ski resorts helping to add the snow Mother Nature neglected to send that week. But he cannot do this unless the voices are switched to mute, or the volume at least turned down. Access to care could do that for him and enable him to give back.

On behalf of my son and all others who cannot speak for themselves, I ask you to keep expanded Medicaid available to New Hampshire residents who need help. For my part, I will do my best to help my son accept the help.

Sandra May

March 20, 2018

Honorable Chairman Frank Kotowski
House Health, Human Services & Elderly Affairs Committee
107 North Main Street
Concord, NH 03301

Good afternoon, Chairman Kotowski and Members of the Committees:

My name is Susan Stearns and I am a resident of Sanbornton.

I am here today in support of reauthorization of Medicaid Expansion. In the interest of full disclosure, I am employed by NAMI New Hampshire (National Alliance on Mental Illness) and serve as board member of the Lakes Region Mental Health Center. However, I do not come before you today in either of those roles, but rather in what I consider to be my most important role – that of a mother.

My child was first diagnosed with an emotional disorder at age 5, a serious one by age 8, and a serious mental illness by the age of 14. Raising my child was not an easy task, but parenting is not for the faint of heart. And, frankly, we were lucky. My employer offered health insurance that covered my child and he was able to access the mental health treatment that kept him at home, in school, and not in an emergency department or inpatient facility – not at any time during his now 21 years of treatment did he require either.

As my child grew up, there were many sobering realizations for me as a mother – that his path would often be different than other children because of his disability; that not everyone in this world would be so patient with his approach to life; that he might not be able to work 40 hours a week for all of his adult life; that he might not have access to treatment.

That last one terrified me. My child had been a treatment success story. As I mentioned before, despite some difficult times, he has never required a visit to the emergency department or a hospitalization. But without treatment – which he would lose access to without insurance – I knew too well what his path would likely be. He would decompensate, become unable to function, be at risk of hospitalization, or even homelessness. Once that happened, after what would likely be a several year period, he probably would be determined to be disabled – and

therefore eligible for traditional Medicaid because his mental illness would have proven so disabling.

1 in 5 children in our state has a mental health disorder. I know I am not the only mother to live with such concerns. I am certainly not the only mother to lose sleep many nights fearing for her child's future access to health care.

My child turned 26 this past fall – during what was his last semester at community college before receiving his degree. (The path to obtaining that degree was long and winding, but he made it.) As he approached his birthday, he and I sat down to apply for the NH Health Protection Program for him. It was a relatively painless process – as much as such things can be. Just a few weeks later the letter arrived saying he was covered. As I read it, I wept.

I realize that implementing Medicaid Expansion in New Hampshire and then reauthorizing it the last time was not a simple thing. Thank you. Words cannot express the gratitude that this mother has for the safety net that Medicaid Expansion has provided to my child. I know I am only one of many parents who feel this way. Thank you for helping us all sleep a little better at night knowing our children can access essential mental health care.

Respectfully,

Susan L. Stearns

Susan L. Stearns
Sanbornton, NH
603-738-5843
slstearns@gmail.com

New Hampshire Hospital Association

House Health, Human Services & Elderly Affairs Committee
March 20, 2018

SB 313-FN
An Act reforming New Hampshire's Medicaid and Premium Assistance Programs, establishing the granite workforce pilot program, and relative to certain liquor funds

Good morning, Mr. Chairman and members of the Health, Human Services and Elderly Affairs Committee. My name is Steve Ahnen and I am president of the New Hampshire Hospital Association, representing all of our state's hospitals. I am pleased to be here today to testify on SB 313-FN to reauthorize New Hampshire's Medicaid expansion program.

New Hampshire's hospitals are partners with the state in caring for our most vulnerable citizens. It is our mission, to care for those who are sick. We take that responsibility very seriously, providing the highest quality of care to anyone who walks through our doors, regardless of their ability to pay.

Hospitals have been strong advocates for New Hampshire's Medicaid expansion program and have long supported its reauthorization. New Hampshire's Medicaid expansion program is providing health insurance coverage to over 50,000 low-income, formerly uninsured Granite State residents. This coverage enables these individuals the ability to be seen by a primary care doctor or in a health clinic, to receive important primary and preventive care, cost-effective management of chronic conditions, and life-saving mental health and substance use services. As a result of this coverage, these patients are now able to receive the right care, at the right time, in the right place.

Reauthorization of this important program will mean that these individuals are able to continue to get the care they need. SB 313 will provide the stability necessary to allow this program to continue, and we thank the hard work by so many, including Senator Bradley, the Senate President, the Governor, bipartisan leaders in both the House and Senate, Commissioner Meyers and many others, for their leadership in bringing this measure forward.

New Hampshire's Medicaid expansion program has helped to reduce the number of uninsured patients seeking care in hospital emergency departments. Since the inception of the program, hospitals statewide have seen a 41 percent reduction in the number of uninsured patients seeking care in the emergency department, a 47 percent reduction in the number of uninsured inpatient admissions, and a 46 percent reduction in the number of uninsured outpatient visits. This has resulted in a dramatic reduction in the amount of uncompensated care attributable to those without insurance: a drop of more than $67 million from $131.2 million in SFY 16 to an

estimated $64.1 million in SFY 2018, a direct reflection of the coverage gains brought about by the New Hampshire Health Protection Program.

We support reauthorization of Medicaid expansion because it's the right thing to do…for our patients, our state and our communities. SB 313 builds on the recommendations of the bipartisan study commission that met over the past year and a half chaired by Senator Bradley. One of the most fundamental recommendations is to move the Medicaid expansion population out of the individual marketplace into one of the existing Medicaid managed care organizations. While we agree with the need to aggressively manage the health of this population and share the belief that the Medicaid MCO's may have more experience with this population than those offering coverage on the exchange, we would be remiss if we didn't point out that this will cause hospitals to lose more than $35 - $45 million annually in reimbursement due to the significantly lower rates paid to providers under the traditional Medicaid program. As you know, New Hampshire's traditional Medicaid provider reimbursement rates are the lowest in the nation. That's why we applaud provisions in this bill that look to raise reimbursement rates for behavioral health and substance use services. We are also pleased to see that the commission established by this bill will look at an overall Medicaid rate and financing structure, including the DSH program, that is sustainable, and ensures access to care across the system.

While it's important to understand those fiscal impacts, it's also important to understand the impact that this program is having on people in New Hampshire. Our hospitals and their clinicians have seen and cared for many of these patients and they see first-hand how this program is making a difference in their lives and in their health. For instance, the person with diabetes who was routinely seen in the hospital emergency room or admitted to the hospital is now able to get the insulin they need to manage their diabetes and receive the care they need with their primary care physician, or the single mom, working two jobs to support herself and her family who is now able to get the ongoing care she needs to take care of her chronic health conditions so that she can continue to support her family. These are just two stories, but there are hundreds, literally thousands occurring every day across New Hampshire that demonstrate the importance of reauthorizing this program.

Reauthorization of New Hampshire's Medicaid expansion program is an important investment in the health of our state and the people it serves. I thank you for the opportunity to testify in support of SB 313 and would be happy to answer any questions you might have.

THE NH PROVIDERS ASSOCIATION | *Representing Alcohol & Other Drug Service Providers in New Hampshire*

House Health, Human Services and
Elderly Affairs Committee
107 Main Street
Concord, NH 03301

March 20, 2018

RE: Support for SB 313

Dear Members of the Committee:

I submit this testimony on behalf of the NH Providers Association—a non-partisan, non-profit membership organization for substance use disorder (SUD) providers seeking ensure high quality substance use prevention, treatment, intervention, and recovery support services. Medicaid expansion dramatically increased access to life-saving services for individuals suffering from alcohol and drug addiction. The Granite Advantage Health Care Program is a critical tool for addressing the addiction crisis. Accordingly, we respectfully urge the Committees to recommend SB 313 *ought to pass*.

1. Reauthorization is crucial to ensuring sufficient infrastructure for SUD treatment.
Despite the increase in health care coverage ensured by the Medicaid expansion, access to some services, specifically residential treatment, remains limited due to the lack of system capacity. Members routinely cite lack of stable funding as a barrier to increasing capacity. Without assurances that Medicaid expansion will be protected, providers are unable to make the financial investment necessary to expand treatment infrastructure.

2. Reauthorization ensures access to care for individuals seeking SUD treatment.
More than 23,000 individuals who accessed care under the NHHPP sought treatment for substance use. These are people actively attempting to address their own addictions, not only benefiting themselves but also their families, communities, and employers. Failure to reauthorize the Medicaid expansion is effectively barring these individuals from getting help and creating a barrier for SUD providers to seek payment for services.

3. Reauthorization of Medicaid expansion is fiscally responsible.
Medicaid expansion enables hundreds of millions of our federal taxpayer dollars to be reinvested in New Hampshire. Failure to reauthorize Medicaid Expansion is a failure to ensure that our tax dollars are used to fight the addiction crisis here at home.

4. Funding for the entire continuum of care including prevention and recovery services must be protected.
As it is currently proposed, SB 313 would fully fund the Alcohol Fund, which is statutorily created, non-lapsing and continually appropriated fund intended to support alcohol education, abuse prevention, and treatment programs. The majority of Alcohol Fund expenditures for SFY 2016-2017 supported prevention, treatment, and recovery services for which there is no third party reimbursement or other payment source. Funding for these critical services must be protected.

Thank you,

Sarah Freeman
Executive Director
The NH Providers Association
(603) 225-9540 ext. 113

March 20, 2018

N.H. State Budget Hearings

Mr. Chairman and Committee Members,

My name is Dick Wiggins and I live in Sanbornton, NH. I grew up in an environment of mental illness and substance misuse. I went on to also abuse drugs and alcohol and have been in recovery for 24yrs. I am active in the recovery community, working with people of all ages affected by addictions and/or mental health issues which drastically affect their lives as well as those who care about them.

I work as a Peer Support Recovery Specialist at the Transitional Housing Service located at the State Office Grounds. My days consist of providing peer support to consumers who live with severe mental illnesses such as schizophrenia, bipolar disorder, anxiety, depression as well as substance misuse. Peer support is an evidence based practice which helps a person find a path to recovery by spending time with a peer having had similar experiences. One of the main principles is giving hope that every person with a mental illness or substance use disorder can achieve recovery and lead a meaningful, healthy life and integrate back into society.

With the re-authorization of the NH Health Protection Program in mind, I strongly support it for providing access to insurance benefits for so many NH citizens who would otherwise not have any. In light of the current opioid (and other addictions) crisis, the early treatment and care of these individuals is so very important. This is a multi-faceted issue which needs our united focus and commitment to help some of our state's most vulnerable (and sometimes forgotten) population. I must emphasize the co-occurrence of mental health and substance misuse issues. My past experience shows me that it isn't so important which came first, rather that we address both with compassion and care so that our community can heal.

Thank you Sen. Bradley and the rest of the sponsors for your consideration on extending the NH Health Protection Program.

Respectfully,

Richard Wiggins, Peer Support Recovery Specialist, NAMI NH

Testimony

My name is Colin Wyman and I am writing of my 34 year old son whom I will refer to as J.
He is married and has a 4 year old daughter. We live in Pelham and J, his wife and daughter live in the in-law apartment in our home.

J experienced a frightening episode in his junior year of high school where he fell into catatonia during which time he was unable to speak. He was hospitalized, eventually recovering after 2 months.

After high school he joined the military, but experienced a similar event and was discharged.
His diagnosis of bipolar with schizoaffective disorder has continued to disrupt his life, losing one entry level job after another with each successive episode. He was, however able to fall in love, get married, and have a beautiful little girl. Family life was good for him, his wife and their young daughter. J faithfully took his medication for 4 years. He was managing a coffee shop and making plans for the future. In the spring/summer of 2016, for a number of complex reasons, he stopped taking his medication. By late summer he had lost his job and was TERRIBLY abusive to his wife. This was the beginning of the worst and longest episode of his life. She expressed multiple times over the succeeding months that she was seriously considering leaving with their daughter. The verbal abuse was incessant and his sleeplessness left her no respite. I reminded her many times that the angry man was the disease and NOT J, the sweet loving man she married.

Together we focused on getting Jay help despite his inability to recognize his condition. We began attending NAMI sessions and eventually joined the Family to Family Class. J lost his ability to sleep and although he is a non smoker, he began chain smoking small cigars at $50.00 a day. J fell into catatonia again. No amount of cajoling or pleading could get him to care for himself or resume his medication. His little daughter asking "why daddy not talk" was heartbreaking as she tried in vain to hug her listless non responsive father.

We eventually forced him into the emergency room at Parkland hospital in Derry NH. He spent 4 days in the emergency room there. He received no medication and could eat nothing. They transferred him to Portsmouth Regional Hospital without notifying us. After 5 days in Portsmouth with the same level of "care" his electrolytes dropped dangerously low. It was only at time that they were able to intervene, moving him out of the mental health ward to a regular room. They gave him an ativan and he snapped out of the catatonia, talking to us while scarfed down a meal. We just happened to be visiting at that time and were so encouraged. You can only imagine our distress when, two hours later they moved him back to the ward and he fell back into catatonia. He was moved the next day to New Hampshire Hospital. His wife and I met his providers, however during our only visit with J, we found him still in the same clothes, unshaven, unwashed, and nonverbal. He was, in effect, imprisoned because he had not verbally approved our visitation. It is important to know that through all the years during J's previous hospitalizations that I have visited him nearly every day when possible. Knowing that he had support and was not alone, and having someone to trust who had an accurate perspective had been a significant part of his recovery in the past. We were, however refused visitation at NHH. The clothes and sundries we brought were refused as well. In his catatonic state he quite obviously was incapable of communicating, and as mental health professionals we would expect them to understand the situation. But it was to no avail.

In late June of 2017 we engaged an attorney for J's wife to obtain guardianship. This was a month long process which was successful and very expensive. After much deliberation we gained the right to have J discharged. Upon his discharge he was in the same clothes with only socks on his feet. He stunk, still unwashed for 3 months. His beard had grown to 5 inches, the longest I'd seen. The three of us were ushered to the door and out into the parking lot, Jay still shoeless.

We brought him home, washed and redressed him, and brought him to Holy Family hospital, this time in Massachusetts. This was only made possible by his wife's insurance.
Within a week they had begun giving him Ativan daily so he could eat and communicate.
We visited almost daily observing his dramatic improvement and supporting him throughout.
It took about two months to get him on a regimen of medication that really works for him.

The Good News in this story is that J has a great new injectable regimen that works perfectly for him thanks to the staff at Holy Family Hospital. More importantly he is able to take ownership of his brain disorder, working with his therapist on a regular basis, something he had NEVER done before. Life is good again for J and he is again the sweet loving father, husband, son and brother we all know and love.

Observations:

Firstly, the guidance, knowledge and support we received from NAMI was CRITICAL to the successful final outcome. I cannot praise or say enough about these people who have long suffered similarly, yet fight the good fight hearts leading.

None of J's recovery would be possible were it not for the private insurance he has through his wife. This allowed him to get care across state lines that is unavailable in New Hampshire.
. The value of insurance cannot be understated here. Private insurance allowed us to arrange for the treatment which has allowed my son to recover to the point where he is able to live back at home with his family and resume his role as husband and father. His family is intact, and we fully expect further along in his recovery that he will return to the work force. Although this experience has had a profound effect on his wife and daughter, they have benefited from his improvement; they are now a strong family unit and will NOT be a burden on the taxpayers of NH.

In final consideration of these experiences, if it was discovered that parents of a child had left that child unwashed and unfed for months, those parents would be criminally negligent. When an individual is unable to communicate their needs due to a medical condition, we, as a society must care for them. The earlier in the disease process this medical care is provided, the better the outcome and the less the cost to the individual, their family, and the taxpayers of New Hampshire. Please, authorize the continuation of Medicaid Expansion so families such as ours can get the care they not only need, but deserve.

Most Sincerely,

Colin Wyman

Thank you, all members of the Health, Human Services and Elderly Affairs committee for accepting this testimony on behalf of many Granite State residents who are covered under the NH Health Protection Program. My name is Amy McCormack. I was born and raised in NH and have lived here most of my life I am a Family Nurse Practitioner, and I see patients in Plymouth. My practice accepts almost every insurance plan available in New Hampshire.

I have a vested interest in in this community and the entire state, and want us to flourish, however I'm alarmed by the state of mental health in New Hampshire. I've been aware of the ER/inpatient issues for a while as I worked in a hospital but I am just now discovering the issues with outpatient care. I am comfortable managing many psychiatric conditions and medications, yet as a Family Nurse Practitioner I have not been adequately trained to properly diagnose or manage all mental health conditions. Just as with other physical conditions (and mental illnesses *can be* physical illnesses as well), often it is appropriate for the patient to see a specialist. Typically, the sooner a patient receives appropriate care, the more effective it is, and the chances for recovery are improved.

I recently saw a patient who is new to both my practice and the state of NH who came to see me with a very long list of medications (psychiatric and otherwise) and diagnosis diagnoses. This individual had been in 3 different ERs within the past week, reported visual and auditory hallucinations, and had no strong support. I explained to the patient that I would refill the medications until they could be seen by psychiatric services. After the patient left I proceeded to try to find somewhere for the patient to go for outpatient services – I felt the need was urgent. Both I and my Medical Assistant called multiple places many times, pleading for appointments with zero luck. Dartmouth Hitchcock Medical Center reported a 3 month wait for urgent psychiatric evaluations; the patient's catchment area (White Mountain) reported a 4 month wait. The patient had Medicaid, and therefor would not be seen by anyone in private practice. When I saw the patient several days later she/he had decompensated to the point that they missed their appointment time, and stated they had forgotten how to get to my office. Obviously, I am extremely concerned about this patient, and even more concerning is that this case is representative of many of my patient's experiences. From my perspective, outpatient/community services are completely failing.

Many of my patients are insured through NHHPP, which enables them to access care for mental health conditions *prior to* progressing to experiencing serious, persistent mental illness. Timely, meaningful treatment can enable people to retain their jobs and keep their families intact, preventing them from becoming a burden on their family or taxpayers.

I implore you to find a way to not only reauthorize Medicaid Expansion, but to improve mental health care for any New Hampshire citizen who finds themselves in need of services. Thank you for your service to all New Hampshire citizens.

Sincerely,

Amy McCormack MSN APRN FNP-C March 20, 2018

Letter to State in support of HB 313 March 20, 2018
from Sharon Morton of Salem NH

Life as we know it changed drastically in Oct 31, 2012- our 11 year old son was falling apart, although he knew his family loved him- the cruelty of Jr high students & bullies, (including a member of the school's administration) turned my introverted son suicidal - short of making an attempt, we got him the help he needed - but that's where the nightmares began that would last years -

We took him to Parkland Medical for a psyche evaluation - at the time I had no idea that the staff member doing the evaluation DOES NOT NEED TO BE PEDIATRIC MENTAL HEALTH - she was cold & cruel. He has Asperger's, and she didn't get his personality at all - we waited in that tiny, and I mean tiny room with only a curtain separating us from the emergency room - my 11 year old & I heard a man's whole story about his Cialis & erection details- no, I am not trying to be funny - we sat in that room in tears for 12 HOURS - not once were we offered food or drink- I could leave him alone & run to a vending machine for chips or candy.

I was told he would be sent to a psychiatric ward for a 24 or 48 hour evaluation - she LIED - at 11:30 at night, we were told a bed was open in Amesbury MA - that was our only option - so we went by ambulance and checked in at 1AM - where my husband had to sit & watch them strip search our little boy who was already terrified, while I filled out form after form...

They withheld his meds for ADHD - yet the Dr. there was evaluating him not even knowing they had already withheld them.

Oh by-the-way - it was not a 24 or 48 hour stay - that clinician from Center for Life Management in Derry had signed him up for a 7 DAY stay-

Mind you he went there as he was suicidal - the schoolwork they had him do was write 5 items about your favorite scientist ON A GRAVESTONE! Again, I am not trying to be funny. Serving mental patients fruit loops and finding that funny is not ok either- yet they did. He later got a roommate who repeatedly threw things around their room - it was terrifying. Our visits were horrible - the way the staff talked to some of the other teens was APPALLING.

My son had nightmares & would wake up crying for 2 years after this - the experience was worse for him than feeling suicidal.

WE NEED MORE BEDS, we need more IN-STATE CARE, we need BETTER, more QUALIFIED individuals and programs. This is something you can go from 0 to 60 with - you could go home tonight & find yourself neck deep in this- your child or grandchild could be in distress & then you will see the deficiencies in our state. Please get these kids, families & adults the help that really is NEEDED. This was back in 2012, before Medicaid expansion - our bills were thousands of dollars, even the ambulance ride for $2500 wasn't covered. The bills from this episode nearly broke us. Five years later we are still paying. More costly, though, was the trauma that was inflicted on our son as we sought help for him. Fortunately, his condition has improved and I'm proud to say that he will be enrolling in college before we know it. There is no need to send our own out of state due to lack of beds or leave young children at the lowest point in their lives in scary situations- please keep Medicaid expansion - it is so very needed in NH.

Thank you for your time. Sincerely,

Sharon Morton of Salem NH.

Towards self-sufficiency...

NH Local Welfare Administrators Association
C/O Cornerstone Association Management
53 Regional Drive, Suite 1
Concord, NH 03301
Telephone: 603-228-1231

March 16, 2018

Honorable Frank Kotowski, Chair
House Health, Human Services and Elderly Affairs Committee
NH State House
Representative's Hall
Concord, NH 03301

Re: Support of NH Granite Advantage Health Care Program for Medicaid Expansion per SB 313

Dear Honorable Chairman Kotowski and Committee Members,

The NH Local Welfare Administrators Association (NHLWAA) is a professional non-profit organization that works to support our municipal members to insure that we are providing the basic needs assistance to our residents (mandated under NH RSA 165) while being cognizant to the delicate balance of spending municipal taxpayer dollars. NHLWAA is submitting this letter in support of extending the Medicaid Expansion through NH Granite Advantage Health Care Program.

We have a unique situation in NH, where residential tax payers are required to become the safety net of all basic needs of residents without a financial limit. No other state has this dependency on its' local municipalities. While municipal welfare does not pay for health care, we must pay for prescriptions, housing, utilities and food. When people cannot afford health care and they fail to get timely treatment, the results are a population disabled by mental health, addiction and other medical conditions that continue their dependency on local welfare and residential tax payers.

Under the Affordable Health Care Act and NH Health Protection Program, municipalities have seen financial impacts with residents having this basic need of health coverage. The first direct financial impact of local welfare expenditures is prescriptions costs which for just 13 cities and 20 towns have reduced expenditures by 67% totaling $195,990 in the first year and in the fourth year we are seeing almost 90 % savings. The second impact, but the more difficult to quantify, is that residents are able to get access to health treatment, especially to surgeons. Some residents are no longer permanently disabled as a result. They have been able to return to work and are no longer dependent on local welfare for the more expensive basic needs expenditures of housing and utilities. Access to Mental Health and Substance Misuse Health Care will continue to reduce the disabled numbers, if not deaths.

NHLWAA understands that the NH Legislature has a difficult choice to fund our State share of the cost of Medicaid Expansion. We have had three years to see the strong positive results of residents having access to medical care. This makes sense not only on a current and fiscal level but also on a basic human needs level.

We strongly urge you to consider these far reaching implications for the relief of the local taxpayers and residents and support SB 313 for continuing the Medicaid Expansion under NH Granite Advantage Health Care Program.

Respectfully yours,

Patricia A. Murphy

Patricia A. Murphy
NHLWAA President
603 423-8535
pmurphy@merrimacknh.gov

TO: HOUSE HEALTH, HUMAN SERVICES, AND ELDERLY AFFAIRS COMMITTEE

FROM: NEAL BYLES, CO-OWNER SCORE 800 TEST PREP; OWNER "WITH THE BAND" AND GROUPIE SQUIRREL TEES,

RE: SENATE BILL #313

DATE: 20 MARCH 2018

Chairman Kotowski, members of the Health, Human Services, and Elderly Affairs Committee, thank you for giving me this opportunity to speak on Senate Bill #313 and Medicaid expansion.

My name is Neal Byles. I am the owner or co-owner of several small businesses, including "With the Band," an online multimedia comic strip, Groupie Squirrel Tees, and Score 800 Test Prep. Through my primary business, Score 800, I teach children and adults how to improve their scores on tests such as the SAT, ACT, LSAT, etc. I have also trained public and private school teachers to better prepare their students for standardized tests, and I have employed several part-time tutors.

Without question, the biggest obstacle to my succeeding as a small business owner has been health care costs. A couple of years ago, due in part to flagging business in test prep, I had to let my insurance lapse—I simply couldn't afford to both have insurance and keep my home.

Anyone who's ever been without health insurance for any length of time knows how stressful it is, how thoughts of "what if" haunt almost every moment of every day. But it isn't just the fear of cataclysmic accident or illness, it's the loss to access to everyday health care essentials, especially medications. I have Attention Deficit Disorder, which, when I was insured, I treated with medication that substantially improved my ability to organize, focus, and complete long term goals, things I've struggled with my entire life, and valuable skills both for teaching and running small businesses. I also have high blood pressure and a genetic predisposition for high cholesterol; I had to give up the medications I used to manage those conditions.

I am humbly aware that I have been extraordinarily lucky these last couple of years. I only had one health event: an abscessed tooth that sent me to the emergency room around this time last year. It was painful, and any student of history knows how dangerous abscesses can be, but ultimately it was one relatively minor incident. Even so, that one minor incident blew a hole in my budget, putting me behind in bills for months, and I am still, a year later, paying off that one emergency room visit, and the subsequent oral surgery, neither of which would I have needed if I had had access to the preventative care insurance provides.

But I have been lucky. I am in good health, which I now know because I currently make little enough that I qualify for Medicaid under the New Hampshire expansion, which enabled me to visit my doctor for the first time in years. Thanks to Medicaid, I don't have to rely so much on luck.

I don't expect to be on Medicaid for long. I have big plans for my businesses this year, and I fully expect to no longer qualify soon, but as any small business owner or parent knows, plans are the Universe's favorite opportunity to play practical jokes, so it would be good to know the expansion will still be there if I need it, and will be available to other workers and small business owners in the future.

Because of the Medicaid expansion, I am healthier, more effective, and more productive than I was without, and the same is true of the majority of Medicaid recipients. We work. We provide. We contribute. The Medicaid expansion doesn't undermine hard work and entrepreneurship. It encourages them. It expedites them. In some of our cases, it makes them possible at all. Please pass SB 313.

Thank you for your time and attention.

March 20, 2018

The Honorable Frank Kotowski
Health, Human Services, and Elderly Affairs Committee
Legislative Office Building
33 North State Street
Concord, NH 03301

Re: Please support SB 313

Dear Representative Kotowski and Honorable Members of the Committee,

I regret that I cannot testify in person today.

Shortly after my daughter Rosie was born, she was diagnosed with cystic fibrosis. Cystic fibrosis is a genetic condition that affects the lungs, digestive system and other organs. Although huge progress has been made in the treatment of CF, it is still a life shortening disease. It requires intensive daily maintenance including medications and treatments, frequent doctors and clinic visits, and unfortunately hospital stays – which can be 2-3 weeks in duration. Unfortunately, organ transplants are often necessary.

Rosie is now 19 and has multiple diagnoses along with her CF– Rheumatoid Arthritis, diabetes, IBS, Depression and others. She had a relatively good life up until her diagnosis with RA when she was 16 and since then daily activities we take for granted can be a struggle. We are fortunate to have the support of her amazing CF team at Dartmouth Hitchcock, RA team at CMC and other doctors to work tirelessly to help maintain her health. Rosie is a sophomore in college and unfortunately is home at the moment due to health issues, we take it day by day. She works so hard to stay healthy - she goes to the gym when she finds it hard to breathe, she goes to class when she cannot climb the stairs. SHE IS AMAZING. We do everything in our power to make life somewhat easy for her. We are very fortunate to have access to good health insurance through my husband's work as all her conditions require a lot of treatments and medication. However, we constantly worry about her 26th birthday and the possibility that she will not have access to adequate insurance. Life is tough when you have to deal with chronic health conditions, worrying about how to pay for treatment should not be part of her life. Nearly 50% of families in New Hampshire who deal with CF depend on Medicaid to pay for healthcare. Medicaid Expansion has enabled families to have the stability in care and hopefully this will help with long-term outcomes. I know Rosie wants to graduate college and work in the Public Health, but being realistic I also know that a high paying job that offers insurance might not be available, Medicaid expansion will give us the comfort of knowing that there will be options open to her. I ask you, as a mother to PLEASE remember Rosie and all the brave Granite Staters who go through every day facing challenges that we will never experience. In a civilized world we ensure that all citizens are taken care of, we need to think of everyone and support those with chronic health conditions – we never know when circumstances can change. I urge you to vote to retain Medicaid expansion in NH.

Thank-you,

Paula Garvey,
30 Holly Hill Drive
Amherst, NH 03031

March 20, 2018

The Honorable Frank Kotowski
Health, Human Services, and Elderly Affairs Committee
Legislative Office Building
33 North State Street
Concord, NH 03301

Re: Please support SB 313

Dear Representative Kotowski and Honorable Members of the Committee:

We work with the underprivileged youth of Strafford County at a non-profit organization, MY TURN, Inc. MY TURN is a program between high school and a career. We offer them opportunities in finding the right career field, giving them an internship in their career field as well as paying for their training. Before we can work on getting these participants into a career, we address the barriers that may be getting in their way from becoming successful on their own. In working with this population of 18-24-year olds we often discuss their insurance situation. Many of our participants have been on and off of Medicaid for years as part of their parents' plans. The parents are often unreliable in keeping up with the paperwork to keep the health insurance on and therefore, once the participants are part of our program, we help them and teach them how to sign up for their own health insurance plan which is through Extended Medicaid. While there have been over a dozen participants that we have helped, there are a few that stick out as important and typical stories of the people of Strafford County.

There was a young woman in our program, named Sarah (name changed for confidentiality reasons). Sarah lives with her mother and walks to work every day, 2 miles each way. Sarah found out that she was no longer going to be covered by Medicaid because they had not turned in the paperwork to renew the plan in time. MY TURN had the Outreach Coordinator from Goodwin Community Health Center to come to the office and she sat on the phone with Sarah and the Department of Health and Human Services to get Sarah on her own plan. In later weeks Sarah fell on the sidewalk on her walk to work and had to go to the hospital as she had twisted her ankle. Without Medicaid, Sarah would have missed more work and had a hefty bill from the hospital or she could have chosen to not miss work because she knew she wouldn't be able to afford to get her ankle looked at by a doctor, neither decision would be good for the well being of Sarah.

We had another young woman who went to pick up her birth control prescription from the pharmacy and was told that her insurance was no longer working and that if she wanted her prescription she would need to pay 200 dollars. The MY TURN program tried to sign her up online but after a week with no response, we reached out to the Outreach Coordinator from Goodwin Community Health again and this participant's health insurance was set up that very day. Goodwin Community Health's pharmacy gave this participant a severe discount and she was able to pick up her prescription for less than 30 dollars and had her health insurance completely on the next day. This is a 20 year old young woman who is working full time, going to school to become an LNA and is supporting her family as the oldest of 6 children.

These two young women are just two examples of how the Extended Medicaid is a necessity in this state. There are many different types of people who are working hard to support their families or themselves and are struggling to make ends meet. They don't have the extra money to spend on new shoes or brand name

toilet paper, let alone the money to cover an emergency such as a fall, like Sarah, or paying out of pocket for a typical prescription. People should be able to have that helping hand while they are getting on their feet, working and trying to improve their lives.

Thank you for your time,

Erin Foran Laurie Basham

Erin Foran and Laurie Basham
Rochester, NH

NHMA
NEW HAMPSHIRE MUNICIPAL ASSOCIATION
EST. 1941

March 19, 2018

Honorable Frank Kotowski, Chair
House Health, Human Services and Elderly Affairs Committee
LOB Room 205
Concord, New Hampshire 03301

Dear Chairman Kotowski and Members of the Committee:

The New Hampshire Municipal Association (NHMA) **supports** the reauthorization of Medicaid expansion in New Hampshire, currently contained in SB 313.

NHMA supports the reauthorization of Medicaid expansion because the benefits it provides to New Hampshire residents with health care issues have, in turn, resulted in significant benefits to local welfare clients resulting in savings in local welfare costs.

In New Hampshire, general assistance is provided by cities and towns through the local welfare program that every municipality is required by statute to operate—and it is paid for 100 percent with local property tax dollars. Unlike many jurisdictions, there is no state-run general assistance program in New Hampshire. Therefore, the continuation of Medicaid expansion is particularly important to municipalities.

Local welfare officials have reported that expanded Medicaid has provided access to medical coverage for individuals who are not otherwise able to afford the care they need to allow them to return to work. When their health problems are treated, these **workers** return to the workforce and no longer have a need for local welfare assistance. The resulting local welfare savings are often difficult to quantify due to the structure of local welfare, but local welfare officials know that these savings, due to Medicaid expansion, are real. Medicaid expansion has also helped to reduce local expenditures for prescriptions.

Expanded Medicaid has been critical in helping to address the state's severe substance abuse situation, which has placed increasing and grueling demands on municipal first responders dealing with addiction-related issues.

For these reasons, the NHMA Board of Directors voted unanimously to support reauthorization. We urge you to reauthorize Medicaid expansion in New Hampshire. Please do not hesitate to contact me if you have any questions or need further information.

Sincerely,

Judy A. Silva
Executive Director

C: House HHS&EA Committee Members
Senator Chuck Morse
Senator Jeb Bradley

NEW HAMPSHIRE MUNICIPAL ASSOCIATION
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March 20, 2018

The Honorable Frank Kotowski
Health, Human Services, and Elderly Affairs Committee
Legislative Office Building
33 North State Street
Concord, NH 03301

Re: Nashua Fire Rescue's support for reauthorization of Medicaid Expansion to support Safe Stations

Dear Chairman Kotowski and members of the committee,

During our recent blizzard, a young man walked through the door of our fire station with his father. He had driven from Lebanon to Nashua, through a "bomb cyclone," to get help to start his path to substance use recovery. He had heard of someone else who had come to a fire station in Nashua for support, and could think of nowhere else to go to save his life. He knew he needed treatment, but did not know where to turn for help.

It took our trained firefighters less than 10 minutes to get him access to a treatment facility.

In Nashua, every fire station is a designated safe environment, where people seeking treatment for their substance use disorder can come for immediate assistance, at any time of the day or night. This program, called Safe Stations, has been lauded across the state and on a federal level as an effective program to fight addiction. It also exists in Manchester, and multiple cities around New Hampshire which have been hit hard by the opioid epidemic, including Rochester, hope to implement the program. To date we have assisted New Hampshire residents from 160 communities.

During our addiction epidemic, it's crucial for New Hampshire that we continue to support programs that work. Safe Stations is one of those programs, and we would find ourselves unable to do our jobs as effectively as we have been so far without expanded Medicaid.

Over 1,000 individuals have gotten substance use treatment through Safe Stations. More than 50 percent of individuals who access Safe Stations have NH Medicaid at their entry to the fire station. Twenty percent of them have no health insurance at all. For individuals to get crucial, life-saving treatment, they need to be able to pay for it, either with quality, affordable health insurance or out of pocket.

Since many of the vulnerable Granite Staters walking through our doors asking for help are unable to pay for treatment out of pocket, expanded Medicaid is what allows them to start their path towards recovery.

Medicaid expansion has resulted in more than doubling our state's substance use disorder treatment capacity, since multiple treatment facilities have only been able to open and stay open

because of Medicaid expansion. If these facilities were not open and operating to save people's lives, our firefighters would have nowhere to direct the Granite Staters who are walking through our open doors.

It's largely agreed upon across our state that New Hampshire's addiction epidemic is our number one public health concern. Its killed hundreds of Granite Staters and costs the state more than $2 billion annually. Reauthorizing expanded Medicaid will be our greatest tool to support programs like Safe Stations and fight the epidemic.

Brian D. Rhodes
Assistant Fire Chief
Nashua Fire Rescue

March 20, 2018

The Honorable Frank Kotowski
Health, Human Services, and Elderly Affairs Committee
Legislative Office Building
33 North State Street
Concord, NH 03301

Re: Please support SB 313

Dear Representative Kotowski and Honorable Members of the Committee:

My story today is, I'm sure, a lot like others' stories. I was left with two children, ages 7 and 5, I had no money to speak of and no means of affording any health insurance for myself and them.

We were barely getting by. Although I was working full time, I needed some extra help and so I was able to qualify for Medicaid. For that short period of time I was able to see to my children's doctors visits, their dental visits and their overall health needs. Without it they would not have had the basic healthcare that ever one needs and deserves.

Although I no longer need Medicaid today there are so many others out there that need that kind of help that I got.

We live in a state that I am proud of and have called my home for the past 46 years.

Continue to make me proud today by expanding Medicaid (NHHPP). We are in a position to help. So please vote to make this happen and when all is said and done we can rest easy knowing that we have contributed to the greater good for all.

Thank you for your time and consideration.

Carol Bowden

Derry N.H.

March 20, 2018

Dear House of Representative Members,

RE: SB 313-FN reforming New Hampshire's Medicaid and Premium Assistance Program

Dear Members of the House of Representatives:

My name is Michelle Lennon and I am a Board Member of HealthFirst Family Care Center, wife a husband who struggles with SUD and Chronic Pain, after an accident, (he fell 40 ft from a roof at work and survived), Director of a Family Resource Center, and Pastor of a church in Tilton. The health care center provides primary care, oral health care, substance use disorder treatment, and behavioral health services to approximately 7000 patients at 3 locations. Approximately 62 percent of the patients live at or below the federal poverty level. The New Hampshire Health Protection Program has changed the lives of those patients and the health center and personally has helped my family as my husband's insurance lapsed after the workman's comp ended. Before the Health Protection Program existed, many of patients, like my husband, did not have health insurance simply because we could not afford it. The New Hampshire Health Protection Program improves patients' access to prescription medicines, lab work, and radiology services that our patients could not afford otherwise. In my husband's case, multiple surgeries and SUD treatment have got him on the road back to health and productive living.

The health center has had many clients who have been able to enroll in the expanded Medicaid program access SUD treatment services go back to work and are once again contributing members of their communities. My husband had his last surgery last October, and thanks to the expanded Medicaid program, will be returning to work in just over a month.

The New Hampshire Health Protection Program is also good for businesses, including the community health center. Since 2014, the year the Program began, the center has seen an 85% percent reduction in uninsured patients. There is the offer a sliding fee discount based on income to patients and since 2014, there has been a 60% percent reduction in sliding fee discounts.

The ability to use the increase in patient revenue to expand services, increase hours of operation, and hire more staff has been an incredible tool in supporting our families at the Family Resource Center as well. Since 2014, HealthFirst Family Care Center has added 3 clinicians and 563 new clients to their health center(s). Since 2014, they have added SUD TREATMENT suboxzone prescribing and associated counseling and two full time Behavioral specialists who are fully integrated into their treatment teams. The New Hampshire Health Protection Program increased access to behavioral health and substance use disorder treatment in our communities. This has allowed our Family Resource Center's Recovery Coaches incredible support in seeing people successful in the recovery from Substance Use Disorder. Please vote in favor of continuing this important tool in accessing services.

Please feel free to contact me if you have any questions.

Sincerely,

Rev. Michelle J. Lennon, Executive Director, Greater Tilton Area Family Resource Center
HealthFirst Family Care, Board Member

Michelle J Lennon

603-960-2128
ntccpastormb@gmail.com

BIA
Business and Industry Association
New Hampshire's Statewide Chamber of Commerce

122 North Main Street, Concord, NH 03301
Tel: 603.224.5388 • Fax: 603.224.2872 • Web: www.BIAofNH.com

March 20, 2018

The Honorable Chair, Representative Frank Kotowski
House Health, Human Services and Elderly Affairs Committee
Legislative Office Building
Concord, NH 03301

Dear Chairman Kotowski,

The Business and Industry Association, New Hampshire's statewide chamber of commerce and leading business advocate, asks the committee to **support SB 313-FN**, an act to reauthorize New Hampshire's expanded Medicaid program for another five years.

BIA supports this legislation because, while not perfect, it's much better than the alternative: allowing the program to sunset. Sunsetting would push 50,000 Granite Staters off healthcare coverage, leave well in excess of $400 million in annual federal support on the table, and result in significant cost-shifting to the business community in the form of higher health insurance premiums for employers *and* employees.

While the reimbursement rate to providers under this bill is lower than in the past, there are counterbalancing factors to consider such as much stronger coordination of care for individual recipients, reduced program costs, and better medical outcomes.

BIA's support for reauthorization is based on our belief that it is better for economic prosperity when individuals and families are insured. The uninsured don't receive appropriate healthcare services when and where they need them, which ultimately leads to a costlier healthcare system. Healthcare providers aren't reimbursed for treating uninsured patients, which ultimately impacts the amount cost-shifted onto other payers, such as businesses and their employees.

We appreciate the opportunity to weigh in supporting SB 313 FN.

Sincerely,

Kevin Flynn
Director of Communication and Public Policy
Business and Industry Association

NEW HAMPSHIRE
PUBLIC HEALTH
ASSOCIATION
Improving Health, Preventing Disease, Reducing Costs for All

4 Park Street, 4th Floor
Concord, NH 03301
603.228.2983 | info@nhpha.org
www.nhpha.org

March 20, 2018

Chairman Kotowski and Members of the Health, Human Services and Elderly Services Committee

The New Hampshire Public Health Association(NHPHA) is writing this letter today in support of SB313, a bill which will maintain health care coverage to those individuals at 138% of the poverty level. NHPHA is a professional organization whose members share the common goal that everyone in New Hampshire live, learn, work and play in safe and healthy environments. One key element to this goal is ensuring that our most vulnerable continue to have access to health care insurance. As public health professionals, we know that health insurance is the key determinant governing the behavior of individuals seeking medical care that is both appropriate and sought after in a timely manner.

We also want to take this time to publicly thank our Representatives in the House for all your hard work to date to provide for health care coverage for these 50,000+ citizens. Without health care coverage, these individuals would otherwise have gone without health care and would still be faced with the insecurity that comes when one no longer can afford to go to the doctor or other medical professionals to keep themselves healthy. For many, the previous New Hampshire Health Protection Program is instrumental in eliminating many of the financial barriers to receiving services crucial to living a full, healthy life. To many of our neighbors, that program is throwing a lifeline to recovery by making substance use treatment and other mental health services available. Given that the many of new enrollees are working in sectors critical to New Hampshire's economy – hospitality, food service, home health care, and construction – it's even more important that we keep those eligible folks healthy and productive.

Continuing this coverage under the new name of New Hampshire Granite Advantage Health Care Program is vitally important for those citizens to continue to have access to care, and to not have to choose between buying groceries and paying for a necessary doctor's visit. Being poor should not result in poor health. New Hampshire must be a state that continues to believe that is no longer acceptable that over 50,000 of our neighbors face the possibility that the safety net of health insurance coverage will be removed and with it the progress that they have made towards better health and a better life. Without the continuation of the program under its new name of New Hampshire Granite State Advantage Health Care Program that safety net is taken out from under those most in need, and health insurance and medical care would once again be placed beyond their reach.

While there are some provisions in SB313 with which we disagree, we realize that today SB313 is a starting point and hope that House of Representatives continues to work in a bi-partisan manner to do what is best for this population by continuing their health insurance coverage without placing on onerous restrictions that could

result in the loss of coverage for some. Our community partners and those in our state legislative bodies need to continue to be there for our neighbors, our co-workers, our family and friends - your constituents - whose health, quality of life, and economic contributions depend upon the continuation of this vital program. And for these reasons, the New Hampshire Public Health Association stands with our allies before you here today, and urge you pass SB313.

If you have any questions or require additional information, my contact information is above.

Sincerely,

Joan H. Ascheim, MSN
Interim Executive Director

New Hampshire Public Health Association
4 Park Street, 4th Floor
Concord, NH 03301
603.228.2983 | info@nhpha.org
www.nhpha.org

Richard Chevrefils
9 Camelia Ave. Unit 6
Concord, NH 03301
603-224-9077

Senate Bill 313: Reforming New Hampshire's Medicaid and Premium Assistance Program

House Health and Human Services Committee

Chairman and Committee Members,

I submit this letter in support of Senate Bill 313, Reforming NH's Medicaid and Premium Assistance Program.

I serve as the current President of the Board of the National Alliance on Mental Illness New Hampshire (NAMI NH). Also, I have had the opportunity to experience the health care needs of New Hampshire citizens throughout my 35 years with the NH Department of Health and Human Services.

It has been my experience that the health care of our citizens is one of the prime factors in the success of families and individuals to function independently, to address challenges to wellness and contribute to the greater good of our state. Without access to good health care options people struggle.

Senate Bill 313, the reforming and the reauthorization of the Medicaid and Premium Assistance Program is a priority to the 50,000 people who currently benefit from access to quality health care through the NH Health Protection Program. To the over 38,000 people who receive mental health services the reauthorization/reforming of the Medicaid and Premium Assistance Program is crucial to their health and their capacity to participate independently and contribute to their families and to our state.

The New Hampshire Health Protection Program has made a difference to the beneficiaries of the program and to all citizens; it has helped people achieve wellness; it has helped people recover; it has helped lower uncompensated care; and it has helped the working poor. The re-authorization/reforming of the Medicaid and Premium Assistance Program will continue to make a difference in the lives of New Hampshire citizens.

Government is about "We the people....." and the action to reauthorize/reform the NH Medicaid and Premium Assistance Program will impact the greater good for all our citizens'

Thank you for all that you do for the people of New Hampshire and thank you for your consideration and action to reauthorize and reform the NH Medicaid and Premium Assistance Program.

Sincerely,
Richard A. Chevrefils
President, NAMI NH Board of Directors

American Heart Association | American Stroke Association
life is why™

Founders Affiliate
2 Wall Street | Manchester, NH 03101
www.heart.org

March 20, 2018

Re: SB 313 – FN An Act reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

To: House Health, Human Services & Elderly Affairs Committee

Dear Chairman Frank Kotowski, Co-Chair Donald LeBrun and Members of the Committee;

On behalf of the American Heart Association and American Stroke Association (AHA/ASA), I would like to provide comments on the importance of New Hampshire continuing to provide health insurance to those covered by the NH Health Protection Program. We appreciate the work and thought that has gone into finding a NH solution to providing healthcare coverage for hard-working granite staters and support a healthy and productive work-force.

The AHA/ASA represents over 100 million patients across the country with cardiovascular disease, including many who rely on Medicaid as their primary source of care.[i] In fact, 28% of adults with Medicaid coverage have a history of cardiovascular disease (CVD).[ii] Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Because low income populations are disproportionately affected by CVD - with these adults reporting higher rates of heart disease, hypertension and stroke – Medicaid is the coverage backbone for the healthcare services these individuals need.

The connection between health insurance and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance, or are underinsured, have higher mortality rates[iii] and poorer blood pressure control than their insured counterparts.[iv] Further, uninsured stroke patients suffer from greater neurological impairments, longer hospital stays,[v] and higher risk of death[vi] than similar patients covered by health insurance. Cardiovascular disease is also costly and burdensome for the individual, their families, and our system of care.

The AHA/ASA supports promoting healthy behaviors and advocates for healthy lifestyles to prevent CVD. But the reality is heart disease is still a prevalent condition and is the second leading cause of death in New Hampshire. Health insurance coverage is an important tool in the fight against heart disease. Conditions such as high cholesterol and high blood pressure can be controlled if detected and treated early and possible prevent costly heart attacks and strokes.

We are supportive of efforts to continue the NH Medicaid Expansion program, but we have some concerns with some of the eligibility criteria outlined within SB 313, particularly the work requirement, which may cause disruption in coverage and create barriers to medical care for

chronic conditions. Individuals with CVD often experience lapses in employment due to their condition or may have been directed by a physician to take time away from work as part of their treatment or recovery. Therefore, participation in work or work searches as a condition of Medicaid eligibility could create barriers to medical care.

Another concern regards the provision on non-emergent use of an ER. Heart attacks, sudden cardiac arrest, and stroke are serious, life-threatening conditions that require immediate emergency care. This provision is very likely to deter patients from seeking emergency care when needed. The AHA/ASA devotes a great deal of resources to educating the public about the warning signs of heart attack and stroke and encouraging them to call 9-1-1 immediately if they or someone nearby is experiencing any of these symptoms. When patients do experience a symptom of a heart attack or stroke, such as acute chest pain, shortness of breath, a sudden, severe headache, or difficulty seeing, they should not try to self-diagnose their condition or worry that they can't afford to seek care. Instead, they must have access to quick diagnosis and treatment in the ED. In some cases, these patients may ultimately be diagnosed with a non-emergency medical condition, but they should not be penalized because they followed the instructions of effective and long-standing public health campaigns and sought emergency treatment.

To prevent and treat heart disease and stroke, it is critically important to ensure that everyone in New Hampshire has access to high quality affordable healthcare. This includes hard working people struggling to support themselves and their families, but whose incomes leave private health insurance premiums out of reach. The AHA/ASA will follow the process to ensure work requirements and other criteria do not reduce access to healthcare services for vulnerable individuals. If you have any questions, please feel free to reach out to the American Heart Association/American Stroke Association at any time.

Sincerely,

Nancy Vaughan

Nancy Vaughan
Government Relations Director – NH
Nancy.vaughan@heart.org
603-263-8329

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[i] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015-2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.

[ii] Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.

[iii] McWilliams JM, Zaslavsky AM, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004;23(4): 223-233.

[iv] Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health insurance status and hypertension monitoring and control in the United States. Am J Hypertens 2007;20:348-353.

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[vi] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA. 2007; 298:2886-2894.

SB 313 March 20, 2018

My name is Heather Pike and I live in Pittsfield.

Imagine you will, a car that goes 100 feet then stops. Then later, starts again, runs a few days then stops. And so on, day after day. No technician seems to know how to fix it but no.other cars are available. This is your only car.

This metaphor sets the stage for understanding the rest of my story.

The human brain is supposed to keep the rest of the body safe, productive and successful. My son's brain seem to be doing its job just fine until he was about 15 years old. Then, all bets were off.

His mental health challenges today mean the actions that we all rely on, such as connecting with those around us or connecting yesterday,tomorrow and today, can be just beyond his reach, on any given day. Plans he makes on days when his brain is functioning better, fall apart when his brain is functioning worse.

To see him on a good day riding his skateboard or shoveling snow there's no hint that this guy just barely into his 20s is actually in frail health. If you noticed his older brother telling him to put on his coat, while he shivers in a T-shirt, or if you stopped to chat and he didn't acknowledge you, you might think him odd. But as a parent, who has seen what his illness has done to him up close, waited during the many debilitated bad days when he cannot leave his room or wondered how he was doing while he was in the hospital on his many stays, you'd know.

This young man depends on services available to him only his coverage by Medicaid, such as a case manager who comes to the house, helps him with all kinds of navigation issues related to his healthcare and life skills, or gets him to his health care appointments, These services are a essential part of his health services.

Imagine how senseless if, he eventually meets his future goal of being an employee, and this small step to independence means he falls into the gap zone that the expansion fills, the "gap" where he could no longer get Medicaid, loosing access to his case manager and his services.

I urge you to ensure that the Medicaid expansion continues.

March 20, 2018

Dear NH House representatives,

I am a Granite State resident who desperately relies on Medicaid Expansion. Due to significant health struggles, I have been unable to work full-time for several years now, and therefore am not eligible for employer sponsored health insurance. I am strongly motivated to continue working as much as I can, however, and have purchased insurance from the Marketplace (Healthcare.gov) with premium assistance in the past. Unfortunately, for low income workers like myself, the cost of keeping my much needed health care in place has been heavy. The worst came In 2018, when my health care premiums for individual coverage on the Marketplace would have doubled from their 2017 rate to over $700 a month! (Sadly, it was for an even less robust plan than I'd had in 2017...) Add deductibles and total out of pocket costs to that, and I was looking at around $12,000 to have coverage for JUST MYSELF in 2018! On my earnings, this cost would be impossible to afford! THANK GOODNESS, I discovered I was eligible for Medicaid Expansion!

Without Medicaid Expansion, we have a State health care system that covers only the most severely destitute with Medicaid, and also creates a huge gap for thousands of individuals and families like myself: those who have no access to employer sponsored plans and are left facing either 1) Marketplace rates that only those with much more substantial means can begin to afford or 2) NO healthcare at all and a hefty tax penalty to pay. Any way you look at it, without Medicaid expansion, low income yet dedicated workers like myself suffer.

PLEASE, I strongly urge the NH House to reauthorize Medicaid Expansion for the thousands of Granite State residents like myself.

Respectfully yours,

Marianne McCall
Concord, NH

Hearing on Medicaid Expansion Reauthorization
Representatives Hall
NH State House
March 20, 2018

My name is Barbara Publicover and I live in Merrimack, NH. I am here today asking for your support in the reauthorization of Medicaid expansion for our most vulnerable citizens of NH. I come first and foremost as a parent of two children with mental health needs. Medicaid expansion has been a topic of conversation in our household over the last several months as my son, who is turning 26 in June, will be aging off our group health insurance. He works for a small company which has not had health insurance in place up until recently. Without this new company benefit, he too would be among the many who would need to access Medicaid expansion.

I also am here as a volunteer facilitator of a NAMI NH support group for the last 6 years. Listening to the angst, fear and sadness that hovers over families who do not have the supports and services that their loved ones need to live full and enriching lives is gut wrenching. We listen and often provide concrete information to families while assuring them things can be better. We always hope that nothing will go wrong, but we know that without the supports and services individuals/people need, most certainly things can go very wrong. We witness the downward spiral when there are gaps in treatment or delays with prior authorizations, resulting in medication lapses. We are also privileged to hear inspiring stories of recovery when individuals receive meaningful and appropriate treatment for their mental health condition(s). Please let this bill be a bill of expansion of the caring and support for all NH families and not just one that we've "checked the box".

Barbara Publicover

75 Amherst Rd

PO Box 1184

Merrimack, NH 03054

March 20, 2018

House Health, Human Services, & Elderly Affairs Committee
Legislative Office Building,
Room 205
33 N State Street
Concord, New Hampshire 03301

Re: Testimony in support of SB 313 Reforming New Hampshire's Medicaid and Premium Assistance Program

Dear Chairman Kotowski and distinguished members of the House Health, Human Services, and Elderly Affairs Committee:

Thank you for accepting my written testimony. My name is Erica Hochberg. I am a social work student, a mother, an advocate for children and young adults, and a resident of Amherst. I am here today to ask you to support SB 313 Reforming New Hampshire's Medicaid and Premium Assistance Program.

Medicaid expansion supports the New Hampshire economy by providing essential low-wage employees access to affordable healthcare and allowing them to continue to work in the restaurant, home health care, child care and travel and tourism positions that New Hampshire so desperately needs. According to the Kaiser Family Foundation, in 2016, Medicaid and CHIP provided health and long-term care coverage to over 180,000 low-income children, pregnant women, adults, seniors, and people with disabilities in New Hampshire. Medicaid is a major source of funding for safety-net hospitals and nursing homes in the state. According to the National Alliance on Mental Illness, over 23,000 New Hampshire residents have used Medicaid expansion to access substance use disorder treatment. Over 130,000 others have used the program to access preventative care; many of those individuals were then able to return to work. The threats to this program by the American Health Care Act put the lives of our residents, and your constituents, at risk. When funding for expanded Medicaid runs out at the end of this year, an additional 50,000 individuals will be without any medical insurance at all.

In my work with adolescents, young adults and families in southern New Hampshire, I have witnessed first-hand the benefits of Medicaid expansion on the residents of our state. Health care has broad impact on a community. In the Manchester area, many of the families enrolled in parenting education and other support programs fall just above the federal poverty line. Their resources are limited. When they have to choose between food, housing and medical care, food and housing always come first. As a result, otherwise avoidable or easily addressed illnesses and injuries go untreated, often causing additional problems such as economic distress or interpersonal struggles between family members. Access to mental health care and substance use disorder treatment services, in particular, are crucial to the families with whom I have worked.

The impact of physical and mental health goes beyond just the individual. Access to health care affects an adult's ability to work. It affects a child's ability to thrive at school. It affects a

parent's ability to react appropriately to their child. A man with an unmanaged chronic health condition cannot show up at work regularly. He is more likely to use emergency room services in the absence of being able to attend preventative appointments and proactively manage his illness. A woman experiencing untreated major depression may be unable to interact with and care for her children. They may be neglected or abused. They may end up in the foster care system. Some may grow up to experience some of the myriad complications of having survived Adverse Childhood Experiences (ACEs). Research has shown that these complications include chronic health issues and substance use, among other things. Children without access to healthcare may not receive the medications they need to manage their asthma, requiring more frequent hospitalization. Their nutrition may not be adequately monitored. Developmental delays, some easily treated if caught early, may go unnoticed, hindering later learning and development.

There is no question that access to healthcare should be a basic human right. If the value of your constituents' lives is not reason enough to support SB 313, consider the state-wide economic implications of missed work and emergency room visits. Consider the impact of substance use: hundreds of our community members overdosed last year. Consider the impact on the elderly residents who contributed to their communities for years and now can't afford their medications. Consider the impact on the children whose basic needs aren't being met. Consider the ways in which so many of our social and economic issues as a state are interwoven with the mental and physical health of our residents. You have an opportunity to provide a crucial safety net to these families and contribute to the health and economic wellbeing of the state. Please vote favorably on SB 313 to continue funding for Medicaid expansion. Thank you for your time and consideration.

Sincerely,

Erica S. Hochberg, M.A.

Friends of New Hampshire Drug Courts

Drug Courts Work – They Transform Lives

Representative Frank R. Kotowski, Chairman
Health and Human Services & Elderly Affairs Committee

March 20, 2018

Re: Reauthorizing Medicaid Expansion

Dear Chairman Kotowski:

On Behalf of the Board of Directors of the Friends of New Hampshire Drug Courts, I want to advise that we are in full support of Medicaid Expansion in New Hampshire. This is a highly cost-beneficial program that serves low-income Granite Staters. In addition to the clear financial justification, the non-financial benefits to the families in this segment of the state's population are substantial (arguably immeasurable).

Medicaid Expansion is New Hampshire's number one tool in our fight against addiction. The program has more than doubled the state's substance use disorder treatment capacity. In 2013 the state had a treatment capacity to serve between 4,000-6,000 individuals – in 2016 that number rose to more than 12,000. Now more then 23,000 individuals have used Medicaid Expansion to access substance use disorder services. Additionally, Medicaid Expansion has prevented health care premiums from rising by drastically reducing the number of uninsured patients seeking care in emergency rooms.

The Friends of New Hampshire Drug Courts are advocates for statewide Drug Courts. When we speak in support of Medicaid Expansion, we speak in support of statewide drug courts. **The statewide drug court program cannot exist without the continuation of Medicaid Expansion.** Medicaid Expansion provides needed health coverage to more than 90% of New Hampshire Drug Court participants. Without this coverage, these programs would no longer exist.

PO Box 326, North Haverhill, NH 03774
Email - info@friendsofnhdrugcourts.org . Website - www.friendsofnhdrugcourts.org

Drug courts are essential to New Hampshire's ability to fight the substance misuse crisis. These programs are evidence-based and effective ways to help people access necessary resources, and reduce the costs associated with incarceration.

Some of the evidence of the success of New Hampshire Drug Courts includes:

- In 2017 the active drug courts served almost 300 individuals.
- In 2014 there was a 10 year recidivism study of New Hampshire Drug Courts; they found 22% recidivism 3 years post-graduation. The current national average is 70%.
- 8 babies were born to sober mothers in NH Drug Court programs in 2016.
- 99% of drug court participants are insured during the program.
- 90% of graduates were employed at the time of graduation from the program.
- Since the drug court program started in New Hampshire in 2004, there have been 352 graduates.
- In 2016 New Hampshire passed a bill to fund and operate a drug court in every superior court in the state. By April of 2018, there will be a drug court in 10 of 11 superior courts.

On behalf of the Board of Directors of the Friends of New Hampshire Drug Courts, I want to once again strongly express our full support for Medicaid Expansion as well as the statewide Drug Court Program. We urge the state legislature to pass this legislation so both programs may continue.

Sincerely,

Ed Rajsteter, President

Carrie Duran
Wolfeboro, NH
NHHPP Beneficiary
House Health, Human Services, and Elderly Affairs Committee
Public Hearing on the New Hampshire Health Protection Program

March 20, 2018

Thank you for the opportunity to tell my story.

My name is Carrie Duran, I am from Wolfeboro, New Hampshire, and I am currently on the New Hampshire Health Protection Program.

I went for a long time without any health insurance due to my low income. I can only work 20 hours a week because I am a single mother, and one of my three children has significant medical needs which require frequent appointments and trips to specialists outside of town. My daughter, Katie has Down syndrome. My father was diagnosed this past year with Alzheimer's and I am now his guardian and caregiver.

When the Affordable Care Act was first implemented, and I found out health insurance was required, I tried to buy it through marketplace, but was then told that my income was too low. After being referred to the New Hampshire Health Protection Program I was thrilled to find out that I could be fully covered for the first time through this program.

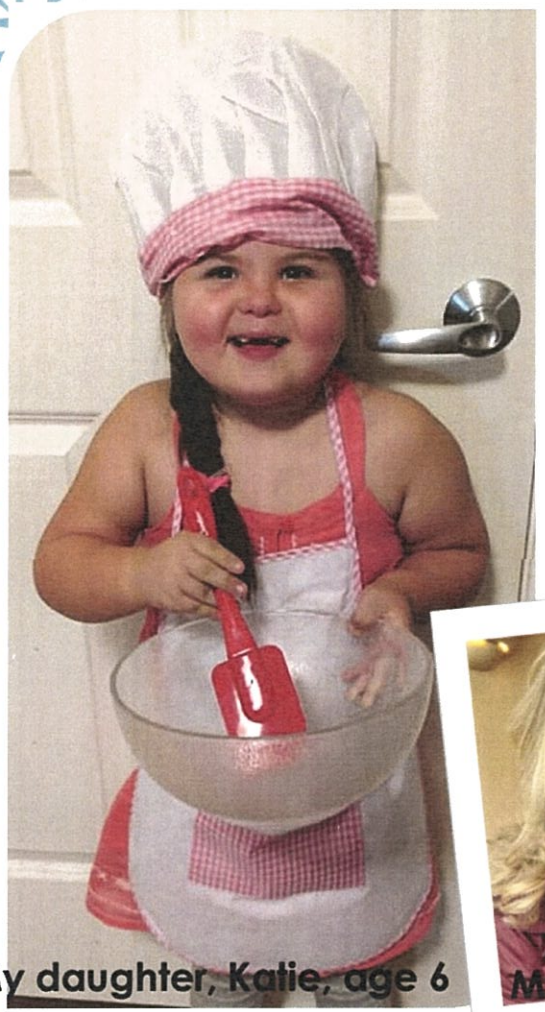
Thanks to the New Hampshire Health Protection Program I am now able to take care of my medical needs such as physicals and preventative care, which I had been putting off previously due to my lack of insurance. I am extremely thankful that I have access to primary and preventative care so that I can be around longer for my children and continue to assist my father. I've attached photos of them with my testimony today. As you can see I have a lot to stay healthy for!

I know that I will be able to pull myself out of this situation, but I need the assistance for a short time. I moved back to New Hampshire with my children after my marriage ended. On top of being a single mother of three, I am a teacher and a full-time student pursuing my credentials in special education. In 2015, I graduated from the New Hampshire Leadership program through the Institute on Disabilities at the University of New Hampshire.

I wanted to make sure my story was heard today because I know there are thousands of hard working Granite Stater's who share a similar story. They are trying to live with dignity and provide for their families. Like me, many others on the program love living in New Hampshire because of all the great things the state has to offer. I hope the New Hampshire Health Protection Program is reauthorized and continues to be something that we are proud of and is something that shows the compassion and wisdom we, as Granite Stater's, are known for having..

Thank you for your time.

Carrie Duran
Wolfeboro, NH



My daughter, Katie, age 6

Down syndrome diagnosis.

Please support Medicaid Expansion to assist Carrie in staying healthy, so she may continue to care for her beloved family.

Thank you!

The Duran Family - Wolfeboro

My father Len. Age 70.

Alzheimer's diagnosis

Randy Robbins
Boscawen

Testimony for Health, Human Services, and Elderly Affairs Committee

March 20, 2018

To the Committee:

I, Randy Robbins, wanted to thank Medicaid for being there in desperate times. I've been suffering from alcoholism for 30 years. I've been chronically homeless, mostly due to my drinking problem. I was living on the streets at the age of 45. I hit a very bad bottom where I lost the choice to drink. I would need medical detox. I would ask for help at the hospital. They would give me an IV bag and send me on my way. I got very frustrated with that. I knew I needed more help than that or I was going to die. Thanks to Medicaid, I was able to get into a 28-day program that got me on the right path to recovery to give me a chance at a sober life. I hope this will be able to help other people that suffer from addiction. It was there to save my life, hopefully there to save another.

Thank you.

Randy Robbins
Boscawen

Thomas Harris
Woodsville
Beneficiary

Testimony for Health, Human Services and Elderly Affairs Committee

March 20, 2018

I got signed up while the prison in 2016 and then got into treatment after prison. I spent 4 and a half years in Concord. I could have gone to treatment instead of prison, but I couldn't afford treatment. The same thing happened to me in 2012. I served twice for the same charge - federal and state. I paid out of pocket for Phoenix House. I used just as heavy in prison as I did on the streets.

I have a five year old son. I missed 2 years with him because I was in prison. I was charged as an adult at age 16.

Now, I am in recovery.

Sincerely,

Thomas Harris
Woodsville, NH

Nikki Casey
Nashua, NH
Testimony for House HHS Hearing re: Medicaid Expansion

March 20, 2018

To the Chairman and members of the committee:

My name is Nikki Casey and I am a woman in long term recovery from drugs and alcohol. I was struggling with a misdiagnosed mental illness and battling my addiction but didn't seek help out of fear of losing my health insurance. Needless to say I ended up losing my job and insurance due to all of the issues I was struggling with. I was now jobless, had no insurance and became increasingly more ill. I was hospitalized twice in a two week span and spent seven days at a crisis center for attempting to commit suicide.

I was able to get enrolled into Medicaid. Because of being on Medicaid I was able to get into Farnum Centers 28 day program. I was also able to get the medications I needed at the time. From there I went on to transitional living and then sober living. I was able to get stabilized and put my life back on track.

I became the house manager of the sober living house, became a recovery coach for an in-home addiction program, and am now currently a Director of a recovery center in Nashua. I now see on a daily basis the need for health insurance for people who normally would not have access to it. It is incredibly challenging in early recovery to maintain a job if you aren't getting the proper care you need. It becomes a cycle. You can't work at a job that provides health insurance because you are too sick due to lack of health insurance and treatment.

Access to healthcare is an essential piece of the puzzle for the entire state. These issues of substance abuse, mental health, and housing will create a ripple effect across the state. It's not an isolated issue or even just a community issue. This is a statewide issue and prevention is our greatest hope. With accessible healthcare we can prevent to go even further into this opioid crisis we can no longer deny.

Nikki Casey
Nashua

March 18, 2018

RE: SB 313-FN reforming New Hampshire's Medicaid and Premium Assistance Program

Dear House Health, Human Services, & Elderly Affairs Committee:

My name is Cathy Smith and I am the Director of Quality Improvement and Population Health at Goodwin Community Health. I also oversee the Strafford County Regional Public Health Network. At Goodwin we provide primary care, oral health care, substance use disorder treatment, and behavioral health services to over 10,000 patients at our Somersworth location. The New Hampshire Health Protection Program has changed the lives of our patients and our health center. Before the Health Protection Program existed, many of our patients did not have health insurance simply because they could not afford it. Our community health center offers our patients a sliding fee discount, which means patients pay based on their income, but not every doctor or lab does this. The New Hampshire Health Protection Program means our patients can access prescription medicines, lab work, and radiology services that they could not afford or access otherwise.

The New Hampshire Health Protection Program is also good for businesses, including our community health center. Since 2014, the year the Program began, we have had a reduction in uninsured patients and a reduction in sliding fee discounts. We were able to use the increase in patient revenue to expand services, increase hours of operation, and hire more staff, expanding access to health care services.

Also, as you may know, the most recent NH County Health rankings indicate Stafford County is 8/10 for health outcomes. The good news is that uninsured dropped to 11%. Access to health care has improved throughout the state as a result of the New Hampshire Health Protection Program.

I ask that you pass SB 313 because the New Hampshire Granite Advantage Health Care Program will allow our patients, businesses, and state to stay healthy. Please feel free to contact me if you have any questions at 603-516-2564.

Sincerely,

Cathy Smith, MSN, RN

Jennifer Bordis
37 Waterford Drive, Sandown, NH
jbordis@comcast.net

My husband and I have three young children 7 and under. At birth, my oldest child was diagnosed with Trisomy 21 which is commonly referred to as Down syndrome. I made the decision to resign from my job as an elementary school teacher to take care of her. In the first few years of her life, my daughter had doctor appointments several times a month to check for and monitor common health complications that come with her diagnosis. At one point, my daughter saw 18 different specialists, and each visit came with a co-pay and other expenses.

We have been fortunate that my husband has earned enough to cover our living expenses, but we would not have been able to cover all of our increased medical costs without the Medicaid expansion. Through Medicaid, my daughter receives occupational and physical therapy. Over the past few years, we have watched her learn new skills and make tremendous advancements navigating her environment safely, becoming more independent with self help skills, and regulating her sensory system which all help her to learn side by side with her peers in a general first grade classroom. Without Medicaid as a secondary insurance, we would not have been able to pay for the hundreds of dollars of co-pays each month for these life-changing therapies.

My daughter is currently only eligible for Medicaid through the expansion, so if the expansion ends, her insurance will also end. The insurance offered through my husband's employer does not cover any occupational or physical therapy for a child with a developmental disability. She would lose all of the therapies that help her navigate her world.

My husband and I have worked our entire adult lives. We pay taxes, and we contribute to the community that we live in. We didn't ask to have a child with medical complications. We don't want to need to use our insurance, but this is why insurance exists. Nobody should have to choose between paying for food and paying for therapy for a child. Nobody should have to choose between paying for a doctor's visit and paying rent. This isn't just about me and my family. Every single person listening today knows a person, like my daughter, with a pre-existing condition. Every person listening today has someone close to them that will get sick in the future and need to use insurance, preferably without astronomically high co-pays and deductibles. The Medicaid expansion made that possible for us. Thank you.

Ryan Emerson
Boscawen

Testimony for Medicaid Expansion for House Committee

March 20, 2018

I got enrolled and got insurance during the second week of a 28-day program at Phoenix House. I struggled with addiction for 7 or 8 years. I was about to be homeless; I lost my job and apartment. I went to respite at Phoenix House, and then I came to the Homestead Inn. I'm still enrolled in the program.

It got me into Phoenix House, then Homestead Inn. It probably saved my life. I'm working now. I've lived at Homestead for 2 months. I have a sponsor; I go to AA every day. I've been sober for 4 months. Now I'm in recovery because of Medicaid. I don't know where I'd be without it.

Ryan Emerson

Jesse M. French
Boscawen, New Hampshire

Testimony for House Health, Human Services, and Elderly Affairs Committee

March 20, 2018

I enrolled in Medicaid Expansion in Claremont, NH at DHHS. I enrolled in August 2017. I have used it at Claremont Hospital for emergency care. I have also used it for detox and a rehabilitation program. I'm still in the program.

It means that I now have a second chance on life, literally. If not for this coverage, I wouldn't be here to talk about it. I just started working again.

Jesse M. French
Boscawen, New Hampshire

Daniel Carr
Boscawen, NH

Testimony for House Hearing
Health, Human Services, and Elderly Affairs Committee

March 20, 2018

I was enrolled in the NHHPP when I came to the safe station in Manchester New Hampshire. I enrolled 11/15/17. I had to enroll in order to get the help I needed. By enrolling I was able to save my life. I am still currently in the program at this time. Having affordable healthcare allowed me to go back to my family as a whole person.

My son gets a better dad and I am able to love and appreciate my wife the way she deserves. I was able to gain employment while on the program.

Daniel Carr

NEW HAMPSHIRE NURSES' ASSOCIATION

25 Hall St. Unit 1E, Concord, NH 03301
PHONE: (877) 810-5972 Ext 701
EMAIL: office@nhnurses.org
WEBSITE: www.NHNurses.org

Written Testimony for Hearing on SB 313
March 20, 2018

SB 313: AN ACT reforming New Hampshire's Medicaid and Premium Assistance Program

- New Hampshire Nurses Association (NHNA) represents more than 24,000 nursing professionals in the state of New Hampshire.
- Nurses represent the largest group of health care workers. We see patients every day that have benefited from Medicaid and the New Hampshire Health Protection Program.
- Nurses care for patients that are able to access care for their substance use disorders because of Medicaid Expansion.
- Nurses care for patients that have improved access to behavioral health services as a result of Medicaid Expansion.
- Nurses care for patients that no longer have to take their daily medications every other day because they can better afford them through Medicaid Expansion.

- On January 23, 2018 NHNA held its annual Legislative Town Hall Forum via webinar to nurses and nursing students across this state. During this event we presented various bills that the NH legislature is considering during the 2018 legislative session which will impact nursing practice or healthcare.
- Supporting the reauthorization of Medicaid Expansion was voted the number one priority by the NH nurses participating in this forum.
- These nurses are your constituents. Nurses understand the value of Medicaid Expansion toward improving access to quality healthcare in New Hampshire for all our patients.
- Nurses understand the critical role that Medicaid Expansion performs in New Hampshire's healthcare system: improving patient access, ensuring providers receive payment for services provided and reducing the amount of uncompensated care.
- Nurses support the passage of a Medicaid Expansion reauthorization bill.
- New Hampshire Nurses Association supports the passage of SB 313.

Presented by Joan Widmer, MS, MSBA, RN, Nurse Executive Director, New Hampshire Nurses Association

BI-STATE PRIMARY CARE ASSOCIATION

SERVING VERMONT & NEW HAMPSHIRE
Improving Access to Health Care for 32 Years
bistatepca.org

March 20, 2018

Representative Kotowski, Chairman
House Health, Human Services, and Elderly Affairs Committee
Legislative Office Building, Room 205
Concord, NH 03301

RE: SB 313-FN reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds

Dear Representative Kotowski and members of the Committee:

Thank you for the opportunity to submit testimony in support of SB 313-FN, which establishes the New Hampshire Granite Advantage Health Care Program and will provide health insurance coverage to individuals living at or below 138% of the federal poverty level. We respectfully request that you recommend SB 313 "ought to pass" in order to protect the Granite State's access to health insurance coverage.

Bi-State is a non-profit organization that advocates for access to primary and preventive care for all New Hampshire residents with a special emphasis on the medically underserved. We represent New Hampshire's 16 community health centers, which are located in medically underserved areas throughout our state. All community health centers are non-profit organizations that provide integrated oral health, substance use disorder treatment, behavioral health, and primary care services to patients regardless of insurance status or ability to pay. New Hampshire's health centers care for more than 113,000 patients, most of whom live below 200% of the federal poverty level or $24,280 annually for an individual.[1] The New Hampshire Health Protection Program, or Medicaid expansion, has been the single most effective piece of legislation at expanding access to health insurance coverage and health care to low income New Hampshire residents.

Since August 2014, more than 130,000 unique individuals have accessed health insurance coverage through the Program.[2] In addition, the percentage of uninsured patients treated by the federally qualified health centers (FQHCs), a subset of the CHCs, decreased from 19.5% to 14.5% from 2014 to 2016.[3] The number of patients served by the FQHCs increased by over 5,000.[4] The Program is one of the most important tools our state has to increase access to behavioral health and substance use disorder treatment, which is critical during the opioid crisis. According to FQHC data, the number of patients who accessed behavioral health services increased by almost 2,300 patients in two years.[5] The number of patients who accessed substance use disorder treatment at FQHCs increased by over 200 patients.[6] Nine of the FQHCs currently offer medication assisted treatment, and the remaining three FQHCs are in the process of establishing programs.[7] Patients who access MAT and other substance use disorder treatment services at health centers also receive behavioral health services, care management services, and other supportive services designed to increase access to care. It is unlikely that health care providers, including the

[1] Health Resources and Services Administration, Uniform Data System, NH Rollup (2016); BSPCA Survey of Membership (2016).
[2] NH DHHS, *NHHPP Premium Asst. Prog.*, 16 (2016).
[3] Health Resources and Services Administration, Uniform Data System, NH Rollup (2016).
[4] Health Resources and Services Administration, Uniform Data System, NH Rollup (2016).
[5] *Id.*
[6] *Id.*
[7] BSPCA Survey of Membership (2017).

community health centers, could have expanded substance use disorder treatment and behavioral health services but for the existence of the New Hampshire Health Protection Program because of a lack of reimbursement for those services. Because adequate reimbursement is such an important issue for continuation of services, we want to highlight a couple of concerns we have with SB 313 as currently drafted.

We have concerns regarding the funding mechanisms included in SB 313-FN, specifically pertaining to the use of monies in the Alcohol Fund. We agree that the use of the fund is appropriate given the utilization of substance use disorder treatment by Medicaid expansion enrollees; however, the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery funds many programs throughout the state and we do not want to see those programs end if there were a lack of "federal or other funds available from within the department of health and human services."[8] Medicaid does not pay for the development of treatment and recovery programs, making the grants available through the Commission critical to the creation and sustainability of substance use disorder treatment programs. In addition, the FQHCs were recently notified by the Department of Health and Human Services that they would receive a substantial reduction in their reimbursement rates for MAT. While we are working to resolve this issue with DHHS, we bring this to your attention to highlight the important role each funding source has for health care providers in our state, particularly when we are trying to increase access to SUD treatment during an opioid epidemic.

Bi-State is also concerned with the work requirement provisions included in SB 313. Any amendment to our Medicaid program through a waiver should "increase and strengthen overall coverage of low-income individuals" in New Hampshire.[9] We want to ensure that any work requirement included in the New Hampshire Granite Advantage Health Care Program does not cause people to lose access to health care because a lack of access to health care can cause a barrier to employment. Research indicates that connecting vulnerable populations with needed care improves employability by providing recipients with stability.[10] Health insurance helps individuals address the barriers to their employment, including the stress of not being able to go to the doctor or pay medical bills; behavioral health conditions; or lack of access to childcare and transportation.[11] The exemptions and exceptions included in the work requirement provisions should reflect New Hampshire's priorities and the lives of Granite Staters. We are grateful that the bill includes the opportunity for DHHS to consider real-life situations, especially given the cost of and lack of access to childcare in our state.

Community health centers see firsthand how important access to health insurance coverage is for their patients. Bi-State and our members want to ensure this program continues, and we want to continue to work collaboratively on a New Hampshire solution to our Medicaid expansion program. For these reasons, we respectfully request that you support access to health insurance coverage and recommend SB 313 "ought to pass." Please feel free to contact me if you have any questions or would like additional information on the community health centers.

Sincerely,

Kristine E. Stoddard, Esq.
Director of NH Public Policy
603-228-2830, ext. 113
kstoddard@bistatepca.org

[8] SB 313-FN, page 15 lines 14-15 (2018).
[9] *About Section 1115 Demonstrations,* https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (last visited Sept. 26, 2017).
[10] *See* Center on Budget and Policy Priorities, *Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment* (July 13, 2017).
[11] *See id.*

AARP Real Possibilities in New Hampshire

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TESTIMONY OF AARP NEW HAMPSHIRE

REGARDING

SENATE BILL 313

AN ACT REFORMING NEW HAMPSHIRE'S MEDICAID AND PREMIUM ASSISTANCE PROGRAM, ESTABLISHING THE GRANITE WORKFORCE PILOT PROGRAM, AND RELATIVE TO CERTAIN LIQUOR FUNDS

BEFORE

THE HOUSE HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS COMMITTEE

CONCORD, NH

March 20, 2018

Good morning. I am Todd Fahey, State Director of AARP New Hampshire. AARP is the nation's largest nonprofit, non-partisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. On behalf of the nearly 40 million members nationwide and more than 230,00 members here in the Granite State, thank you for the opportunity to speak today. We are here today to urge you to favorably pass **Senate Bill 313.**

According to a Demographic Profile of the New Hampshire Health Protection Program prepared by the New Hampshire Department of Health and Human Services, there were some 53,357 people enrolled in this program as of February 1, 2018. Among those numbers, 32% of them were above the age of 45. See attached Exhibit A. Drilling down further, 17% of them were between 45 and 54 year old and 15% were over the age of 54. This group is unique in three key ways: (i) because of the onset of certain health conditions at this time of life particularly for those with low incomes; (ii) because, in many cases, many of these people are working and are among – or soon will be among – New Hampshire's 173,000 working family caregivers, and; (iii) because health insurance is age rated meaning an older person may have to pay as much as three (3) times the premium that a younger person would have to pay. This makes it difficult for people in this age group to afford health insurance at a time when it is important to be covered. Providing coverage provides various direct and indirect benefits.

Age-Related Health Changes:

While all Americans are now living longer, the prevalence of chronic conditions increases during midlife. It goes without saying that treating chronic conditions makes more sense than not and that this program permits treatment to occur. Uninsured people with chronic illnesses are less likely to receive the care they need to manage their health conditions than their insured counterparts. Sick people become less productive, increasingly less able to care for themselves, and simply more expensive to care for as they become sicker.

Earlier interventions with health care for those who are not eligible for Medicare (under 65 years old) *and* who are eligible for those program often are likely to become the "dual eligibles" which means they will depend upon Medicare for their primary and acute health needs (hospital, physician services, laboratory and x-ray services) *and* on Medicaid for help with their Medicare cost sharing and the long-term service and supports (LTSS) needs. Again, providing access to this program (and its health care provisions) now will yield dividends later at our population ages.

Working Caregivers:

It is no secret that New Hampshire is an aging state with 2.6% unemployment. A 2013 AARP study estimated that – nationwide - close to 40% of those eligible for this program are already working. Of course, access to the type of care this program provides will permit them to remain employed, which is a key consideration in a state that wants and needs to grow its economy, has thousands of unfilled jobs and is facing the band of workers – those 65 to 75 – most readily able to fill many of them. It makes economic sense for us to do everything we can to fortify our workforce, particularly at the older end of it, by providing sensible access to healthcare so that they can, indeed, go to work and stay employed. And, (in many instances) once they finish working at their jobs - thus helping themselves and our economy - many provide countless hours of care (without pay or burden on the state) to their loved ones.

Direct and Indirect Benefits of Insuring this Group:

Due to age rating, obtaining health insurance can be cost prohibitive for older people of lower income. Hence, they either go without care this should have or they, as a last resort, head to our state's emergency rooms to receive care that (had they received preventative care beforehand) could have prevented the trip in the first place. Such previously uninsured Granite Staters now have, on account of this vital program, health coverage needed to be seen by a primary care doctor or in a health clinic, the ability to obtain primary and preventative care, cost-effective management of chronic conditions and life-saving mental health and substance abuse treatment. We do need to celebrate, support and care for our older residents. Continuing this program is one way critical way to do that.

We respectfully encourage this committee to consider this critical cohort, continue this program and build upon prior successes over the next five years. Thank you for your kind attention to this important matter.

Respectfully submitted,
AARP New Hampshire

By: _____

Todd C. Fahey, J.D.
Its State Director
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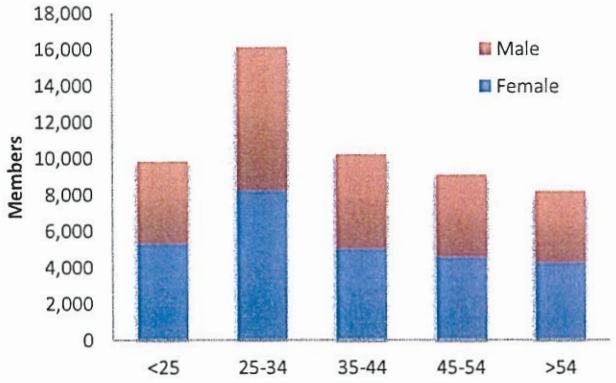
(603) 230-4109 (direct) / (603) 738-0346 (mobile)

EXHIBIT A

NH Health Protection Program Demographic Profile, 2/1/18

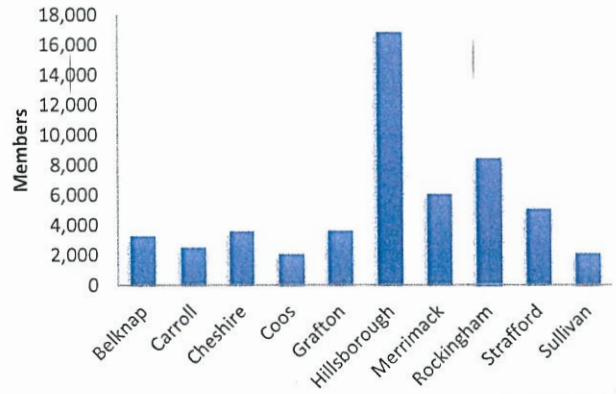
Data Source: 2/2/18 extract from MMIS

Enrollment by Age Group and Gender



Members	Gender			Age
Age Group	Female	Male	Total	Percent
<25	5,292	4,502	9,794	18%
25-34	8,224	7,875	16,099	30%
35-44	5,046	5,153	10,199	19%
45-54	4,595	4,494	9,089	17%
>54	4,286	3,890	8,176	15%
Total	**27,443**	**25,914**	**53,357**	
Gender Percent	51%	49%		

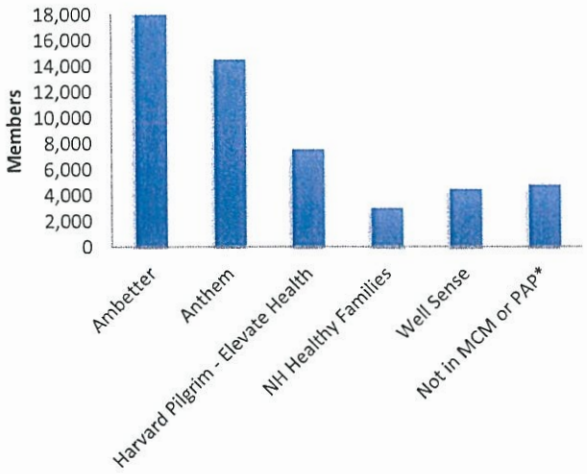
Enrollment by County



County	Members	Percent
Belknap	3,247	6%
Carroll	2,523	5%
Cheshire	3,527	7%
Coos	2,046	4%
Grafton	3,579	7%
Hillsborough	16,831	32%
Merrimack	6,028	11%
Rockingham	8,417	16%
Strafford	5,051	9%
Sullivan	2,094	4%
Total*	**53,343**	

*Excludes members with unknown county

Enrollment by Health Plan



Health Plan	Members	Percent
Ambetter	19,033	36%
Anthem	14,480	27%
Harvard Pilgrim - Elevate Health	7,540	14%
NH Healthy Families	3,033	6%
Well Sense	4,486	8%
Not in MCM or PAP*	4,785	9%
Total	**53,357**	

* Members not yet in a plan are in their initial plan selection window, waiting until the first of the month to join a plan, or are in the Health Insurance Premium Payment part of NHHPP. Members in Medicaid MCOs are either medically frail or are in their PAP plan selection window after having migrated from a standard Medicaid category to NHHPP.

AMMONOOSUC COMMUNITY HEALTH SERVICES, INC.

March 12, 2018

Dear Sir or Madam,

I am writing to you on behalf of our Board of Directors, our staff, and the over 10,000 patients to whom we provide primary medical, behavioral, pharmacy, oral health, and enabling care services. Ammonoosuc Community Health Service, Inc. (ACHS) is a Federally Qualified Health Center serving the North Country since 1975. We provide integrated primary preventive health care services to 1 in 3 of the 31,000 residents who live in the 26 towns that comprise our service area.

We have taken the time to ask our patients to voice their opinion regarding the importance of our elected representatives investing in primary preventive healthcare such as that offered by ACHS. Attached you will find a petition where over 1,600 ACHS patients have provided their signature attesting to the following three points:

- *First, we are writing in appreciation of your continued bi-partisan support of Federally Qualified Health Centers in general and for Ammonoosuc Community Health Services in Specific.*

- *Second, we are writing to let you know we realize the economic challenges we are all facing to balance individual, local, state, and federal budgets.*

- *Third, we are requesting that you give thoughtful consideration to your budget deliberations and continue to make investments in primary preventive healthcare through Federally Qualified Health Centers such as Ammonoosuc Community Health Services. This is an investment into an efficient and effective means of ensuring citizens are healthy. Healthy citizens are the solution to job growth and economic development.*

We thank you in advance for your making an investment in job growth and economic development that will keep your community and constituents healthy and employable what better way to say, "I understand why you elected me to office" than to invest into healthy people; healthy people who will grow our economy.

We believe SB 313 New Hampshire Granite Advantage Health Care Program is just such an investment.

The New Hampshire Granite Advantage Health Care Program will enable ACHS to demonstrate significant outcomes, as we did with the NH Health Protection Program, in three areas. These areas are consistent with the Centers for Medicare and Medicaid Services (CMS) Triple Aim.

First ACHS *demonstrated enhanced patient experience* outcomes as follows.

- ACHS was first recognized as a National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) at the highest level 3 in 2009. As a PCMH, ACHS integrates medical, behavioral, pharmacy, nutrition, dental, vision, and enabling patient navigational services including medical / legal partnership.

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- A NHHPP patient was addicted to heroin for several years. She accessed detox, rehab, primary care, counseling, and now long term residential care. She is thriving and learning the life skills and stress management to enter the work force and to parent again.

- A NHHPP patient who is a self-employed general contractor with very rare office and a number of emergency department (ED) visits for chest pain due to uncontrolled hypertension. The patient had an average blood pressure (BP) a year prior to NHHPP of 152/95 (max 170/104); average BP after NHHPP was 119/75 (max 128/77). Investment of $216 for each of two offices plus meds costing ~$12/month. Savings to system- no ED visits at $2,168[6]. no myocardial infarction, no stroke, avoiding hospitalizations at $2,412[7] which allows him to care for his disabled wife with lung cancer, in addition to working full time and employing his son.

- A NHHPP patient who is 20 years old and an expectant father experiences depression, ADD, explosive disorder. His score for depression as measured by the PHQ 9 went down from 18 to 0. He has no trouble with law. He had six ED visits ($13,008) 2013, one 2014 ($2168), none so far in 2015. H has no self-injurious behavior past 18 months.

- A NHHPP patient who is a 32-year-old mom, no health care from last postpartum visit in 2012 (Pre-NHHPA) until preventative visit Jan 2014 (NHHPP). Breast lump addressed (benign), Pap/HPV co-test done. Partner referred for vasectomy.

- A NHHPP patient who is a diabetic. Hb a1c down from 13.4 on 11/1/13 to 7.9 on 3/4/14 and thus avoids ED visit and potential hospitalization.

- A NHHPP patient addicted to heroin worked with an ACHE Patient Navigator. The patient has been in transition, moving to sober living in Manchester, NH, for a 3 month stay. Patient maintains sobriety. The journey has been arduous: 1) Cottage Hospital ED for heroin withdrawal and suicide ideations 2) Medical detox at Serenity House in Manchester with continued rehabilitation 3) Follow-up with primary care and Licensed Alcohol Drug Councilor 4) Access to NA and AA 5) Placement in residential care for more intensive counseling and life skill building. Patient will access some much-needed dental care (sliding-fee-scale discount eligible in that NHHPP does not provide an adult dental benefit) at ACHS clinic when she completes her transitional living care.

- A NHHPP patient who is a 31-year-old mother of three was addicted to heroin for a couple years after a back injury. Patient wanted to get into treatment. Went to Friendship House and got clean. Came out and only because of NHHPP was she able to follow through with counseling, and get on naltrexone which is an opioid blocker. Patient is now caring for her children and has a fulltime job. Reduced cost of: include and are not limited to possible foster care for children in some circumstances, treating her for Hepatitis C or HIV, and now is a contributing member of society and a tax-paying citizen.

---

[6] How Much Does It Cost to Go to the ER?, Lindsay Abrams, February 28, 2013, http://www.theatlantic.com/health/archive/2013/02/how-much-does-it-cost-to-go-to-the-er/273599/

[7] Average cost per inpatient day across 50 states, Emily Rappleye, May 19, 2015, http://www.beckershospitalreview.com/finance/average-cost-per-inpatient-day-across-50-states.html

- A NHHPP patient who is a 55-year-old with coronary disease that every time he goes off his medications he has a tens of thousands of dollars helicopter ride to Dartmouth Hitchcock Medical Center for a stent. The patient shifts between NHHPP and Health Insurance Marketplace plans because he is self-employed and has income fluctuations. He still experiences some disruptions in care and this is an opportunity to have a smoother transition for patients who have this experience.

On behalf of our ACHS Staff, our Board of Directors, and the patients we serve, I thank you for your thoughtful consideration of the New Hampshire Granite Advantage Health Care Program.

SB 313 New Hampshire Granite Advantage Health Care Program will improve our community's access to primary and preventive care and it will improve access to care statewide.

We know that health insurance coverage allows New Hampshire residents to manage chronic diseases, lowers out-of-pocket expenses, and reduces mortality rates.

Be mindful, be active, and be well,

Edward D Shanshala II, MSHSA, MSEd
Chief Executive Officer, ACHS
603/991-7756
Ed.Shanshala@achs-inc.org

Douglas Harman
Board President, ACHS
603/991-8179
Harman.dc@gmail.com

TABLE OF CONTENTS

AMMONOOSUC COMMUNITY HEALTH SERVICES, INC.

"I truly don't know what we would do if we lost Medicaid"

Jessica Brooks, mother of Zach, age 3, with Downs Syndrome

One week after Zach was born, the Brooks family found out he had Down's Syndrome. Luckily, the family qualified for Medicaid, enabling them to afford the initial EEG which led to Zach's infantile spasm diagnosis. Recently denied Social Security Insurance, Jessica who works in human services, has had to get a second job to make ends meet. She worries everyday about losing Medicaid – her lifeline for doctor and specialist care for Zach. She says, "I don't think people know how much goes into the care of a child with special needs, and how much it costs to get that care. I don't know what we would do if we lost Medicaid."

"After my brain aneurysm and multiple brain surgeries, I am left with double vision and cannot work. Medicaid, helps me get the medical care I need, so at least I still can still care for my son."

Ken Kimball, TBI survivor, age 49

Ken was 39 and employed as a graphic designer when he had a brain aneurysm and was helicoptered to Dartmouth Hitchcock Medical Center for multiple brain surgeries. He underwent months of rehabilitation to learn to walk and talk again. Today, he has made a tremendous recovery, but still has lingering effects from the injury – including permanent double vision, vertigo and cognitive deficiencies. Unable to work, he relies on Medicaid for his ongoing health care. On his limited income, he simply would not be able to make it without Medicaid.

"Without the help from Medicaid as a young mother, I would not have been able to make ends meet, nor complete my education"

Lisa Bujno, Assistant Medical Director and former Medicaid recipient, age 58

Lisa was a young single mom, when she relied on Medicaid to help her and her daughter receive affordable health care. With this support, she could complete her education and go on to obtain her nurses license, so she could serve others in health care. Now an APRN, Lisa is the Assistant Medical Director at Ammonoosuc Community Health Services. Prior to that she worked as a program manager for the Veterans Administration. Her temporary reliance on Medicaid, had a remarkable impact on her life.

"Jim can now get the diabetes and eye care he desperately needs"

"Jim", NHHPP recipient, age 56

"Jim" is a 56-year old diabetic male. Recently, he lost his job after 30 years. With no 401k, no pension and no health insurance, he developed depression. ACHS was able to help him apply and get on NHHPP, which has been very beneficial for him. He is now able to get much needed health care for a variety of needs related to his diabetes, including eye complications and is now able to see behavioral health specialist.

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Roberto lost NHHPP because his disability income was just a mere $148 over the limit

"Roberto" became disabled due to medical conditions and was unable to return to work. While he qualified for Social Security disability, he lost NHHPP because his disability income is over the criteria by a mere $148.

In rural Coos County, Al uses NHHPP to get to his eye appointments"

"Al" is legally blind and unable to drive. With limited family around to assist him, he was able to utilize the transportation component of NHHPP to get to and from appointments. This was a huge benefit to the patient as he lives in rural Coos County where there are minimal public transportation options, and the out of pocket rate of a ride service is $1.60/mile. Transportation through NHHPP is the only affordable option for Al.

"Medicaid...is literally keeping me alive"
"Stan", Medicaid recipient, Age 59

"Stan" is a 59-Year old male with many chronic conditions including, Diabetes, High Cholesterol, Hypertension and a Vascular leg issue for which he needs surgery for. He has a SafLink phone and has accessed Medicaid for transportation, imaging, medication, physical therapy and specialty care. He credits Medicaid and Food stamps for "Literally, keeping me alive.".

"What a life-changer... I'm a completely different person!"
"Anita", Mom and NHHPP recipient

"Anita" is a patient of Dr. Nelson. She has two children on Medicaid. Her spouse was insured through work but told her it was "too expensive" to add her to his plan and that she was "on her own" for her own bills - refusing to assist her with her healthcare costs. She has severe anxiety and depression but could not afford her medications or mental health appointments. She has since divorced her husband and become eligible for NHHPP. This has been a life-changer for the patient as she can now access the services she needs on a regular basis and is able to get and take all her prescribed medications. This has increased her over-all well being and she says she is now "a completely different person!"

Ammonoosuc Community Health Services, Inc.

25 Mt. Eustis Road • Littleton, NH 03561 • 603.444.2464 • Fax 603.444.3441 • www.ammonoosuc.org

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We thank you in advance for your making an investment in job growth and economic development that will keep your community and constituents healthy and employable What better way to say "I understand why you elected me to office" than to invest into healthy people; healthy people who will grow our economy.

PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Gretchen Weiss	Gretchen S. Weiss	Benton, NH
2. Cheryl Marchetti	Cheryl Marchetti	N. Haverhill, NH
3. Amber Carle	Amber Carle	Groton, VT
4. Danny Emerson	Danny L. Emerson	E. Ryegate VT
5. Kimberly Clough	Kimberly Clough	N. Haverhill N.H
6. Karen McNamara	Karen McNamara	Easton, NH
7. Joshua White		Woodsville NH
8. Michele Woolfort	Michele Woolfort	Woodsville, NH
9. Tammie Lyden	Tammie Lyden	Woodsville, NH
10. Diana Jones	Diana Jones	N. Haverhill, NH
11. Florence Jones	Florence G. Jones	N. Haverhill, NH
12. Nadine Cicarella		Bath NH
13. Brandy Helm	Brandy L Helm	Ryegate VT
14. Robert Rockstraw	Robert Rock	Ryegate VT
15. Carrie A Daly	Carrie A Daly	Haverhill NH
16. Violet Veillette	Violet Veillette	
17. Jessica Fiore	Jessica Fiore	Bath NH
18. Betty Dube	Betty Dube	N. Haverhill, NH.
19. Jennifer Lycett	Jennifer Lycett	Gilford NH.
20. Michelle Frost	Michelle Frost	Woodsville NH
21. Patricia Jacobs	Patricia Jacobs	N. Haverhill NH
22. Mary T. Martel	Mary T. Martel	No. Haverhill, N.H
23. Brandi L. Bonner	Brandi Bonner	Benton, NH
24. Elizabeth Peters	Elizabeth Peters	Bath NH
25. Danielle Burnap	Danielle	Woodsville NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Penny Achilles	Penny Achilles	~~Woodsville~~ Groton, VT
2.	Danielle Achilles	Danielle Achilles	Groton, VT
3.	Samantha French	Samantha French	Bath, NH
4.	Sunshine Robles	Sunshine Robles	Woodsville, NH
5.	Lisia Gadoua	Lisia Gadoua	Woodsville, N.H.
6.	Suzanne Morrison	Suzanne Morrison	Woodsville
7.	Patricia. L Jacobs	Patricia L Jacobs	N. Haverhill NH 03774
8.	Kim Lapierre	Kim Lapierre	Monroe, N.H. 03771
9.	Teresa Thibault	Teresa Thibault	Wells River, VT 0508
10.	Jestina O'Dell	Jestina O'Dell	Woodsville, N.H. 0378
11.	Betsy Babcock	Betsy Babcock	Landaff NH
12.	Adam Achilles	Adam Achilles	Groton, VT
13.	Chad Call	Chad Call	East Ryegate, VT
14.	FRANCESCO M PESCE JR		Benton, NH
15.	Miranda Fullerton	Miranda Fullerton	N. Haverhill, NH.
16.	Earl French	Earl French	Bath, NH
17.	Michael Reynolds	M Reynolds	Landaff, NH
18.	Jesse Tyler	Jesse Tyler	Landaff, NH
19.	Peter Stimpson	Peter Stimpson	Northumberland, NH.
20.	David Achilles	David Achilles	Groton VA
21.	MARY L. DIMICK	Mary L. Dimick	McINDOE FALLS, VT
22.	Tina L Champagne		Lisbon NH
23.	Gail Bunnell	Gail Bunnell	Monroe, NH
24.	Michelle D Cote	Michelle D. Cote	Lincoln, NH
25.	Clarissa Hemenway	Clarissa Hemenway	South Ryegate, VT

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Janice Lebron	Janice Lebron	Groton, VT.
2.	Silvestre Lebron	Silvestre Lebron	Groton VT
3.	Jane M. Chamberlin	Jane Chamberlin	Benton, N.H.
4.	Lisa Woodbeck	Lisa Woodbeck	Piermont N.H.
5.	Robert Astle	Robert Astle	Woodsville, NH
6.	Amy Bragg	Amy Bragg	
7.	Rosalie Farr	Rosalie Farr	Haverhill, NH.
8.	Cameron Wood	Cam Wood	Bath, NH
9.	Tori L Dimock	Tori M Dimock	Woodsville NH
10.	Lee Soporik		Woodsville NH
11.	LORI SANTORA	Lori Santora	Bath, NH
12.	Darlene McCrumb	Darlene McCrumb	Bath NH
13.	Bruce Tupper	Bruce Tupper	MONROE N.H.
14.	[redacted] Diane Lord	Diane Lord	Ryegate, VT
15.	Abigail Kennedy	Abigail Kennedy	Bath NH
16.	Linda McLean	Linda McLean	S. Ryegate VT.
17.	Wendy Chamberlain	Wendy Chamberlain	S. Ryegate, VT.
18.	Janet L Moulton	Janet L Moulton	No Haverhill NH
19.	Rebecca L Lynnell	Rebecca L Lynnell	N. Haverhill NH
20.	WANDA L Leonard	Wanda L Leonard	No. Haverhill, NH
21.	Marie D. Lamothe	Marie D. Lamothe	Warren, N.H.
22.	PETER E LAMOTHE	Peter E Lamothe	WARREN N.H.
23.	Leslie Keith	Leslie Keith	Woodsville NH
24.	Jeffrey Fullerton	Jeffrey Fullerton	N. Haverhill NH
25.			

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1. Barbara Fullerton	Barbara Fullerton	N. Haverhill, N.H.
2. SABRINA M. HADLEY	Sabrina M. Hadley	WOODSVILLE, N.H.
3. Norman D Ingalls	Norman D Ingalls	N. Haverhill, NH
4. Lisa Colombi	Lisa Colombi	Dalton NH
5. Deborah Wyman	Deborah Wyman	Haverhill N.H.
6. Chester Wyman	Chester Wyman	Haverhill N.H
7. Jessie Hannon	Jessie Hannon	Barre, VT
8. Lisa Winne	Lisa Winne	Wells River, VT
9. Kristie L. Barnes	Kristie Barnes	Lyman NH
10. Jessica Santiago	Jessica Santiago	Wells River, VT
11. Ally Nihe		Benton NH
12. Angelica Smith	Angelica Smith	Grantham NH
13. DOROTHEA BRAGDON	Dorothea Bragdon	WOODSVILLE NH
14. Holly Dennis	Holly Dennis	Haverhill, NH
15. ALFRED M. LAMARRE	Alfred M Lamarre	Woodsville N.H.
16. Chelsea Fullerton	Chelsea Fullerton	North Haverhill NH
17. Bruce Bishop	Bruce Bishop	North Haverhill NH
18. Dianne Reynolds	Dianne Reynolds	Lincoln, NH
19. BONNIE BRILL	Bonnie Brill	NEWBURY, VT
20. Rachel Sweet	Rachel Sweet	Newbury, VT
21. Cindy Brooks	Cindy L Brooks	Lyman, NH
22. John Adams	John Adams	Littleton NH
23. Shawn Pitts	Shawn Pitts	
24. John Donelin	John Donelin	Bath, NH
25. AMANDA MARSHALL	Amanda Marshall	N. HAVERHILL, NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Carol-Ann S. Blake	Carol-Ann S. Blake	Bethlehem, NH
2.	Craig Giguere	Craig Giguere	Littleton NH
3.	Laurie JACKSON	Laurie Jackson	Bethlehem N.H.
4.	Andrea Huntoon	Andrea Huntoon	Lincoln NH
5.	Connie Wilson	Connie Wilson	Littleton NH
6.	Julie Locke	Julie Locke	Francona NH
7.	Emily Robinson	Emily Robinson	Bethlehem, NH
8.	Ashley Belmore	Ashley Belmore	Littleton
9.	Stephen Hopkins	Stephen Hopkins	Littleton
10.	Lisa Eatmorne	Lisa Eatmorne	Littleton
11.	Brian Call	Brian Call	Littleton NH
12.	James J McGovern	James J McGovern	Lisbon NH
13.	Margaret Gale	Margaret Gale	Bethlehem, NH
14.	William Oliver	William Oliver	Francona NH
15.	Shon Grant	Shon Grant	Lyman NH
16.	Skylar Emmons	Skylar Emmons	Littleton
17.	Emily Russell	Emily C Russell	Bethlehem NH
18.	Gwen Knot	Gwen Knot	Littleton, NH
19.	Kara McNamara	Kara McNamara	Easton, NH
20.	Cassie Audette	Cassie Audette	Littleton NH
21.	DONNA REYNOLDS	Donna Reynolds	Francona NH
22.	Sally Sherrard	Sally Sherrard	Littleton
23.	Ellen Wallace	Ellen Wallace	Bethlehem NH
24.	Jillyan Newell	Jillyan Newell	Bethlehem, NH
25.	Melissa Rose	Melissa Rose	Lisbon NH

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1.	Karen Collman	Karen Collman	Francona NH
2.	Lori Berry	Lori Berry	Guildhall VT 0354
3.	Nancy D Gahm NANCY D. GAHM	Nancy D Gahm	Whitefield NH 03598
4.	James C. Burghoff Jr.	James C Burghoff Jr.	Whitefield, NH 03598
5.	David S Hopkinson	David Stephenson	Whitefield NH 03598
6.	JANICE K. RUTH	Janice K. Ruth	Whitefield, NH 03598
7.	ROGER HUTCHINS	Roger Hutchins	DALTON NH 03598
8.	PATRICIA A CHERRY	Patricia A Cherry	Whitefield NH 03598
9.	SHIRLEY TETREAULT	Shirley Tetreault	Whitefield NH 03598
10.	Lucille Gherardi	Lucille Gherardi	Littleton NH 03561
11.	George Bond	George Bond	Whitefield, N.H. 03598
12.	Michael C Cowell	Michael Cowell	Whitefield NH 03598
13.	William Archibald	William Archibald	Moultonboro NH 03254
14.	William Newsom	William Newsom	Whitefield NH 03598
15.	Virginia A. Glines	Virginia A. Glines	Whitefield, N.H. 03598
16.	Larry Rexford	Larry Rexford	" " "
17.	Michael L. Dickerman	Michael L Dickerman	Littleton, NH 03561
18.	Dianne L Morneau	Dianne L Morneau	Twin Mt., NH 03595
19.	Maynard L'Heureux	Maynard L'Heureux	Whitefield N.H. 03598
20.	Janet Christenson	Janet Christenson	Jefferson, NH
21.	Vivian Roy	Vivian Roy	Whitefield, NH
22.	Evelyn D. Hagan	Evelyn D Hagan	Bethlehem, NH
23.	Laurie Payette	Laurie Payette	Littleton NH
24.	Barry Demers	Barry M. Demers	Littleton N.H.
25.	Rebecca Fenton	Rebecca Fenton	Lyman N.H.

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1. Hanes M. Chase	Hanes M. Chase	Whitefield, N.H.
2. Sandra Gordon	Sandra Gordon	Jefferson, N.H.
3. Heather Potter	Heather Potter	Dalton, NH
4. Gladys Hanks	Gladys Hanks	Whitefield, N.H.
5. ANNIE TERHAAR	Annie Terhaar	Whitefield NH
6. Eva m. Parker	Eva m Parker	39 Huron st Whitefield
7. Judith R. Picard	Judith R. Picard	342 Union Rd, Dalton N
8.		
9. Jenna Currier		Whitefield-26
10. Cynthia Vermette	Cynthia Vermette	Whitefield, NH
11. Gail Cady	Gail Cady	42 Headegmaster Dalton
12. Joseph T. Elgosin	Joseph T. Elgosin	Whitefield, NH
13. Jean L. Bergin	Jean L Bergin	Whitefield NH
14. Red Elk	Red Elk	Jefferson NH
15. Gary Goodness	Gary Goodness	Whitefield, N.H.
16. GERALD HOLMES	Gerald Holmes	Dalton NH
17. Edith Worcester	Edith Worcester	W. Whitefield, N.H.
18. Tiffany Challinor	Tiffany G. Challinor	Whitefield, NH
19. Elyn Packard	Elyn Packard	Dalton NH
20. George E. Moreira, Sr.	George E. Broder	Groton, NH 03593
21. Georgia A. Brodeur	Georgia Brodeur	Carroll NH 03595
22. Kellie Briggs	K. Briggs	Whitefield
23. Michelle Gamache	Michelle Gamache	Twin Mt.
24. TERRY HAZEN	Terry Hazen	WHITEFIELD
25. Susan Lynch	Susan Lynch	Lyman, N.H.

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1.	BRUCE T ROLLINS	Bruce Rollins	Twin Mountain NH
2.	Jennifer Ross	Jennifer Ross	Littleton NH
3.	Kelly Paige	Kelly Paige	Lisbon, NH
4.	~~Bud Bourassa~~		
5.	Bud Bourassa	Bud Bourassa	Lincoln NH
6.	Becky Bourassa	Becky Bourassa	Lincoln N.H.
7.	Ernest Hansberger	Ernest Hansberger	Franconia N.H.
8.	Erica Tardiff	Erica Tardiff	Twin Mt., NH
9.	Genesis Wren Miller	Genesis Miller	Franconia NH.
10.	Mary Pelletier	Mary Pelletier	Monroe, N.H.
11.	Annabelle Dorr	Annabelle Dorr	Littleton NH.
12.	Keanna Salmon	Keanna Salmon	Littleton NH
13.	William P O'Connor	William P O'Connor	Franconia N.H.
14.	Robert Fenimore	Robert Fenimore	Bethlehem NH
15.	David C. Warren	DAVID C. WARREN	LITTLETON NH
16.	SUSAN A. Bushby	Susan A. Bushby	Lisbon N.H.
17.	Jodi Fleurie-Wohlleb	Jodi Fleurie-Wohlleb	Lyman N.H.
18.	PETER GOREAU		WATERFORD VT.
19.	Virginia E Hyatt	VIRGINIA HYATT	Littleton N.H.
20.	Donna L Ciecha	Donna Ciecha	Lisbon NH
21.	Burton Engerson	Burton Engerson	Littleton NH
22.	Jacqueline Engerson	Jacqueline Engerson	Littleton, NH
23.	John M Chase	JOHN M CHASE	LISBON, NH.
24.	Derek Annesser	DEREK ANNESSER	FRANCONIA, NH

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1. Elizabeth Ball	Elizabeth R Ball	Franconia N.H.
2. Brad Ball		Franconia N.H.
3. Carol Cooke	Carol Cooke	Littleton N.H.
4. Michael G Connell		Whitefield NH.
5. Stanley W. LeBlanc		Clarksville, N.H.
6. Cecile McCulloch		East Concord Vt.
7. Rebecca Mathews	Rebecca L Mathews	Whitefield NH
8. Rose Israel		Bethlehem NH
9. Linda Sawicki		Whitefield NH
10. Lawrence Wotton		Whitefield NH
11. Sandra C Rankel	Sandra L Rankel	Monroe, NH
12. Patricia Cherry	Patricia Cherry	a Whitefield N.H.
13. Donna Sleep	Donna Sleep	Whitefield N.H
14. Margaret Michaud		Dalton, NH
15. Janice K. Ruth	Janice K. Ruth	Whitefield, NH
16. Theodore O Read Jr		Bethlehem N H
17. Pamela W. Read		Bethlehem, NH
18. Margaret A. McKenna		Lisbon, N H
19. Ronald Gooden		Whitefield,
20. Ryan Trahan		Littleton N H
21. Jeannette Fogg		Dalton, N.H.
22. Louise Paquette		Jefferson NH
23. Stanley L Parker	STANLEY L PARKER	Whitefield N.H
24. Wendy Mcwhirter		Bethlehem NH
25. Clare L Broom		Bethlehem. N H.

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Brian J Call	Brian J Call	Littleton NH 035
2.	Dianne M. DeMatteo	Dianne M. DeMatteo	Bethlehem NH 035
3.	Zachary M. Gilding		Littleton NH 03561
4.	ALMA JEAN BOISVERT	a.j. Boisvert	EASTON NH 0378
5.	Paul Konkel	Paul Konkel	Littleton NH
6.	James Palmerchuck	James Palmerchuck	Bethlehem, NH 0351
7.	Amy Lemire	Amy Lemire	Littleton, NH
8.	Amy Audette		Dalton
9.	MELISSA EMERSON		Sugar Hill, NH
10.			
11.			
12.	Jennifer Chardon	Jennifer Chardon	Jefferson, NH
13.	Diana Corey	Diana Corey	Littleton
14.	Lisa Colombi	Lisa Colombi	Lancaster NH
15.	FORREST. E. GIRARD	Forrest E. Girard	33 Bryan ST
16.			29 Bryan
17.	Sally Sherrard	Sally Sherrard	Littleton, NH
18.	DANIEL BOIS	Daniel Bois	BETHLEHEM NH
19.	Eric Mena		63, Redington
20.	Laura E. Tweiten	Laura E. Tweiten	Littleton, N.H.
21.	Tod W. Tweiten	T. Twe	" "
22.	DEANNE Blodgett	Deanne Blodgett	26 west Dredo Littleton NH
23.	Dianna Warner	Dianna Warner	1 Newton MHP Lttn NH 03561
24.	Deborah L Dickinson	Deborah Dickinson	101 cottage St Bethlehem NH
25.	Carroll C lough	Carroll C lough	Littleton NH

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1. Edithmacy Elliott	Edithmacy Elliott	Northumberland N.H.
2. Roberta Terrill	Roberta Terrill	Whitefield NH
3. Rudley TERRILL	Rudley Terrill	Whitefield, NH
4. NANCY D. GAHM	Nancy D Gahm	Whitefield, NH
5. DONNA L. Smith	Donna L Smith	Littleton, NH
6. Michelle L. Gamache	Michelle L. Gamache	Twin Mt. NH
7. Rebecca L. Beno	Rebecca Beno	Bethlehem, NH
8. CAROL S. RIBNER	Carol S. Ribner	Jefferson NH
9. John Prather	John Prather	Groveton NH
10. Valerie Fitchett	Valerie Fitchett	Whitefield NH
11. MARGARET A McKENNEY	Margaret A McKenney	Lisbon, NH
12. Rhonda Stover	Rhonda Stover	Littleton, NH
13. Diane Cross	Diane Cross	Whitefield, NH
14. ARdeANE R. RIVES	Ardeane R Rives	Whitefield, N.H.
15. GERALD D. ROY	Gerald D. Roy	" "
16. LEE ANN TRACEY	Lee Ann Tracey	Bethlehem, NH
17. Mark Worcester	Mark Worcester	Whitefield NH.
18. Elise Lawson	Elise Lawson	Bethlehem, NH
19. BEVERLY HINES	Beverly Hines	Whitefield NH
20. REBECCA HUNT	Rebecca Hunt	Bethlehem
21. Caitlin Bouchard	Caitlin Bouchard	Campton NH
22. DORIS COOK	Doris Cook	Littleton, N.H.
23. LINDA COLE	Linda Cole	Bethlehem N.H.
24. EDGAR C CORMIER	Edgar C Cormier	Whitefield N.H.
25. Diana Murphy	Diana Murphy	Whitefield N.H.

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1	SANDRA M TAYLOR	Sandra M Taylor	LISBON, NH
2.	Douglas D Pecor		Lisbon, NH
3.	William Steele		Franconia, NH
4.	Jennifer Sawls	Jennifer Sawls	Franconia, NH
5.	BARBARA Leydon	BARBARA LEYDON	FRANCONIA NH
6.	Sylvia Clough	Sylvia Clough	Littleton NH
7.	Gene Rudy		Littleton NH
8.	Donald A. Coleman		Littleton NH
9.	JEFFREY BLODGETT		FRANCONIA, NH
10.	JOEL BEDOR		Littleton, N.H.
11.	Wendy Kern	Wendy J. Kern	Littleton, N.H.
12.	Betsy Hansberger	Betsy Hansberger	Franconia NH
13.	Michelle Briggs	Michelle Briggs	Whitefield, N.H.
14.	Bette Roberts	Bette Roberts	Littleton NH
15.	Julie Bailey		Monroe NH
16.	Bobbie McIntyre	Roberta M McIntyre	Sugar Hill, NH
17.	Pamela Dexter	Pamela Dexter	Franconia NH
18.	LEWIS DEXTER, JR.	Lewis Dexter	"
19.	Karen Bumsa	Karen J Bumsa	Landaff, NH
20.	BARBARA V. BELZ	Barbara V. Belz	Franconia, NH
21.	CARL BELZ	Carl Belz	FRANCONIA, N
22.	Colleen Fadden		Essex Jct VT
23.	Joyce A. Krill	Joyce A. Krill	Franconia, NH
24.	Philip M. Krill	Philip M. Krill	Franconia, NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Jason Bailey		Dalton. NH
2.	Judith Tetley		Lincoln NH
3.	Peter Rogers		Guilford VT
4.	Donald J. Bissonnette II		Sugar Hill, NH.
5.	Betsey Phillips		Franconia, NH
6.	Jewel F. Paquette		Littleton, N.H.
7.	Walter I Hyde		Bethlehem, N.H.
8.	Dolores Hammerle		Littleton, N.H.
9.			Landaff NH 03585
10.	David Howe		Bow, NH
11.	William N MORIN		LINCOLN NH
12.	Frank Whiting		Littleton NH
13.		minor signed in error. N. Brown, RN.	
14.	Robertson Williams		Franconia NH
15.	Annabelle Brown		Lunenburg Vt.
16.	Megan Arlet		Lincoln NH
17.	NEIL CLARKE		Monroe NH
18.			FRANCONIA, NH
19.	PETER MACOTT		FRANCONIA, NH.
20.	Trudy Keeler		Littleton, N.H.
21.	Robert Keeler		Littleton, N.H.
22.	JAMES C. FORREST		FRANCONIA, NH
23.	MARY Nehring		Franconia NH
24.	Jackie Young		Lunenburg, VT

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Kim Dodge		Littleton NH
2. Teresa Gallant	Teresa Gallant	Whitefield NH
3. Jacqueline Scott	Jacqueline Scott	Whitefield NH
4. Andrea Patten		Lyman NH
5. Donald Hitman		Lisbon, NH
6. Roger Johnson		Bethlehem, NH
7. David A. Harris		Littleton N.H.
8. Chris Clark		Bethlehem NH
9. William D. Bass		Franconia, NH
10. Nina Garfield		Bethlehem, NH
11. Theora Wright	Theora Wright	Dalton N.H.
12. CHRISTOPHER BROOKS	Christopher Brooks	Bethlehem NH
13. Mary Van Hegt		Lyman NH.
14. [illegible]		Landaff, NH
15. JOSEPH NELSON	Joseph Nelson	FRANCONIA
16. ALICE NELSON	Alice C. Nelson	" "
17. KATHLEEN NELSON	Kathleen Nelson	Franconia, NH
18. Kimberly Carpenter	Kim Carpenter	Gilman, VT
19. ~~Courtney Bowler~~		
20. Courtney Bowler	Courtney Bowler	Littleton, NH
21. David D Wentworth		Littleton NH
22. Lissa Boissonneault	Lissa Boissonneault	Sugar Hill NH
23. Donald J. Boissonneault		Sugar Hill NH
24. Paula M. Mason		Bethlehem NH

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1.	JACK CATALANO	Jack Catalano	TWIN MTN, NH
2.	Dorinda Gilman	Dorinda Gilman	Lincoln N.H.
3.	KATHERINE STODDARD	Katherine Stoddard	LITTLETON, NH
4.	PATRICIA A McCABE	Patricia A McCabe	FRANCONIA, NH
5.	Charles H. McCabe II	Charles H McCabe II	FRANCONIA, NH
6.	[illegible]	[illegible]	Whitefield, NH
7.	MARLENE GALLINELLI	Marlene Gallinelli	Littleton NH
8.	Louise B. Smith	Louise Smith	Littleton NH
9.	Richard W Smith	Richard W Smith	Littleton NH
10.	Anna Jackman		Littleton, NH
11.	GERARD V. GRIMA	Gerard V Grima	Francona NH
12.	Pauline T. Richey	Pauline T Richey	White Field, NH
13.	Kenneth E. Richey	Kenneth E. Richey	Whitefield NH
14.	Kristina E Barrett	Kristina Barrett	Franconia, NH
15.	CHRISTINA GARGANO		FRANCONIA, NH
16.	Miquela Dumont		Lisbon NH
17.	[illegible] SPARKS		Littleton NH
18.	~~[illegible]~~		
19.	Sylvie Locke	Sylvie Locke	Whitefield, NH
20.	Samantha Locke	Samantha Locke	Whitefield, NH
21.	[illegible]	[illegible]	Littleton, NH
22.	M. WAYNE HOLBROOK	M. Wayne Holbrook	LITTLETON NH.
23.	Douglas W. Bean	Dgh W.	LISBON, NH.
24.	Jamie L. Hight	JAMIE L. HIGHT	EASTON, NH

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1. ERROL S PETERS	Errol S Peters	Sandoff, N.H
2. Cecelia M. Beshlw	319 mt Eustis Rd,	Lisbon N.H.
3. Deanne Symons	Broadcreast.	[illegible]
4. Ronald Sheehan	Ronald Sheehan	Littleton N.H.
5. Moira North	Moira North	Franconia NH
6. Hope Godwin Yeargle	Hope Godwin Yeargle	Littleton NH.
7. HAROLD FRIEDMAN	Harold Friedman	BETHLEHEM NH
8. Della Gerlach	Della Gerlach	Littleton, N.H.
9. Eva Twombly		THORNTON, N.H.
10. WALTER Twombly		THORNTON, N.H.
11. Jenny Ricker	Jenny Ricker	Whitefield, NH
12. CAROL W Bays	J C Bays	Bethlehem NH
13. Jhni Fer Roberts		Bradford VT
14. [illegible]		Franconia NH
15. Earl Minor-Babin	Earl Henri Babin	Littleton, NH
16. Ailsa K Gagel	Ailsa K. Gagel	Sugar Hill, NH
17. Della MacAdam	Della MacAdam	Lyman N.H.
18. Marcia de Steuben	Marcia de Steuben	Franconia NH
19. Anthony F. Poekert	Anthony Poekert	Dalton, NH
20. Kathleen Vaughan	Kathleen Vaughan	Littleton NH
21. Monica Smith	Monica Smith	Littleton, N.H.
22. ROBERT KARMAN	Robert A. Karman	Franconia NH
23. Erica Kerstetter	Erica Kerstetter	Bethlehem NH
24. James Mac Williams	James Mac Williams	Sugar Hill, NH

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1.	Erilca Marble	Erika Marble	Littleton, NH
2.	Tom McGann	Tom McGann	West Danville, Vt
3.	Julie Morse	Julie Morse	So. Ryegate VT
4.	Barbara Mace	Barbara mace	SO. Ryegate Vt
5.	Wendy Chamberlain	Wendy Chamberlain	So. Ryegate VT
6.	Laura Mace	Laura Mace	So. Barre VT
7.	John Alden Phinney	John Alden Phinney	Rumney N.H.
8.	Ted Fellows		L. Hooksett
9.	Phyllis Bellavance	Phyllis Bellavance	Bethlehem, NH
10.	Joan Emerson	Joan M Emerson	Woodsville
11.	Kathe Tortorice	Kathe Tortorice	Franconia
12.	ANDREA VARGO	Andrea Vargo	BATH N. H.
13.	Debbie A. Geoffroy	Debbie A. Geoffroy	Lyman, N.H.
14.	Michael J. Geoffroy	Michael Geoffroy	Lyman, N.H
15.	Joy M. Beaulieu	Joy M. Beaulieu	Littleton, NH
16.	Kelly R. Sorum		Pike, NH
17.	Jen White	Jennifer White	East Ryegate VT
18.	Kim Bay	Kimberly Bay	Wells River, VT
19.	Tom Mc Gann	Tom McGann	West Danville, Vt
20.	DAVID T. SALYERS	David T Salyers	Haverhill, NH
21.	Trissa Tilson	Trissa Tilson	Littleton, NH
22.	KATHLEEN DEEDY	Kathleen Deedy	WSBORO, N.H.
23.	David Morrison	David Morrison	Wentworth, NH
24.	MEL COBB JR	Mel Cobb	WOODSVILLE, NH
25.	ROBERTA HEATH	Roberta Heath	WARREN, NH

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1. Ellen Leavitt		Bethlehem NH
2. Lucia Branson		Lisbon NH
3. CARL BELZ		Franconia, NH
4. JACILINE R YOUNG		Lunenburg, VT
5. Doug Harrington		Lyndonburg, VT
6. Stephanie Mallick		Franconia, NH
7. Bradford Bailey		Monroe, NH
8. Donna Paquette		Lisbon N.H.
9. Regina Bowler		Littleton NH
10. Sharon Holbrook		Littleton N H
11. Louise Smith		Littleton, NH
12. Richard W Smith		Littleton, NH
13. James R. Gibb		Sugar Hill N.H.
14. PAUL L. GAMACHE		BRETTON WOODS N.H.
15. David L. Miller		Littleton NH
16. Beverly Pelletier		Littleton, N.H
17. David R Miller		Littleton N.H.
18. Pamela H. Yarosh		Sugar Hill NH
19. Crowden Peckett		Easton N.H
20. Virginia Cunningham		Lisbon
21. IW Locke		Landaff
22. Jan Eblick		Littleton, NH
23. SCHUYLER W. SWEET		Littleton, NH
24. JOHN D WOLF JR		Whitefield, NH
25. MARIAN Edmunds		Franconia NH.

Sent 9/6/11

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1.	Vea Jenks	Vea Jenks	Piermont, N.H.
2.	Dave Eastman	Dave Eastman	Groton, Vt.
3.	Solimar Birch	Solimar Birch	Lisbon NH
4.	Sadie Burgin Burleigh	Sadie Burgin Burleigh	Stolon, Vt
5.	Mary Gilbert	Mary Gilbert	Bradford, Vt.
6.	Pauline Baillargeon	Pauline Baillargeon	N. Haverhill NH
7.	Norm Iggells	Norm Iggells	N. Haverhill NH
8.	Harold J Graham	Harold J Graham	Woodsville NH
9.	TERESA GRAHAM	Teresa Graham	Woodsville NH.
10.	Richard Comstock	Richard Comstock	Lisbon NH
11.	Lisa Gadwah	Lisa Gadwah	Woodsville NH
12.	Aaron Solunt	Aaron Solunt	Bath NH
13.		Brian Chase	
14.	STEPHAN A. ELLIOT	Stephan A. Elliot	S. Ryegate, Vt
15.	TOM MCGANN	Tom McGann	West Danville, Vt
16.	Harold J. GRAHAM	Harold J Graham	Woodsville N.H.
17.	Sunshine Gadwah	Sunshine Gadwah	Woodsville, NH
18.	Pam Gilbert	Pamela Gilbert	North Haverhill NH
19.	James Seide	James Seide	Lyman, NH
20.	Tammy K Burley	Tammy K Burley	Woodsville NH
21.	Trish Jacobs	Trish Jacobs	N. Haverhill, NH
22.	T. ALDEN WILCOX	T. Alden Wilcox	Woodsville, NH
23.	Peter E Lamb	Peter E. Lamb	Warren, NH
24.	Suzanne Rutchick		
25.	Trevor Allen	TREVOR ALLEN	N. HAVERHILL NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Susan Brady	Susan Brady	Bethlehem, NH
2.	Mary Pelletier	Mary Pelletier	Monroe, NH
3.			
4.	Kathy Perry	Kathy Perry	Lyman NH
5.	James W. Marcou	James W. Marcou	Bethlehem N.H
6.	Isabel Costa	Isabel Costa	Easton, NH
7.	Kathe Tourtou	Kathe Tourtou	Franconia, NH
8.	Sharon Penney	Sharon Penney	Franconia, NH
9.	Colette Clough	Colette Clough	Littleton NH
10.	Judy M. Grinstead	Judy M. Grinstead	Littleton, NH
11.	9/26/11	Mary Chapman	Littleton, NH
12.	IAN EDICK	Ian Edick	Littleton NH.
13.	Maureen A. Dexter	Maureen A. Dexter	Littleton, NH
14.	Judy Sanborn	Judy Sanborn	Whitefield, NH
15.	Tenley S Boulton	Tenley S Boulton	Whitefield, NH
16.	Robert P. Karman	Robert P. Karman	Franconia, N.H.
17.	ELAINE R. BURDEE	Elaine B. Burpee	Sugar Hill NH.
18.	GERRY RAMBACK	Gerry Ramback	11
19.	ERIC PRICE	Eric Price	Franconia, NH
20.	Chris Fowler	Chris Fowler	Franconia NH
21.	ZBIGNIEW MROCZKO	Zbigniew Mroczko	WHITEFIELD NH
22.	Bradford Bailey	Bradford Bailey	Monroe, NH
23.	Chris Laganos	Chris Laganos	Sugar Hill NH
24.	Lisa Civitello	Lisa Civitello	Lancaster NH
	Gareth Blake	Gareth Blake	Littleton NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Rosalee Gooden	Rosalee Gooden	Whitefield NH
2.	Ronald Gooden	Ronald Gooden	Whitefield NH
3.	Jessie Mason	Jessie Mason	Dalton NH
4.	Bill Houghton	Bill Houghton	Whitefield NH
5.	Claire Houghton	Claire Houghton	Whitefield NH
6.	DONNA McALLASTER	Donna McAllaster	Stewartstown NH
7.	Roderick McAllaster	Roderick McAllaster	Stewartstown NH
8.	Leslie L Lundberg	Leslie L Lundberg	Sugar Hill NH
9.	Celine P Rodger	Celine P Rodger	Whitefield NH
10.	Katrina L Colby	Katrina Colby	Whitefield NH
11.	PETER HALL	Peter Hall	WHITEFIELD NH
12.	NANCY T. SHEEHAN	Nancy T. Sheehan	LITTLETON NH
13.	RONALD S. SHEEHAN	Ronald S. Sheehan	Littleton NH
14.	Cynthia Locke	Cynthia Locke	Whitefield NH
15.	Amanda Bell	Amanda Bell	Whitefield NH
16.	Jennifer McVetty	Jennifer McVetty	Littleton NH
17.	Cynthia Bonach	Cynthia Bonach	Whitefield NH.
18.	Kayne Bailey	Kayne Bailey	Groveton NH
19.	Kathryn Bilodeau	Kathryn Bilodeau	Littleton NH 03561
20.	Karen Kradjian	Karen Kradjian	Littleton NH 03561
21.	Jennifer Hagan	Jennifer Hagan	Twin Mountain NH 0359
22.	Mary Estabrooks	Mary Estabrooks	Whitefield NH
23.	Rebecca L Matthews	Rebecca L Matthews	Whitefield NH
24.	Audrey Sundman	Audrey Sundman	Lisbon NH
25.	Carol Koivar	Carol Koivar	Bethlehem, NH

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. REBECCA WEBB	Rebecca Webb	Bethlehem NH
2. June A Davis	June A Davis	Littleton NH
3. Cynthia Frederton	Cynthia Frederton	Bethlehem
4. JUDITH ENGLE	Judith Engle	DANVILLE VT
5. Scott McCall	Scott McCall	LITTLETON NH. 03561
6. John Prather	John Prather	Groveton N.H. 03582
7. Cynthia Chase	Cynthia Chase	140 Main St. #1 Rol
8. Barbara C. Lloyd	Barbara C. Lloyd	Littleton
9. JEAN BOWMAN	Jean Bowman	Bethlehem
10. WILLIAM BROWN	William Brown	BETHLEHEM
11. Christina Dodge	Christina Dodge	Littleton, NH
12. Grainger Swain	Grainger Swain	Littleton, NH 03561
13. PAT KELLOGG	Pat Kellogg	Littleton NH 03561
14. Richard Bachelder	Richard Bachelder	Lyndonville VT
15. Lawrence Shattuck	Lawrence Shattuck	Littleton, NH. 03561
16. Beverly Frankiewich	Beverly Frankiewich	Sugar Hill, NH 03586
17. Madeleine Perry	Madeleine Perry	Lisbon NH 03585
18. John Perry	John Perry	" " "
19. Lisa Beaudoin	Lisa Beaudoin	Littleton NH 03561
20. Robyn Lindquist	Robyn Lindquist	Dalton, NH
21. JOHN COLONY	John Colony	SUGAR HILL NH
22. Peggy Moore	Peggy Moore	Littleton NH
23. Ellen Chase	Ellen M. Chase	Lisbon NH
24. Paul A PeLLetier	Paul A Pelletier	Littleton NH
25. Matt Michaud	Matt Michaud	Littleton NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Mary E Bunnell	Mary E Bunnell	Bath, N H
2.	APRIL JANSSEN	April Janssen	LISBON, NH
3.	Patricia Meddings	Patricia Meddings	Littleton, NH
4.	SUSAN K KEARSEY	Susan K Kearsey	Twin Mtn, N H
5.	Jeanette Guerin	Jeanette Guerin	Bethlehem, N. H.
6.	Lisa Landon	Lisa Landon	Littleton, NH
7.	Tiffany Mooney	Tiffany Mooney	Lancaster
8.	Denise Donahue	Denise Donahue	Littleton, N.H.
9.	Lynn Rochester	[illegible]	Littleton, NH
10.	Pamela Reid	Pamela Reid	Bethlehem, NH
11.	Mindy Pinardis	[illegible]	Bethlehem NH
12.	Jessica Frost	Jessica Frost	Bethlehem NH
13.	Tim Doughty	Tim Doughty	Bethlehem NH
14.	Elizabeth Padula	Elizabeth Padula	Lancaster NH
15.	Lynn Bethney		Littleton, NH
16.	Shirley Plaisted		Littleton, NH
17.	Marjorie A Sanborn	Marjorie A Sanborn	Lancaster, NH
18.	Christy MacArthur	C MacArthur	Lisbon, NH
19.	Cindy Colavecchio		Bethlehem NH
20.	Amber Bailey		Littleton, NH
21.	Colleen Knight		Littleton NH
22.	Eleanor Leighton	Eleanor Leighton	Littleton, NH
23.	Tori Andrews	Tori Andrews	Littleton NH
24.	Rosemary Amarena	Rosemary Amarena	Whitefield NH
25.	Karen Worrell	Karen Worrell	Whitefield, NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Kimberly Santosa		Littleton, NH
2.	Jennifer LaFlam		Littleton, NH
3.	Rhiannon McCarthy		Littleton NH
4.	DEBORAH McCARTHY		LITTLETON, N.H. 03561
5.	Aree Ryan	Aree Ryan	LANCASTER
6.	Jennifer Laid-Hepburn		Bethlehem, NH 03574
7.	Amy Hill		Landaff, NH 03585
8.	Robin Blake		Littleton NH
9.	Deanna Jack		Littleton, NH
10.	Sarah Davis		Woodsville, NH
11.	Crystal Chilafoe		Whitefield NH
12.	Leah Washburn		Twin Mtn NH
13.	April WASHburn		Bethlehem N.H.
14.	[illegible]	<--> Amy Aldrich	Littleton NH
15.	Budget Beaton	Budget Beaton	Lancaster NH
16.	Buttercup Beaton	Buttercup Beaton	
17.	Steven Hoyt		Bethlehem NH
18.	Carla A. Peacock	Carla A. Peacock	Littleton NH
19.	RICK HUNT		Littleton, NH
20.	Carolyn Hunt		Littleton, NH
21.	Barbara Fortier		Littleton N.H.
22.	Gennaro Morando		Whitefield N.H.
23.	Rob & Pat Prather (John M Prather)		Groveton NH
24.	PATRICIA PRATHER		Groveton, NH
25.	Tammie Hoyt		Littleton NH

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Linda Sawicki	Linda Sawicki	Lebanon, NH
2. Carole Bigar	Carole E Bigar	Bethlehem, NH.
3. Audrey Crowe	Audrey Crowe	Franconia, NH
4. Gerald N Roy	GERALD N ROY	Whitefield NH.
5. Nancy T. Sheehan	Nancy T. Sheehan	Littleton, N.H.
6. Stephen Huggins		Bethlehem, NH
7. Richard Moore	Richard Moore	Franconia, NH
8. Gloria Moore	Gloria Moore	Franconia, NH
9. Betty Gauthier	Betty Gauthier	Whitefield, NH
10. ~~Mary Chandler~~		
11. Mary Chandler	Mary Chandler	Jefferson NH
12. Cynthia Barnett	Cynthia Barnett	Whitefield Lancaster Rd
13. Vicki Flynn	Vicki Flynn	Whitefield, NH
14. Dorothy Tate	Dorothy Tate	Whitefield NH
15. Dorothy Stroat	Dorothy Stroat	Whitefield NH
16. Stella Roberts	Stella Roberts	[illegible] NH
17. Cathy Geisz	Catherine Geisz	Dalton, NH
18. CAROL RIBER	Carol S Riber	Jefferson NH
19. Elizabeth Colligan	Elizabeth Colligan	Bethlehem, NH 03574
20. Virginia Grimes	Virginia A. Grimes	Whitefield, NH.
21. Claire Houghton	Claire Houghton	Whitefield
22. George Ouland		Lisbon, NH 03585
23.		Whitefield
24. John Rather		Groveton NH
25. George Bond	George Bond	Whitefield, N.H.

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Patricia Prather	PATRICIA PRATHER.	GROVETON, NH 03582
2.	Jean Bergin	Jean Bergin	Whitefield, NH 03598
3.	B A Boisquet	B A Boisquet	Whitefield NH
4.	SARAH Tingley	Sarah Tingley	Whitefield NH
5.	Pamela Shillieto	Pamela Shillieto	Bethlehem NH
6.	Rhonda Chandler	Rhonda Chandler	Littleton NH.
7.	Janet Christenson	Janet Christenson	Jefferson NH
8.	Kellie Briggs	K. Briggs	Whitefield, NH
9.	Mary Chandler	Mary Chandler	Jefferson. NH
10.	Janice K. Ruth	Janice K. Ruth	Whitefield, NH
11.	THERESE L. JONES	Therese L Jones	Dalton, NH
12.	WILLARD W LUCAS	Willard W Lucas	Bethlehem
13.	Kathy Dubois	Kathy Dubois	Lancaster NH.
14.	Rosalie gooden	Rosalie gooden	whitefield NH
15.	Ronald Gooden	Ronald Gooden	Whitefield NH
16.	Bethany Woodward	Bethany Woodward	Littleton, N.H.
17.	Winifred Robinson	Winifred Robinson	Littleton N.H.
18.	CATE DiBUSKI	Cate DiBuski	Whitefield, NH
19.	Rebecca Webb	Rebecca Webb	Bethlehem NH
20.			
21.			
22.	Amelia St. John	Amelia St. John	Littleton, NH
23.	Sue Rouillard	Sue Rouillard	Whitefield NH
24.			
25.			

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Denise Crowley		Twin Mt NH
2. Emily Robinson	Emily Robinson	Bethlehem NH
3. Kim Santora		Bath, NH
4. Patina welch	Patina welch	Littleton NH, Littleton,
5. Sally Sherrard		580 N. Skinny Ridge Rd
6. Carolyn Hunt		Littleton, NH
7. Alonzo "Lon" W. Henderson		120 Lafayette Rd; Sugar Hill NH
8. Florence Riggles	Florence Riggles	4 Crawford St. Littleton NH
9. Alan B KERT III		4 Elm St #106 Lancaster, N
10. Patricia A. Fryer	Patricia A Fryer	1407 N. Littleton Rd, Littleton, NH
11. PAUL REITSMA		141 EUSTIS LITTLETON NH
12. Mary Pelletier	Mary Pelletier	2763 Littleton Rd Monroe
13. Joanna Emmons	Joanna Emmons	Whitefield NH
14. Jacqueline M Carbonneau	Jacqueline M Carbonneau	401 Clough Hill Rd, Lyman
15. David A Carbonneau	David A Carbonneau	401 CLOUGH HILL RD, LYMAN
16. KATHLEEN D DUFFY	Kathleen D Duffy	NISSON NH
17. Marcia Wise	Marcia L Wise	65 Colby St Colebrook
18. William & Diane Sutton	Sutton	1 Cubb St, Lan,
19. Theresa J. Tuthill-Smith	Theresa S. Tuthill-Smith	Lisbon NH
20. Angela J Bucle	Angela J Bucle	Franconia Box 73 N.H. 03580
21. Eva & Allegra & Robert	30 Brickyard Rd	Littleton N. H 03561
22. Edith Ahern		Littleton NH
23. Thomas McGuire		Littleton NH
24. Patricia Garvin	PATRICIA GARVIN	Franconia NH
25. Julie Monahan	Julee Monahan	Lancaster NH

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Donna Paquette	Donna Paquette	Lisbon N.H.
2. DORIS A Bean	Doris A Bean	Bethlehem NH
3. Susie M Drew Leslie G Drew	Susie M Drew	Sugar Hill NH
4. Kelly Irving	Kelly Irving	Littleton NH
5. Linda Bennoch	Linda Bennoch	Whitefield NH
6. MICHAEL SULLIVAN		BRTHLEHEM NH.
7. James I Moody	James I Moody	Bethlehem, NH.
8. Harold Aldrich	Harold Aldrich	Sugar Hill N.H.
9. Cynthia Berlack	Cynthia Berlack	Franconia N.H.
10. Elizabeth Burpee	Elizabeth Burpee	Franconia, NH
11. Jane McElwain	Jane McElwain	Sugar Hill, NH
12. Joseph B Hare		LITTLETON, N.H.
13. Nancy Abbi Cassidy	Nancy Cassidy	Lisbon, NH
14. Elizabeth Stowell	Elizabeth Stowell	Franconia, N.H.
15. Dave Harris		L. Hebron, N.H.
16. Jeff Phillips		Lillleton NH
17. Kelly Eastman	Kelly Eastman	Littleton, NH
18. Rita L. Besaw	Rita L. Besaw	Franconia, N.H.
19. CHARLES BESAW	Charles K Besaw	" "
20. William Bedor		Littleton NH.
21. Edward Rolfe	Edward Rolfe	Franconia, NH
22.	RICHARD O. MORRIS	FRANCONIA NH
23. George Roorbach		Franconia, N.H.
24. Roberta Gaudes	Roberta Gaudes	Jefferson, N.

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1. Deanna Emmons	Deanna Emmons	Dalton NH
2. Barbara V. Belz	Barbara V. Belz	Franconia, NH
3. Merton Rymph	Merton Rymph	Lisbon, N.H
4. Robert P Peckett	Robert P. Peckett	Sugar Hill, NH
5. Sara Crowell	Sara Crowell	Lyman, NH
6. Leslie Merchant	Leslie Merchant	Littleton NH
7. Timothy Cowles		Franconia NH
8. Maureen A Dexter	Maureen A Dexter	Littleton, NH
9. DAVID PICKMAN		BATHLEHEM, NH
10. Jenny Rucker	Jenny Rucker	Whitefield, NH
11. Scott Carner		Lancaster, NH
12. HORACE C BURRINGTON	Horace C Burrington	LITTLETON NH
13. Shirley Burrington	Shirley Burrington	Littleton N.H
14. ANNE Davis		Dalton NH
15. Jeanne M. Streeter	Jeanette M. Streeter	Littleton, NH
16. SAM FLETCHER	Sam Fletcher	Franconia NH,
17. John D. WOLF JR.	John D. Wolf Jr	Whitefield NH.
18. Herbert D. Lloyd	Herbert D Lloyd	Bethlehem NH
19. Kathleen M. Ardolino	Kathleen M. Ardolino	Lisbon, NH.
20. GEORGE P. ARDOLINO	George P Ardolino	Lisbon NH
21. RONALD S. SHEEHAN	Ronald S Sheehan	Littleton NH
22. JOSEPHINE L. OTT	Josephine L Ott	Lyman, NH
23. Sylvia C. Clough	Sylvia Clough	Littleton NH
24. Richard W Sprague	Richard W Sprague	Bethlehem NH
25. Catherine Ahlson	Catherine Ahlson	Lincoln NH

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1. Danielle Beaulieu	Danielle Beaulieu	Franconia, NH
2. Erin E. Piriano	Erin E. Piriano	Brookfield, VT
3. Heidi A. Wright	Heidi A. Wright	Franconia, NH
4. Jane H. O'Donnell	Jane H. O'Donnell	Littleton, NH
5. NINA BROWN	Nina Brown	LISBON NH
6. Amanda Scott	Amanda Scott	N. Stratford, NH
7. Joseph Clark	Joseph Clark	LITTLETON NH.
8. Kasey Q Nightingale	Kasey Q Nightingale	Lisbon, NH
9. DOUGLAS EVELYN	Douglas Evelyn	Sugar Hill, NH
10. LINDA SHULDA	Linda Shulda	Lisbon, NH
11. GREG L. ANDERSON	GREG L. ANDERSON	FRANCONIA, NH
12. Kris Pastorza	Kris Pastorza	Easton, NH
13. John Matyas	John Matyas	St. Johnsbury, VT
14. [illegible]	[illegible]	[illegible], NH
15. Krystal Murray-Brown	Krystal Murray-Brown	Bethlehem NH
16. Timothy Williams	Timothy C. Williams	Sugar Hill NH,
17. Denyo Draper	Denyo Draper	Easton, NH
18. Darleen Sarausky	Darleen Sarausky	Littleton NH
19. Barbara Serafini	BARBARA SERAFINI	Sugar Hill NH
20. Robert P. Karman	ROBERT P. KARMAN	FRANCONIA
21. Edith Aldrich	Edith Aldrich	Littleton NH
22. Kathy Bentley	Kathy Bentley	N. Woodstock, VT
23. JANET HILL	Janet Hill	Bethlehem NH
24. LINDA LEGER	Linda Leger	Littleton
25. HARRIET MCMANN	Harriet McMann	LITTLETON NH

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1	Della Mae Aldrich	Della Mae Aldrich	Lyman N.H.
2.	Louise B. Smith	Louise B Smith	Littleton, NH
3.	David Aldrich	David aldrich	Lyman NH
4.	Gail Yule	Gail R. Yule	Franconia
5.	Gertrude Keeler	Gertrude Keeler	Littleton, NH
6.	Bob Keeler	Bob Keeler	Littleton, N.H.
7.	Nancy E. Collins	Nancy E. Collins	Littleton NH
8.	Melinda A Aubin	Melinda Aubin	Littleton NH
9.	Rita Z. Beson	Rita Z. Beson	Franconia, NH
10.	Teresa M. Griggs	Teresa M Griggs	Lisbon, NH
11.	EDWARD LEJSON	Edward Lejson	Littleton, N.H.
12.	Cynthia Federton	Cynthia Federton	Bethlehem, NH
13.	Sharon CRAIGIE	Sharon Craigie	Littleton, NH.
14.	Carl Campbell	Carl L Cpbl	Lincoln, NH
15.	HAROLD FRIEDMAN	Harold Friedman	Bethlehem NH
16.	Pamela J Landry		Lincoln, N.H.
17.	ANTHONY F IACQUA	Anthony F Iacqua	LITTLETON NH
18.	Floyd GRAMMO	Floyd Grammo	Littleton NH
19.	MARY LOU STAFFORD	Mary Lou Stafford	Littleton NH
20.	Dexter STAFFORD	Dexter Stafford	Littleton NH
21.	MERI HERN	Meri Hern	Sugar Hill NH
22.	SIDNEY REGEN	Sidney Regen	SUGAR HILL, NH
23.	Kathryn Mannetto	Kathryn Mannetto	Sugar Hill N.H
24.	David Mannetto	David Mannetto	Sugar Hill N.H
25.	KATHIE LOVETT	Kathie Lovett	FRANCONIA, NH

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1. Billi-Jo LaFrance	Billi-Jo LaFrance	Dalton, NH
2. Kathleen Boswell	Kathleen Boswell	Littleton NH
3. Melissa L. Norris	MNorris	Bethlehem, NH
4. Corey J. Norris	CNorris	Bethlehem, NH
5. Zoe Norris	[illegible]	Bethlehem, NH
6. Josh Tilson	[illegible]	Littleton, NH
7. Amy Veneziano	Amy Veneziano	Sugar Hill, NH
8. Nicole Slattery	Nicole Slattery	Franconia, NH
9. Nancy Gigliello	Nancy Gigliello	Bethlehem, NH
10. Melissa Hodge	Melissa Hodge	North Haverhill NH
11. Dayna Deass	Dayna Deass	Littleton NH
12. Evelyn Ford	Evelyn Ford	Franconia NH
13. Jennifer Martin	Jennifer Martin	Whitefield, NH
14. Pamela Haynes	Pamela Haynes	Littleton NH
15. Dana Haynes	Dana Haynes	Littleton NH.
16. Russell Angell	Russell Angell	Groveton, NH. 03582
17. Victoria Lard	Victoria Lard	Littleton, NH
18. Elizabeth Lacue	Elizabeth Lacue	Littleton, NH
19. Pauline Palmer	Pauline Palmer	Easton
20. John Williams	John Williams	Lancaster N.H.
21. Marilyn MacDonald	Marilyn MacDonald	Groveton NH
22. Donald A Cronquist	Donald A Cronquist	Littleton, NH
23. Mary Saikin	Mary Saikin	Littleton
24. Mary Lynch	Mary Lynch	Littleton
25. Vicki Potter	[illegible]	Lancaster NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Bonnie Boswell	Bonnie Boswell	Whitefield N.H.
2.	ROBERT TYLER	Robert Tyler	LITTLETON N.H.
3.	WILLETTE F. STONE	Willette F Stone	bay, NEWPORT, VT
4.	EDWARD THOMSEN	Edward Thomsen	
5.	Mellisa LaPage	Mellisa LaPage	Gilman, VT
6.	TEAGAN LaPage		Littleton NH
7.	Lisa Mackenzie	Lisa Mackenzie	Lyman NH
8.	Chad Proulx		Bethlehem, NH
9.	Charlene G. Miles	Charlene Miles	Bethlehem N.H.
10.	Phyllis A. Sprague	Phyllis Sprague	Bethlehem, N.H
11.	Freda L. Hamm	Freda L. Hamm	Littleton, NH
12.	Brigitte Bean	Brigitte Bean	Littleton NH
13.	Connie Lorkon	Connie Lorkon	Littleton, NH
14.	Barbara Oakes	Barbara Oakes	Littleton, N.H.
15.	Jamie Currier	Jamie Currier	Littleton NH
16.	Heather Bean	Heather Bean	Littleton NH
17.	Catherine Moss	Catherine Moss	Littleton NH
18.	Theodora Simonds		Littleton NH
19.	Keri Boynton	Keri Boynton	Easton, NH
20.	Deborah Stewart	Deborah Stewart	Woodsville NH
21.	Ashley Farmer	Ashley Farmer	" "
22.	Rodney Peters		Littleton NH
23.	Stephanie Moms	Stephanie Moms	Haverhill NH
24.	Anya Bailey	Anya Bailey	Littleton NH
25.	Kimberly Bamford	Kimberly Bamford	Whitefield NH

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1. Carrie A. Paulin	Carrie A Paulin	Gilman, VT
2. Christy Downing	Christy Downing	Lancaster, NH
3. Trevor Hosford	Trevor Hosford	Lancaster, NH
4. Kelly L. Faberdeau	Kelly L. Faberdeau	Littleton NH
5. Constance Patnoe	Constance Patnoe	Lancaster, NH
6. Dennis Patnoe		Lancaster NH
7. Jane O Dickerman		Bethlehem NH
8. Jana Kaplan		Bethlehem, NH
9. Steven Auclair		Twin Mt NH
10. Patricia McLure		Lancaster, NH.
11. Jane Lucas		Bethlehem, NH
12. Kim Crane		Lancaster, NH
13. Jane N. Trombley		Littleton NH
14. Virginia A. Glines		Whitefield, N.H.
15. Karey D. Marsh		Whitefield, NH
16. Pauline Di Natale		Whitefield, N.H.
17. Suzanne O'Gara		Whitefield NH
18. A Kay Hutchins		Dalton, NH
19 Christa Bryant		Groveton, NH
20. Heidi Larsen		Franconia NH
21. REBECCA HUNT		Littleton, NH
22. Eleanor D. Howard		Sugar Hill NH
23. Jean L Carbonneau		Franconia, NH.
24. Wilma Johnson		Haverhill, NH
25.		Twin Mt

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Cynthia Chase	Cynthia	Littleton, N.H. 03561
2. Wilma J Spencer	Same	Lincoln, NH 03251
3. Aaron Cockrell		
4. Phil Bergeron		Bethlehem, NH 03574
5. Richard W Sprague		Bethlehem, NH 03574
6. Lee Gamble	Sandra Gamble	Franconia NH 03580
7. Sharon Holbrook		Littleton, NH 03561
8. M. WAYNE HOLBROOK		Littleton, NH 03561
9. Cheryl H. Compton		Bethlehem NH 03574
10. John Compton		Bethlehem NH 03574
11. Stephanie A. McMahon		Whitefield, NH 03598
12. Deborah J. Lewis		Bethlehem NH 03574
13. SALLY GREEN		BETHLEHEM, NH 03574
14. Charlotte Amadon		Lunenburg, VT 05906
15. Shane Cunningham		Bethlehem NH 03574
16. Deborah Pierce		Lunenburg VT 05906
17. Marilyn Putney		Littleton NH 03561
18. Dell Mae Aldrich		Lyman N.H. 03585
19. Stephen A Chardon		Francoma, N.H. 03580
20. Barbara Deming		Lisbon NH 03585
21. David C. Deming		Lisbon NH 03585
22. LAWRENCE E. HARTSHORN		Gilman VT. 05904
23.		Littleton NH 03561
24. Melinda Aubin		Littleton NH 03561

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Debra Bryant	Debra Bryant	Glencliff N.H. 03238
2. Angie Semertzakis		Warren, NH
3. James L. Butler II	James L. Butler II	Warren, N.H.
4. James L. Butler III	James L. Butler III	Wentworth, N.H.
5. Andrew Bourassa	Andrew Bourassa	Ashland NH 032
6. Judy Whitcher	Judy Whitcher	Warren N.H. 03279
7. David Whitcher	David Whitcher	Warren, NH 03279
8. John Semertzakis		Warren, NH 03279
9. Dolores Mueller		Warren, NH 032
10. Charles J. Hall	Charles J. Hall	Rumney, N.H.
11. Warren Stickney		Groton, NH
12. Theresa Evans	Theresa M Evans	Wentworth, NH
13. Doug Bruning	Doug Bruning	Groton
14. Joanne Hansen	JOANNE HANSEN	Warren, NH
15. Kathleen Bushaw	Kathleen Bushaw	Warren, NH
16. Christian Poissant		Rumney N.H.
17. Denise Brown	Denise Brown	Wentworth, NH
18. Rebecca Fuges	Rebecca Fuges	North Haverhill, NH
19. Charles T. Eddy	CHARLES T. EDDY	WARREN, NH
20. Rosemarie Womble	Rosemarie Womble	Wentworth N.H.
21. Diane Finlay	Diane N Finlay	Pike, NH
22. Deb Dickmann	Deborah Dickmann	Glencliff, NH
23. Joan Amos		Wentworth, NH
24. Bobbie Jo Briggs	Bobbie Jo Briggs	Warren NH
25. Kelly Maul		Warren NH

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1.	RHONDA CHANDLER	Rhonda Chandler	Franconia, N.H.
2.	Elizabeth Allen	Elizabeth Allen	Twin Mountain, N.H.
3.	Gina D'Orazio	Gina D'Orazio	Littleton, NH
4.			
5.			
6.	Robert B. Ferrini	Robert B. Ferrini	Colebrook, NH
7.	Meli Hern		Sugar Hill, NH
8.	Connie Wilson		Bethlehem NH
9.	Cynthia Chase	Cynthia Chase	Littleton, N.H.
10.	Estalee Fernald	Estalee Fernald	Bethlehem, NH
11.	Elaine Rentz	Elaine Rentz	Lunenburg VT
12.	Julee Monahan	Julee Monahan	Lancaster, NH
13.	Paul Kaegin		Bethlehem, NH.
14.	George E. Brooks Sr.		Canaan, NH
15.	Edith Patch		Littleton N.H
16.	Tina Drew	Tina Drew	Littleton NH
17.	Marlene May	Marlene May	Littleton NH
18.	Dennis Grenier	Dennis Grenier	Groveton N.H.
19.	KATHY DUFFY	Kathleen Duffy	LISBON NH
20.	Leslie Pellegrin	Leslie Pellegrin	Lisbon NH
21.	Michele Rzepa	Michele Rzepa	Dalton NH
22.	Audrey Crowe	Audrey Crowe	Franconia, NH
23.	Rachael Crowe	Rachael Crowe	Franconia, NH
24.	Rick Pellegrin		Lisbon NH
25.			

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	SONIA GERMAN		FRANCONIA NH
2.	WILLIAM GERMAN		FRANCONIA NH
3.	James Ivan Ash		Bethlehem, NH
4.	Tammy Foster		Sugar Hill NH
5.	JS Hutchinson	JS Hutchinson	Sugar Hill.
6.	ELSPETH RICHARDSON		SUGAR HILL NH
7.	Angela Presby	Angela Presby	Littleton NH
8.	Kimberly DuBois	Kimberly DuBois	Littleton NH
9.	Megan Willey	Megan Willey	Littleton NH
10.	Pauline Aldrich	Pauline Aldrich	Sugar Hill NH
11.	SUSAN KURTZ	Susan Kurtz	FRANCONIA, N.H.
12.	Betty Coday	Betty Coday	Lisbon NH.
13.	Dylan Coday	Dylan Coday	Lisbon NH.
14.	Betsey Phillips	Betsey Phillips	Franconia NH
15.	Milton B Ba	Milton B Ba II	Bethlehem NH.
16.	Brett Hamel	Brett Hamel	Easton N.H.
17.	ROGER ALDRICH		SUGAR HILL N H
18.	ELEANOR FINK	Eleanor Fink	FRANCONIA, N.H
19.	Patricia McTeague	Patricia McTeague	Lincoln, N.H
20.	Thomas Palmer		Franconia NH
21.	Melissa Locke	Melissa Locke	Landaff NH
22.	JAMIE STRAND	JAMIE STRAND	Franconia NH
23.	Kathleen Fava	Kathleen B Fava	Littleton NH
24.	Shauna McTeague		Lincoln, NH

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1.	Hayley Berney	Hayley Berney	Bethlehem, NH
2.	Frank Gramma		Littleton, NH
3.	James Hogan	James Hogan	Franconia NH
4.	GARY BRONUM	Gary L. Bronum	LISBON N.H.
5.	Jessica wright	Jessica wright	LTTN N.H
6.	Adrien R Dutilly	Adrien R. Dutilly	LINCOLN, N.H.
7.	June Dutilly	June C Dutilly	Lincoln, NH 03251
8.	Bette Mageun		Littleton NH
9.	Beatrice Naylor	Beatrice Naylor	Lisbon, N.H.
10.	Stephen C. Cox		Whitefield, NH
11.	DANIEL A SPARKS		Littleton N.H.
12.	Myles Lobdell		Landaff, NH
13.	Sara E Crowell	Sara E Crowell	Lyman NH
14.	Priscilla Locke		Easton, N.H.
15.	Barbara Waites	Barbara Waites	Bethlehem, NH
16.	Debbie Aldrich	Debbie Aldrich	Sugar Hill NH
17.	LAURIE BONNETT	Laurie Bonnett	GROVETON NH
18.	Roberta S. Higgins	Roberta S. Higgins	Lisbon
19.	JADE LESINE		LITTLETON, NH
20.	DONALD LEVESQUE		Littleton, NH
21.	Holly Hayward	Holly H. Hayward	Sugar Hill NH
22.	Stephanie Westover	Stephanie Westover	Bethlehem, NH
23.	Deb Considine	Deborah Considine	Littleton, NH
24.	Darlene Roy	Darlene Roy	Lunenburg, VT

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1. Marilyn L. Knowlton	Marilyn L Knowlton	Franconia, NH
2. Anne Cosgrove	Anne Cosgrove	St. Johnsbury, VT
3. Rebecca Lewis	Rlewis	Waterford, VT
4. Kimberly ann Roby	Kimberly Roby	Littleton, N.H.
5. HAROLD L KNIGHT	Harold L Knight	LITTLETON N. H.
6. Courtney L Silva	Courtney L Silva	Littleton NH
7. Heather Silva	Heather Silva	Littleton, NH
8. Samantha Prindiville	Samantha Prindiville	St Johnsbury, VT
9. Lynn Dahl	Lynn Dahl	Littleton, NH
10. Patricia J. Cavileer	Patricia Cavileer	Littleton, NH
11. Brendan Dunlue	Brendan Dunlue	Littleton, NH
12. Jessica Thwaites	Jessica Thwaites	Lisbon, NH.
13. Craig R Beane	Craig R Beane	Littleton NH
14. Todd Colpitts	Todd Colpitts	Littleton NH
15. Cathy Grimes	Cathy Grimes	Woodsville NH
16. Michael Morton	Michael Morton	Littleton, N.H
17. Ashley Tesriquez	Ashley Tesriquez	littleton N. H.
18. GORDON STOCKMAN	Gordon Stockman	Littleton NH
19. William J. Barnes	William J Barnes	Lisbon, N.H.
20. LINDA BARNES	Linda Barnes	Lisbon, NH
21. Jamie Lavigne	Jamie Lavigne	Sugar Hill NH
22. SHARON GEARY	Sharon Geary	Littleton, NH
23. Emily Nute	Emily Nute	Littleton, NH
24. EDWARD TAYLOR	Edward Taylor	LISBON NH
25.		

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1. Nina M Brown	Nina M Brown	Lisbon, NH.
2. Byron Aldrich	Byron Aldrich	Lisbon, NH
3. Suzanne M. Valliere	Suzanne M. Valliere	Dalton, NH.
4. Eleanor Fink	Eleanor Fink	Franconia, NH.
5. Julie Ellsworth	Julie Ellsworth	Littleton N.H.
6. John Ellsworth	John Ellsworth	Littleton N.H.
7. Brenda R. Knapp	Brenda R. Knapp	Littleton N.H.
8. Jason R Pearson	Jason R Pearson	Littleton NH.
9. Marge Tarsey	Marjorie Tarsey	Littleton NH
10. Brigitte Taylor	Brigitte Taylor	Bethlehem N H
11. Holly Eastman	Holly Eastman	Littleton, NH. 03561
12. Danielle Beaulieu	Danielle Beaulieu	Franconia, NH
13. Peter Higbee	Peter Higbee	Berlin, NH
14. Judith F Aydelott	Judith F Aydelott	Franconia, NH
15. Carl Belz	Carl Belz	Franconia NH
16. Donna Flanders	Donna Flanders	Franconia, NH
17. Harvey Flanders	Harvey Flanders	Franconia, NH
18. Karl Wickenheiss	Karl Wickenheiss	Sugar Hill NH
19. Daniel Albright	Daniel Albright	Dalton NH
20. Jeffrey Corey	Jeffrey Corey	Littleton N.H.
21. Rosemary Ellms	Rosemary Ellms	Sugar Hill NH
22. Luci Pineault	Luci Pineault	Littleton N.H.
23. Stephen G. Cox	Stephen G. Cox	Whitefield NH
24. Linda Marion	Linda Marion	Littleton NH

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1. Abra A. Stefanos		Pike NH
2. Eugene C. Jarnett		Orfordville NH
3. Ellen Clark	Ellen Clark	Warren NH
4. Bobbie Jo Briggs	Bobbie Jo Briggs	Warren NH
5. LAURIE MITCHELL	LAURIE MITCHELL	Warren NH
6. Margaret E Bixby	Margaret Bixby	Warren, N.H.
7. Sandra Briggs	Sandra Briggs	Warren, NH
8. Sharon Sanborn	Sharon Sanborn	Wentworth, N.H.
9. Warren Stickney		Warren, NH
10. Mary Hill	Mary Hill	Plymouth NH
11. Dorothy C. Powell	Dorothy C. Powell	Wentworth 03282
12. Bobbie Jo Briggs	Bobbie Jo Briggs	Warren NH
13. Bob Boisvert	Bob Boisvert	Bristol NH
14. Elizabeth P.C. Wilkin	Elizabeth P.C. Wilkin	Warren, NH
15. Tony L. Nelson		Dorchester
16. Debra Bryant	Debra Bryant	Glencliff N.H
17. Leon J. Kerr	Leon J. Kerr	Rumney, NH
18. Bernadette V. Dupont	Bernadette V. Dupont	Plymouth, NH
19. Albert Cooney	Barbara Hall	878 Dorchester Rd. Rumney
20. CHARLES T. EDDY	C. Eddy	WARREN NH
21. Cher Woods	Cher Woods	Plymouth NH
22. Denise Brown	Denise Brown	Wentworth, NH.
23. LUANN TALIAFERRO	Luann M Taliaferro	Dorchester NH
24. Denise Brown	Denise Brown	Wentworth NH.
25. Sarah K Hall	Sarah K Hall	Warren NH

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1. JANET HILL		Bethlehem NH
2. Christine Mays		Lisbon NH
3. Mary Devine		Twin Mtn NH
4. Marie Snyder		Sugar Hill NH
5. Cassy Lynn Janes		Bethlehem, NH
6. Shane Cunningham		Bethlehem NH
7. Ronald Valliere		Dalton, NH
8. Jason Beard		Bethlehem NH
9. Joanna Ennon		Whitefield, NH
10. Caitlin O Connor		Littleton, NH
11. Sarah Brooks	SARAH BROOKS	SUGAR HILL, NH
12. NITRA LAHRI		Bethlehem, NH
13. DANIEL SPARKS		Littleton N.H.
14. Steve Briggs		Whitefield NH
15. John D. Wolf Jr	JOHN D. WOLF, JR.	W. Rutland, VT.
16. George & Rita Swan		Waterford VT 05819
17. MAUD L. THOMPSON		Littleton, NH
18. ALEX THOMPSON		BETHLEHEM, NH
19. Lucy Downey		Franconia N.H.
20. William Downey		Franconia, NH.
21. Helene Pelletier		Littleton N.H.
22. Doris a Bean		Bethlehem NH.
23. ANNE C TERHAAR		Franconia NH
24. ANNE PECKETT		EASTON NH

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. MELANIE HAMILTON	Melanie Hamilton	Lyman NH
2. WOODY MILLER	Woody Miller	Sugar Hill, NH
3. Herbert H. Hunt	HERBERT H HUNT	Sugar Hill N.H.
4. N. BEVERLY DOYEN	N Beverly Doyen	Littleton, NH
5. Lisa Bourbeau		Sugar Hill NH
6. Debra Hanson		N. Woodstock, NH
7. Marge Le Blanc	Marge LeBlanc	Littleton NH
8. Melanie Blinstrub	Melanie Blinstrub	Groton NH
9. Valerie Francis	Valerie Francis	Bethlehem NH
10. Kaitlyn Dutton		Franconia, NH
11. Elise Drake		Franconia NH
12. JANICE KNIGHT	Janice Knight	FRANCONIA NH
13. Bud Bergeron		Lincoln, N.H.
14. Thayer Newport	Thayer Newport	Littleton N.H.
15. Anne Terhaar	ANNE C TERHAAR	Franconia, N.H.
16. Jean Pelletier	Jean Pelletier	Bethlehem, NH
17. Jim Gray		Littleton, NH
18. Amy Vencina	Amy Vencina	Sugar Hill, NH
19. Sylvia Forge		Lisbon NH
20. [illegible]	[illegible]	Franconia, N.H.
21. Kent H. Gordon	Kent H. Gordon	Jefferson, NH
22. Courtney Brady	Courtney Brady	Bethlehem, NH
23. Denys Draper	Denys S Draper	Easton, NH
24. Mindy Lagasse	Mlagasse	LITTLETON NH

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1. Lawrence Jones	Lawrence Jones	Wentworth NH
2. Jonathan Moulton	Jonathan Moulton	Wentworth NH
3. Betty Stickney	Betty J. Stickney	Warren, NH
4. Arnold Evans	Arnold C. Evans	Wentworth, NH
5. Wally Foggs	Wally Foggs	Rumney N.H
6. Eric Jones	Eric Jones	Glencliff, NH
7. Lewis Bancroft	Lewis Bancroft	Warren, NH
8. Donald Holmes	Donald Holmes	Warren NH
9. Ken Mills	Ken Mills	Rumney NH
10. Beverly Wright	Beverly A Wright	Glencliff, N.H.
11. Thomas King	Thomas King	Warren N.H.
12. Cathy Oikle	Cathy Oikle	Rumney NH.
13. Charles Virginia Burnham	Charles Burnham	Glencliff NH
14. Virginia Burnham	Virginia Burnham	Rumney, N.H.
15. Mary F Cataldo	Mary Cataldo	North Haverhill NH
16. Laurie Linhares	Laurie Linhares	Wentworth NH.
17. Maresa M. Mills	Maresa M. Mills	Wentworth, NH
18. Avis Cushing	Avis Cushing	Warren, NH
19. Eleanor R. Murray	Eleanor R. Murray	Wentworth NH
20. Susan W. Spencer	Susan W. Spencer	Warren NH
21. Marshall T. Wootton	Marshall T. Wootton	Rumney N.H.
22. Estella Ramsay ↔	Estella Ramsay	Warren NH
23. Kathleen S. Evans	Kathleen Evans	Wentworth N.H
24. Catherine E. Somma	Catherine E. Somma	Warren, NH
25. Michele E. Juraska	Michele E. Juraska	Warren, NH
Constance Kondasis	Constance Kondasis	Bristol NH
Claudia Mennado	Claudia Mennado	Bristol NH

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1.	PHILIP T STRUHSACKER	Philip T Struhsacker	FRANCONIA, N.H.
2.	MARJORIE M STRUHSACKER	Marjorie M Struhsacker	FRANCONIA, N.H.
3.	Michael Russell	Michael Russell	Franconia, NH
4.	SIDNEY REGER	Sidney Reger	SUGAR HILL, NH
5.	A Leighton	A Leighton	Sugar Hill NH
6.	DIANA WRIGHTSON	Diana Wrightson	Lancaster N.H.
7.	Roger Clough	Roger Clough	GLYMAN N.H.
8.	Barbara Williams	BARBARA WILLIAMS	Franconia, N.H.
9.	Gladys Landry	Gladys Landry	Dalton N.H
10.	A C Edmunds	A C EDMUNDS	FRANC
11.	Marian Edmunds	MARIAN EDMUNDS	FRANCONIA -
12.	Robert Labonte	ROBERT LABONTE	FRANCONIA
13.	Mary Lou Stafford	Dexter Stafford	Littleton N.H.
14.	MICHAEL E SERGEI	Michael Sergei	FRANCONIA NH.
15.	GARY WILLIAMS	Gary Williams	Lyman, NH
16.	Thelma Branscombe	Thelma Branscombe	Lincoln, NH
17.	Louise Gregoire-Allen	Louise Gregoire-Allen	Franconia, NH
18.	Miriam Russell	Miriam Russell	Franconia NH.
19.	Ned Wilson	Ned Wilson	1170 RTE 117 SUGAR HILL NH
20.	Dale C. Jette	Dale C. Jette	Bethlehem, N.H.
21.	Robin Fenton	Robin Fenton	Littleton NH
22.	Fay Lloyd	Fay Lloyd	Bethlehem, NH
23.	Herb Lloyd	Herb Lloyd	Bethlehem NH
24.	GERARD F. BENSON	Gerard F. Benson	EASTON, NH

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1. Janice Lebron	Janice Lebron	Groton, VT.
2. Silvestre Lebron	Silvestre Lebron	Groton VT
3. Jane M. Chamberlin	June Chamberlin	Benton, N.H.
4. Lisa Woodbeck	Lisa Woodbeck	Piermont N.H.
5. Robert Astle	Robert Astle	Woodsville, NH
6. Amy Bragg	Amy Bragg	
7. Rosalie Farr	Rosalie Farr	Haverhill, NH
8. Cameron Wood	Cam Wood	Bath, NH
9. Toni Dimick	Toni M Dimick	Woodsville NH
10. Lee Soparnik		Woodsville NH
11. Lori Santoro	Lori Santoro	Bath, NH
12. Darlene McCrumb	Darlene McCrumb	Bath NH
13. Bruce Tupper	Bruce Tupper	Monroe N.H.
14. [redacted] Dianelucd	Diane Lucd	Ryegate, VT
15. Abigail Kennedy	Abigail Kennedy	Bath NH
16. Linda McLeod	Linda McLeod	S. Ryegate VT.
17. Wendy Chamberlain	Wendy Chamberlain	S. Ryegate, VT.
18. Janet L Morton	Janet L Morton	No Haverhill NH
19. Rebecca L Lynnell	Rebecca L Lynnell	N. Haverhill NH
20. Wanda L Leonard	Wanda Leonard	No. Haverhill, NH
21. Marie D. Lamothe	Marie D Lamothe	Warren, N.H.
22. Peter E Lamothe	Peter E Lamothe	Warren N.H.
23. Leslie Keith	Leslie Keith	Woodsville NH
Jeffrey Fullerton	Jeffrey Fullerton	N. Haverhill NH

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1.	Carol Heneneway	Carol Heneneway	Littleton. NH
2.	Michelle Routhier	Michelle Routhier	Bethlehem NH
3.	CHRISTINE LATULIP		LITTLETON, NH
4.	Margaret Connors		Sugarhill NH
5.			
6.	Meri Hern	Meri Hern	Sugar Hill NH
7.	Elwood Mardin	Elwood mardin	Lisbon NH
8.	Jeff Mann		Whitefield NH.
9.			
10.	Andrew Cook	Andrew Cook	Lisbon NH.
11.			
12.	Joanne C. Blaney	Joanne C. Blaney	Bethlehem NH
13.	Lisa May	Lisa May	Lisbon NH
14.	DEBORAH BROWN	Deborah Brown	LANDAFF NH
15.	Josh T. Jun		Littleton NH
16.	Rose Larrivee	Rose Larrivee	Littleton NH
17.	Kim Carver		Lisbon, NH
18.	B Serafini	B SERAFINI	Sugar Hill NH
19.	John Matyas	John Matyas	Lyndonville, VT
20.	Michael P. Pascale	Michael P. Pascale	Franconia N.H.
21.	Melanie Kerr	Melanie Kerr	Sugar Hill NH
22.	Tina Doherty	Tina Doherty	Bethlehem NH
23.		Marlo Morris	Bethlehem NH
24.	Caitlin O'Connor	Caitlin O'Connor	Littleton, NH
25.	Margaret E. Gale	Margaret E Gale	Bethlehem NH

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1.	Doris B. Mitton	Doris B. Mitton	Dalton, N.H
2.	DEBORAH ERNST	Deborah Ernst	LITTLETON, NH
3.	JILL T. PaKos	Jill T. Pa	Lincoln N.H.
4.	Robin Tenoff	Robin Tenoff	Littleton, N.H
5.	Wendy Manning	Wendy Manning	Franconia, NH
6.	Francis Grumad		Littleton NH
7.	Rosalie Robertson	Rosalie M Robertson	Sugar Hill
8.	Dawn Greenleaf	Dawn Greenleaf	Franconia NH
9.	~~Becky DiChristopher~~	~~Becky DiChristopher~~	~~Lyman, NH~~
10.	Rebecca Dawn DiChristopher	Rebecca DiChristopher	Lyman, NH
11.	ELWOOD MARDIN	Elwood Mardin	Lisbon NH
12.	MIRANDA YOUNG	Miranda Young	Franconia NH.
13.	alyson Yang	alyson Yang KN	Grafton, MA.
14.	TOM ROSS		Littleton, NH
15.	STEPHEN M. WELLS	Stephen M. Wells	Franconia, NH
16.	Margaret Rambeck	Margaret Rambeck	Bethlehem, NH
17.	Robert Fenimore	Robert Fenimore	Bethlehem, NH
18.	PETER K. MOGREN	Peter K. Mogren	Sugar Hill, N.H.
19.	JOSEPH NELSON	Joe Nelson	FRANCONIA, NH
20.	Megan Willey	Megan Willey	Littleton NH
21.	Wayne Clough	Wayne Clough	Littleton NH
22.	Deane Palm	Deane Palm	Littleton, NH
23.	Laurie Murphy	Laurie Murphy	Littleton, NH
24.	JAMES I Moody	James I Moody	Bethlehem, N.H.

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1.	LENISE CROWLEY		TWIN MT., NH
2.	CYNTHIA HOUGHTON		Littleton, NH
3.			
4.	Marlo Norris		Bethlehem NH
5.	Bonnie Mattox		Franconia, NH
6.	Savanah Miller		Littleton NH.
7.	Le Ann Bladgett		Littleton N.H.
8.	Carol-Ann S. Blake		Bethlehem, N.H.
9.	ALDEN H. BLAKE		" "
10.	GINA D McHugh		Littleton N.H.
11.	Audrey Crowe		Franconia, NH
12.	Edith Aldrich		Littleton N.H.
13.	David Lee Ash		Littleton N.H.
14.	Judith Stanley		Bethlehem, NH.
15.	Sally Sherrard		Littleton, NH
16.	Melissa Emerson		Sugar Hill, NH
17.	Michele MacCorison		Twin Mountain, NH
18.	MARK GROBLEWSKI		LYMAN NH
19.	MARY RICKER	Littleton	N H
20.	ALAN C DUPUIS		Litt NH
21.	Richard A. FAGNANT		Woodsville / Monroe
22.			
23.	Linda LaFrance		Littleton, NH
24.	Maelinda LaFrance		Littleton NH
25.	June C. Dutilly		Littleton NH

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1.	DANNY A. ROWAN	Danny A. Rowan	Colebrook, N.H.
2.	SARAH A AVERY	Sarah A Avery	Littleton N.H
3.	Eileen Shea	Eileen Shea	Littleton, NH
4.	Melissa Emerson	Melissa Emerson	Sugar Hill, NH
5.	Edith Aldrich	Edith Aldrich	Littleton N.H.
6.	Sheila Heartbeat	Sheila Heartbeat	Lisbon NH
7.	Thomas H Campbell	Thomas H Campbell	Littleton, NH
8.	Patricia R. Campbell	Patricia R Campbell	Littleton, NH
9.	BARBARA V. BELZ	Barbara V. Belz	Franconia, NH
10.	DONNA M. HUSSEY	Donna M. Hussey	Littleton, NH
11.	Catherine M Lewis	Catherine M Lewis	Littleton, NH
12.	Carlton LaSelle	Carlton LaSelle	Littleton NH
13.	SCOTT BRIGGS	Scott Briggs	Littleton NH
14.	Carlene Gadapee	Carlene Gadapee	Littleton NH
15.	DIANE SUTTON	Diane Sutton	Lancaster, NH
16.	Bill SUTTON	Bill Sutton	Lancaster, NH
17.	ELWOOD MARDIN	Elwood Merdin	Lisbon NH
18.	MELODY CARRIERS	Melody Carriers	Whitefield NH
19.	NICK MIKE	Nick Mike	Franconia, NH
20.	Fred MAYO	Fred Mayo	Lisbon NH
21.	MARY G.T. FOWLER	Mary G.T. Fowler	Franconia, NH
22.	FLORENCE RUGGLES	Florence Ruggles	Littleton NH
23.	Carolyn L. Hunt	Carolyn L. Hunt	Littleton, NH
24.	Beverly A Frankenbach	Beverly A Frankenbach	Sugar Hill, NH
25.	CHRISTINE CURRAN	Christine Curran	Bethlehem N.H.

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1.	FAVOR JENKINS	Favor Jenkins	WENTWORTH N.H.
2.	Arline Hill	Arline Hill	Wentworth, N H
3.	MARSHALL MCLTIN	Marshall McLtin	RUMNEY, NH
4.	CHARLES CAMERON	Charles Cameron	PIKE N.H.
5.	Heather Berthuit	Heather Berthuit	Warren, NH
6.	Philip L. KENDALL	Philip L Kendall	Wentworth N.H.
7.	Miranda Goggin	Miranda Goggin	GLENCLIFF, NH
8.	Allison Morrison	Allison Morrison	Wentworth, NH 03282
9.	Angela Balch	Angela Balch	Warren N.H.
10.	CHARLOTTE S. PARK	Charlotte S Park	Rumney, NH 03266
11.	GEORGE R. EKWALL	George R Ekwall	PIKE NH 03780
12.	Shirley Coon	Shirley C Coon	" " "
13.	Hollie Pike	Hollie Pike	Warren NH
14.	Claudia Meringolo	Claudia Meringolo	Bristol NH
15.	Elizabeth Wilkin	Elizabeth Wilkin	Warren, NH
16.	Mary Cataldo	Mary Cataldo	North Haverhill, NH
17.	Elizabeth Davison	Mary Cataldo POA	North Haverhill NH
18.	Donna Renkert	Donna Renkert	Warren NH.
19.	Dorothy A. Powell	Dorothy A. Powell	Wentworth, NH 03282
20.	Philip Belyea	Philip Belyea	Glenclyff, NH
21.	ANNA RIVERS	Anna Rivers	WARREN, NH
22.	DOUGLAS CLARK	Douglas Clark	WARREN NH
23.	Stephanie J Bonilla	Stephanie J Bonilla	Groton NH
24.	Denise Brown	Denise H. Brown	Wentworth, NH
25.			

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1.	Lisa McDonough		Littleton, NH
2.	Tina Doughty		Bethlehem NH
3.	Peter R. Dawton		Franconia, NH
4.	JOE ANN T. VAN GELDER		Bethlehem NH
5.	FRADA KAPLAN		Lyman NH
6.	LAWRENCE HALEY		LYMAN, N.H
7.	MABEL A. MACKIE		Littleton, N.H.
8.	Patel Ramanlal		Franconia, NH
9.	Florence Webb		Landaff NH
10.	Marlo Norris		Bethlehem NH
11.	Teresa Driggs		Lisbon NH
12.	ALDO Griggs		Lisbon, N.H
13.			
14.	Joann Jesseman		Franconic NH
15.	Dan Champney		Bethlehem, NH
16.	Pamela Reid		Littleton, NH
17.	Peggy Moore		Littleton NH
18.	Michelle Leavitt		Littleton NH.
19.	Linda Butler		Twin MA. N.H.
20.	Amanda Verret		Lisbon, NH
21.	Jake O'Dell		Lisbon, NH
22.	Allison Kummerle		Bethlehem NH
23.	PAMELA ARNDST		LITTLETON, NH
24.	MERI HERN		SUGAR HILL NH

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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Jennifer R. Frazier	Jennifer R. F—	Littleton NH
2. Lawrence R. Frazier	[signature]	Littleton NH.
3. Amy M Cole	Amy Cole	Littleton NH.
4. LINDA SHULDA	Linda Shulda	LISBON, NH
5. Deborah Brown	Deborah Brown	Bethlehem, NH
6. LYNN KENERSON	[signature]	Sugar Hill NH
7. Heidi Wright	Heidi Wright	Franconia, NH
8. HAROLD FRIEDMAN	Harold Friedman	Bethlehem N.H
9. SUE FRIEDMAN	Sue Friedman	Bethlehem, NH.
10. Jane ODonnell	Jane ODonnell	Littleton NH
11. Leslie PeMegrin	Leslie PeMegrin	Lisbon, NH
12. LINDA ALBUQUERQUE	[signature]	BETHLEHEM NH
13. Robert Fenimore	[signature]	Bethlehem NH
14. Evan Steinbeck	[signature]	Bethlehem NH
15. BARBARA V. BELZ	Barbara V. Belz	Franconia, NH
16. Amy A. Boy	[signature]	Sugar Hill, NH
17. Susan H Simpson	[signature]	Franconia NH
18. Raven Thompson	Raven Thompson	Franconia, NH
19. Edward L. OBrien	[signature]	Easton, NH.
20. Connie EMERSON	Connie Emerson	Lisbon, NH
21. Rick Tellegrin	[signature]	Lisbon NH
22. Frank Gramms	[signature]	Littleton
23. Trevor Hamilton	[signature]	Franconia
24. Amelia St. John	Amelia St. John	Littleton

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1.	Rosalie Robertson	Rosalie Robertson	Franconia
2.	Trevor Hamilton		Franconia, NH
3.	Maureen Thoma	Maureen Thoma	Bethlehem
4.	Megan Haggett	Megan Haggett	Littleton
5.	ERNEST MESSIER		LITTLETON
6.	Schuyler W. Sweet		Littleton, NH
7.	Arlett Baird	ARLETT BAIRD	Franconia, NH
8.	Bette Roberts		Littleton
9.	Glen Marro	Glen Marro	Whitefield
10.	Amy Gall	Amy Gall	Bath NH
11.	Weston Lemay		Littleton NH.
12.	Julie Ellsworth		Littleton N.H.
13.	Lena M		Bethlehem NH
14.	Cameron Mintz	Cameron Mintz	Bethlehem NH
15.	Audrey Crowe	Audrey Crowe	Franconia, NH
16.	Robert Laboncte	Robert Laboncte	Franconia NH
17.	Daniel A Sparks	DANIEL SPARKS	Littleton, N.H
18.	Jean Pelletier		Bethlehem, NH
19.	Marge LeBlanc	Marge LeBlanc	Littleton NH
20.	Tom Fillion	Tom Fillion	Littleton NH
21.	GARY S. BRANUM	Gary S. Branum	LISBON N.H.
22.	Heather	Heather	Lyman, NH
23.	Melanie Hamilton	MELANIE HAMILTON	Lyman NH
24.	Teresa Amey		Sugar Hill

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1.	Gail M. Hicks	Gail M Hicks	Littleton NH
2.	Patricia Leach	Patricia Leach	Littleton NH
3.	Rosalie Robertson	Rosalie Robertson	Franconia
4.	STEPHEN HUDON		LANDAFF, NH
5.	JOHN D. WOLF JR.	John D. Wolf Jr.	Whitefield, NH.
6.	RALPH BRIGHT	Ralph Bright	EASTON, NH
7.	Leslie Bunt	Leslie Bunt	Sugar Hill NH
8.	Joshua Munn	Joshua Munn	Littleton NH
9.	NANETTE AVRIL	Nanette Avril	Franconia, NH
10.	Gil Yule	Gil Yule	Franconia, NH
11.	Lucy Downey		Franconia
12.	William Downey	William Downey	Franconia
13.	Liam Downey	Liam Downey	Franconia
14.	Kasey Quinn Nightingale	Kasey Nightingale	Lisbon
15.	Bill Kenney	J. William Kenney	Easton
16.	Savannah Mitton	Savannah Mitton	Littleton, NH
17.	Kelly Iverson	Kelly Iverson	Whitefield, NH
18.	Cathy Strasser	Cathy Strasser	Sugar Hill N.H.
19.	Teresa McLeod	Teresa McLeod	N. Haverhill, NH
20.	J & N Johnson		Sugar Hill - NH
21.	Jeff Blodgett	JEFF BLODGETT	FRANCONIA
22.	Amy Gall	Amy Gall	Bath, NH
23.	JAY DESTROISMAISONS		LISBON, NH
24.	Karen Chiota	Karen Chiota	Lisbon, NH

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1.	J. William Steele		Franconia, NH
2.	Flossie I. Steele		" "
3.	Janet DeTilly		Lincoln NH.
4.	Evi Twombly		Thornton, NH
5.	Walter Twombly		Thornton, NH
6.	John A. Russell		Sugar Hill, NH.
7.	Josh Yeargle		Littleton NH.
8.	Rachel Clark		Bethlehem NH
9.	Richard S. Holland		Littleton, NH
10.	JADE MILLER		N. Woodstock, NH
11.	ZBIGNIEW MROCZKO		WHITEFIELD, NH.
12.	JOY Sullivan		Bethlehem NH
13.	Mary Lou Stafford		Littleton N.H.
14.	Dexter STAFFORD		"
15.	Christy Riordan		Bethlehem NH
16.	Curtis W. Mardin		Littleton, N.H. 03561
17.	Deborah Harris		Littleton NH 03561
18.	Susan Kool		Littleton NH
19.	Lynn Kenerson		Sugar Hill NH
20.	michelle Herbert		Littleton NH
21.	Francis Grammo		Littleton NH
22.	Howard Mills		Sugar Hill NH
23.	Kristin Ely		
24.	Deborah Marcotte		Bethlehem NH

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1.	LETA RAINVILLE	Leta Rainville	Lisbon NH
2.	Katelyn Sirois	Katelyn Sirois	Bethlehem NH
3.	Kim Clos	Kim Clos	
4.	Scott Powers		Franconia NH
5.	Brooke Campbell	Brooke Campbell	Bethlehem, NH
6.			Whitefield NH
7.	Geneva Gasper	Geneva Gasper	Bretton Woods NH
8.	Ethel Roberto	ETHEL ROBERTO	SUGAR HILL, N.H.
9.	Ashley Bama	Ashley Bama	Littleton, NH
10.	DENNIS SULLIVAN	Dennis Sullivan	Franconia, N.H.
11.	Kim Clos	Kimberly Clos	Littleton NH.
12.	Tammy Cote	Tammy Cote	Lit. NH
13.	Geneva Gasper	Geneva Gasper	Bretton Woods NH
14.	NANCY BLAMPIED	Nancy Blampied	Sugar Hill, N.H.
15.	BLAKE ROBINSON	Blake Robinson	Sugar Hill, NH
16.	Ashley Balmer	Ashley Balmer	Littleton, NH
17.	DENNIS SULLIVAN	Dennis Sullivan	Franconia
18.	Van Steinbeck		Bethlehem NH 0352
19.	Michelle Jackson		Bethlehem NH 0357
20.	Tracy L. McNamara	Tracy L. McNamara	Littleton NH 03561
21.	ANDREW PELOQUIN		LITTLETON NH
22.			Littleton, NH
23.	Cheryl W. Merrill	Cheryl W. Merrill	Littleton, NH
24.	Michele Campbell	Michele Campbell	
25.	John Stanley	John Stanley	Bethlehem, NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	RUSSELL ANGEL	Russell Angel	Groveton, NH.
2.	[illegible]	[illegible]	Franconia NH.
3.	Helen PIKE	[illegible]	Waterford, VT
4.	Peggy Moore	Peggy Moore	Littleton NH
5.	Keith Garneau	Keith Garneau	Bethlehem NH
6.	Crystal Haggon	Crystal Haggon	Littleton NH
7.	Carolyn Francis	Carolyn Francis	Whitefield NH
8.	Marlo Notis	[illegible]	
9.	Sally Sherrard	Sally Sherrard	Littleton NH
10.	Ashley Belmore	Ashley Belmore	Littleton, NH
11.	Richard N. Moore	Richard N. Moore	Bethlehem NH
12.	Lyn Thomas	[illegible]	Littleton, NH
13.	Robert Sherburne	[illegible]	Franconia NH
14.	Mike Ritter	[illegible]	Bethlehem NH
15.	Barbara Lloyd	[illegible]	Jefferson NH
16.	Tori Breen	Tori Breen	Bethlehem, NH
17.	SANDRA KONICEL	Sandra Konicel	St J, VT
18.	JOAN DUBE	Joan Dube	LITTLETON N.H
19.	Tammy Cote	Tammy Cote	Lit. NH
20.	Erin Stokesbury	Erin Stokesbury	Bethlehem, NH
21.	Susan M. Wentworth	Susan M. Wentworth	Northumberland NH
22.	Erin Stokesbury	Erin Stokesbury	Bethlehem, NH
23.	Sharon Small	Sharon Small	Littleton, NH
24.	[illegible] Howe		
25.		Tatyana Becker	Lisbon, NH
	Tara M Berry	Tara M Berry	Dalton, NH
	Nicole Brockney	Nicole Brockney II	St. Johnsbury, VT.

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1.	Jennifer Ingerson	Jennifer Ingerson	Bethlehem NH
2.	Linda J. Sergei	Linda J. Sergei	Franconia NH
3.	Mary Pelletier	Mary Pelletier	Bethlehem NH
4.	GAETANO V GRIMA	Gaetano V Grima	Franconia NH
5.	Kristy Rowe	Kristy Rowe	Waterford, VT
6.	Kelly Irving	Kelly Irving	Littleton NH
7.			
8.	Mary Edick	Mary Edick	Littleton NH
9.	JAN EDICK	Jan Edick	Littleton, NH.
10.	ROBERT DERRINGTON	Robert Derrington	LITTLETON, N.H.
11.	Martha Bruce	Martha Bruce	Franconia NH
12.	Phil B	Phil Becony	Bethlehem, NH
13.	Colette Clough	Colette Clough	Littleton NH
14.	Debra Baker	Debra Baker	Littleton NH
15.	Joyce Krill	Joyce Krill	Franconia, NH
16.	JEAN-MARC TREBUCHON		BETHLEHEM, NH
17.	William Bedor	William Bedor	Littleton, N.H.
18.	Catherine Strasser		Sugar Hill NH
19.	Carl D. Martin		Sugar Hill NH
20.	DAVID FICKMAN		BETHLEHEM, NH
21.	NINA TOUTANT		Lisbon, N.H.
22.	Cynthia L. Johnson	Cindy Johnson	FRANCONIA, N.H.
23.	SHARON HANCE	Sharon Hance	FRANCONIA N.H.
24.	Molly Fulton	Molly Fulton	Bethlehem, NH

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1.	Cathy Hayward	Cathy Hayward	Littleton, NH
2.	Robin Howard	Robin Howard	Landaff, NH
3.	Jennie King	Jennie King	Littleton NH
4.	PAT BOISUER	Pat Boisuer	Littleton NH
5.	Janet Murphy	Janet Murphy	Littleton, N.H.
6.	Cathy Beaau	Cathy Beaau	Littleton N.H.
7.	Kimberly A. Hamel	Kimberly A. Hamel	Bethlehem NH
8.	Katelyn Sirois	Katelyn Sirois	Bethlehem NH
9.	Eileen Shea	Eileen Shea	Littleton, NH
10.	EDWARD SHIRSHAC	Edward Shirshac	DALTON, NH.
11.	[illegible]		
12.	Jenny Burge		Dalton, N.H.
13.	Kristy Nelson / Kristy Nelson		Woodsville, NH
14.	Joan Nash	Janette Lee Nash	Wentworth, NH
15.	Sara Somers		
16.	SCOTT JONAS		LISBON, N.H.
17.	Heather Paye	Heather Paye	Littleton, NH
18.	Katie A. Burgess	Katie A. Burgess	Littleton, NH
19.	Jessica Gautreau	JESSICA GAUTREAU	LISBON, NH
20.	Jeff Jesseman		Franconia NH
21.	JAMES FOLEY		BETHLEHEM N.H.
22.	Jenny Rogers	Jenny Rogers	Franconia, NH
23.	Ryan Parcell		Bethlehem, N.H.
24.	James E Herbert	JAMES E HERBERT	TWIN MT, NH

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1.	Edward Blaisdell	Edward Blaisdell	Ashland NH
2.	Theresa Evans	Theresa Evans	Wentworth NH
3.	Deborah Dickman	Deborah Dickman	Plymouth NH
4.	JACKLYN CROSBY		WARREN, NH
5.	Kathrin Beckett		Groton NH
6.	Felida Penn		Wells River, VT
7.	BERNARD MURPHY	Bernard Murphy	No. Haverhill N.H 03774
8.	Sharon Sanborn	Sharon Sanborn	Wentworth, N.H
9.	JEFF CROSBY		WARREN, N.H.
10.	GEORGE ANDERSON		WENTWORTH NH
11.	Tamara Bevins	Tamara Bevins	Wentworth NH
12.	CHARLES J. HALL	Charles J. Hall	Rumney N.H.
13.	Melissa Barton	Melissa Barton	Wentworth N.H.
14.	KERRY BROWN	Kerry Brown	Wentworth, N.H.
15.	RICHARD BROWN		Wentworth, NH
16.	Samuel E. Fulford	Samuel E. Fulford	Orford N.H.
17.	Ellen Comeau	Ellen Comeau	Rumney, NH
18.	Kaitlin Blodgett	Kaitlin Blodgett	Rumney, NH
19.	Taylor Newberry		Plymouth N.H
20.	Roxanne "B." Thompson	Roxanne B. Thompson	Ashland
21.	Dan Thompson	Dan Thompson	ashland
22.	Linda M. Dow	Linda Dow	Ashland
23.	Alice A. French	Alice A. French	Plymouth
24.	John A. Bean	John A. Bean	Plymouth

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1.	Colleen McEwan	Colleen McEwan	Jefferson NH
2.	Elise J. Lawson	Elise J. Lawson	Bethlehem, NH
3.	Shannon Leslie	Shan Le	Bethlehem, NH
4.	Rachel Bell	Rachel Bell	Littleton, NH
5.	MELANIE HAMILTON	Melanie Ham	Lyman NH
6.	Josh Tilson		Littleton NH
7.	Dan Champney		Bethlehem, NH
8.	Nadine Ciccarello		Bath, NH
9.	Irene Gillery		Twin Mt. NH
10.	Jen Chandon		Jefferson, NH
11.	Rodney Stone		Bethlehem NH
12.	Wayne A. Derby		03574
13.	WILLIAM ALLISON JR		Littleton 03561
14.	Kaylee Osborne		Littleton NH
15.	Francis Gramma		Littleton NH
16.	Rick Pellegrin		Lisbon NH
17.	Laurie MacGregor		Lisbon, NH
18.	Patrick Flanagan	PATRICK FLANAGAN	Littleton NH
19.	Cathy Besaw	Cathy Besaw	Littleton N.H.
20.	M Scales	Monica Scales	Twin Mt NH
21.	Adam Wetherbee	Adam Wetherbee	Littleton, NH
22.	Robin Howard	Robin Howard	Landaff, NH
23.	Dorothy Jaynes	Dorothy Jaynes	Monroe NH
24.	Eleanor Hughes	Eleanor Hughes	Warren, NH

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1. LISA MURE		Holderness NH
2. Heather Chabot	Heather Chabot	Campton, NH
3. Jane Whitcher Woodes	Jane Whitcher	Warren
4. Margaret Whitcher	Margaret Whitcher	"
5. Joyce Balch Woodes	Joyce Balch Woodes	Westleboro
6. Kendra Hurd	Kendra Hurd	Meredith
7. Katlin Blodgett	Katlin Blodgett	Rumne
8. Theresa Evans		Wentworth
9. MARK A. EVANS	Mark A. Evans	Wentworth, N.H
10. Deborah Hill	Deborah Hill	Pike NH
11. Jessica Hill	Jessica Hill	Pike NH
12. SUSAN MCLEAN	Susan McLean	Warren NH
13. GEORGE ANDERSON	George Anderson	WENTWORTH NH
14. NEAL KELYEA	Neal Kelyea	PLYMOUTH
15. DONNA RENKERT	Donna Renkert	Warren, NH
16. PETER H. ALFORD	Peter H. Alford	WARREN, N.H.
17. E. Blais Aldridge		Woodsville, NH
18. Bree Mchugh	Bree Mchugh	Warren NH
19. JANET MUIR	Janet Muir	BATH, NH
20. Sharon Sanborn		Wentworth, N.H.
21. Katlin Blodgett		Rumney NH
22. Charles J. Hall	Charles J. Hall	Rumney NH
23. Galena Fair		Warren NH
24. Stephanie Woodley	Stephanie Woodley	Laconia, NH

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Ashley Pinco	Ashley Pinco	Littleton, NH
2.	Jenny Burge	Jenny Burge	Dalton NH
3.	Angela Bucke	Angela Bucke	Franconia
4.	Mindy Parades		Bethlehem NH
5.	Jean Bowman	Jan Bowman	Bethlehem NH
6.	Michelle Jackson	Michelle Jackson	Bethlehem NH
7.	Marlo Nassis		Bethlehem NH
8.	~~Mark~~ MARK HERSEY		LISBON NH
9.	NANCY HERSEY	Nancy Hersey	Lisbon NH
10.	Joanna Lyman		Whitefield NH
11.	Suzanne Drew		Easton, NH
12.	Carlene T Whitcomb	Carlene T Whitcomb	Littleton NH
13.	Anastasia Shepheard		Littleton NH
14.	Catherine Gould	Catherine Gould	Littleton NH
15.	Margaret Williams		Littleton NH
16.	Jennifer E King	Jennifer E. King	Littleton NH
17.	Sarah Ann Allen		Littleton, NH
18.	Irene Gillery		Twin Mt NH
19.			Lunenburg VT
20.	Jessica Emerson	Jessica Emerson	Littleton, NH
21.	Alice K Frazer	Alice K. FRAZER	Monroe, NH
22.	Jillyn Nurell		Bethlehem, NH
23.	Michael Scanlon		Littleton, NH
24.	Kathleen D Duffy	KATHLEEN D DUFFY	LISBON, NH

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1. Clare L. Brown	Clare L. Brown	Bethlehem, NH
2. Lucille Gherardi	Lucille Gherardi	Littleton, NH
3. Nancy Sheehan	Nancy Sheehan	Littleton, NH
4 Carol B Boucher	Carol B Boucher	Bethlehem NH
5. Betty Gauthier	Betty Gauthier	Whitefield, NH
6. Mary M. Bates	Mary M. Bates	Lancaster, NH
7. Kathryn Parker	Kathryn Parker	Whitefield, NH
8. Nancy Mitigny	Nancy Mitigny	Twin Mtn NH
9. Sheila Keach	Sheila Keach	Littleton, NH
10. Helen Brennan	Helen Brennan	Dalton NH
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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Juliette Ainsworth		Bethlehem
2. Sarah DeAngelis		
3. Cassy Lynn Janes	Cassy L. Janes	Littleton, NH
4. Laura Kathreiner		Bethlehem, NH
5. Ashley Lafontaine	Ashley Lafontaine	Littleton NH
6. Cassie Audette		Littleton, NH
7. Richard Snelling		Bethlehem N.H.
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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Floyd GRAMMO	FEG	Littleton NH
2.	PETER ANDERSON		Sugar Hill NH
3.	Linda F Brown		Franconia NH
4.	MATT B Brown II		Franconia NH
5.	Rhonda Caswell		Bethlehem
6.	Valerie Basnar		Lisbon NH
7.			Franconia, NH
8.	Jennifer Walsh		Sugar Hill, NH
9.	Juliane Mackay		Littleton, NH
10.			Franconia NH
11.	ARYLYNE KIMBALL		Bethlehem, NH
12.	Dorothy E Carpinetti		Sugar Hill, N.H.
13.			Jefferson NH
14.			Bethlehem, NH
15.	Krystal Murray-Brown		Bethlehem
16.	Deborah Considine		Littleton, NH
17.	CURTIS W MARDIN		Littleton, N.H.
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1. Jon Walker	Jon Walker	East Ryegate, VT
2. Elaine Walker	Elaine Walker	E. Ryegate, VT
3. Staci Hood	Staci Hood	Newbury, VT
4. FRAN HUNT	Fran Hunt	So Ryegate, VT
5. BARRY MACDONALD	Barry MacDonald	N. Woodstock NH
6. Deb Simard		Bath, NH
7. Paul Motta		Woodsville NH
8. Doreen Hubert	Doreen K. Hubert	Danville, VT
9. Donald Hubert	Donald R. Hubert	Danville, VT
10. Barbara A. Bullard	Barbara A. Bullard	Woodsville, NH
11. Nicole Morris	Nicole Morris	Woodsville. NH
12. Jessica Darling	Jessica L Darling	S. Ryegate VT
13. STEPHEN WHITNEY	Stephen Whitney	Bath, NH
14. Valerie Brewer	Valerie Brewer	Woodsville, NH
15. Michael C. Lewis	Richard C. Lewis	E. Ryegate, VT
16. Tammy K Bunley	Tammy K Bunley	Woodsville NH
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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	PATRICIA JACOBS	Patricia Jacobs	N. Haverhill NH
2.	Holly Ilsley	Holly Ilsley	Bath, NH.
3.	Naomi George	Naomi George	Woodsville NH
4.	Chynna Lowe	Chynna Lowe	Littleton NH
5.	Karianne Rives	Karianne Rives	Woodsville NH
6.	Michelle Frost	Michelle Frost	Woodsville, NH
7.	Celeste A. Rheaume	Celeste A. Rheaume	N. Haverhill, NH.
8.			H NH
9.	DANIEL W. FOWLER II		N. HAVERHILL
10.	Lynne Butler	Lynne Butler	N Haverhill, NH
11.	Michelle Keegan	Michelle Keegan	N Haverhill NH
12.	Tori Grotjan	Tori Elaine Grotjan	Lisbon NH
13.	Pamela Gilbert	Pamela W Gilbert	N Haverhill NH
14.	Dolores Vitkofsky	Dolores Vitkofsky	Lisbon, NH
15.	Kimberly A Campbell	Kimberly Campbell	Woodsville, NH
16.	Richie Veilleux	Richie Veilleux	Lisbon NH
17.	MARIA M OLIVEIRA	Maria Oliveira	NO. HAVERHILL NH.
18.	MARGARET McGOVERN	Margaret McGovern	Woodsville, NH
19.	Theda Allen		
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1. Ethan Smith	Ethan Smith	Woodsville NH
2. Fallon-Dawn Smith	Fallon Smith	Woodsville NH
3. Ashley Marie Johnson	Ashley Johnson	Bradford Vt
4. Kathleen M. Johnson		Benton, NH
5. Marlene Sarkis		Haverhill NH
6. Lisa Veillette	Lisa Veillette	Lisbon N.H.
7. Michelle Keegan	Michelle Keegan	N. Haverhill, NH
8. Abigail Brown	Abigail Brown	N. Haverhill, NH
9. Lori Robbins	Lori Robbins	Bath
10. Ashley MacDonald	Ashley MacDonald	Lincoln, NH
11. Joan Emerson	Joan M Emerson	Woodsville NH
12. Bette Hannaford	Bette Hannaford	Lisbon, NH
13. Chrystal Aldrich	Chrystal L Aldrich	Haverhill NH
14. Andrea Vargo	ANDREA VARGO	Bath NH
15. Chris Hood	Chris Hood	N. Haverhill N.H
16. Heidi Comstock	Heidi Comstock	Lisbon, NH
17. Elizabeth Tyler	Elizabeth Tyler	N. Haverhill NH
18. Karen McNamara	Karen McNamara	Easton, NH
19. Jennifer Leggett	Jennifer Leggett	Gilford NH
20. Mandy Austin		
21. Lea Jenny		Piermont N.H.
22. Patricia Jacobs	Patricia Jacobs	N. Haverhill, NH
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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Sean Sweeney		Littleton, NH
2. Crystal Miller		Littleton NH.
3. Heather Morrison		Lisbon, NH.
4. Lyne M Mon		Bethlehem,
5. Don Lefebvre		Bethlehem, NH.
6. Rebecca Cumming		Bethlehem, NH
7. Michelle Routhier		Bethlehem, NH
8. Carol Hemenway		Littleton, NH
9. Dan Champney		Littleton, NH
10. Mitch Asney		Littleton NH
11. Maelinda LaFrance		Littleton NH
12. WAYNE DEMARS		BETHLEHEM NH
13. Robyn Balch		Gilman, VT
14. Duane PJ Jocca		Littleton, NH
15. Angie Benton		St Johnsbury, VT
16. PD		Bethlehem NH
17. Tina Doughty		Bethlehem NH
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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Teresa C. Brooks	Teresa C. Brooks	Littleton NH
2.	Carol A. Hemenway		Littleton, NH
3.	Stephen M. Noyes		Bethlehem NH
4.	JAMES A. COMMETTE	James A. Commette	Jefferson, N.H.
5.	Michelle Arsenault		Bethlehem NH
6.	Edward D Shanahan		Bethlehem NH
7.	ROBERT S. WEIR		BETHLEHEM, NH
8.	SHAWN. TESTER		Lyndonville, VT
9.	Kenneth L. Riebel		Littleton, NH
10.	Robert M TORTORICE		FRANCONIA, N/H
11.	Denise Crowley	DENISE CROWLEY	TWIN MTN NH
12.	Donald A. Bazzell		Haverhill, N.H.
13.	Charles J. Wolcott MD	Charles J. Wolcott MD	Sugar Hill, NH
14.	DAVID L. NELSON, D.O.		BENTON, NH
15.	Linda Stephens		Littleton, NH.
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1. Jessica Brunette	Jessica Brunette	Littleton, NH
2. Patricia McNamara	Patricia McNamara	Littleton, N.H.
3. Dee Hammerle	Dolores Hammerle	Littleton, N.H.
4. Kris Hennessey	Kris Hennessey	Lisbon NH
5. Kay Kerr	Kay Kerr	Bethlehem NH
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1.	LouAnn J. Knight	LouAnn J Knight	Littleton NH
2.	Margaret Michaud	Margaret Michaud	Dalton NH
3.	Ellen Walker	Ellen Walker	Bethlehem NH
4.	Tori Andrews	Tori Andrews	Littleton NH
5.	SANDRA CRONIN	Sandra Cronin	LUNENBURG VT
6.	Violette Guerra	Violette Guerra	N. Concord VT
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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Marlaina O'Reilly	MO'Reilly	Wentworth, NH
2.	Kim Pinkham	Kim Pinkham	N. Haverhill, NH
3.	Douglas M. Epsch		West Burke VT
4.	Lori J. Bird	Lori J. Bird	N. Haverhill, NH
5.	KRIS Hennessey	KTH	LISBON NH
6.	Andrew Colman		KVT Woodsville NH
7.	Graham Lydon		Woodsville NH
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1.	Michael KERIVAN		Bethlehem NH.
2.	Karen Carrivee	Karen Carrivee	Bethlehem NH.
3.	EVELYN M. SNOW	Evelyn M. Snow	Lisbon, N.H.
4.	Dolores WETMORE	Dolores Wetmore	WHITEFIELD, N.H.
5.	Cynthia Vermette	Cynthia Vermette	Whitefield, NH
6.	Rodger Vermette	Rodger Vermette	Whitefield, NH
7.	Heather Brownell	Heather Brownell	whitefield, NH
8.	Eileen Hurlbert	Eileen Hurlbert	Lancaster, N. H.
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1. Jon Walker	Jon Walker	East Ryegate, VT
2. Elaine Walker	Elaine Walker	E. Ryegate, VT
3. Staci Hood	Staci Hood	Newbury, VT
4. FRAN HUNT	Fran Hunt	So Ryegate, VT
5. BARRY MACDONALD	Barry S MacDonald	N. WOODSTOCK NH.
6. Deb Simon		Rumney, NH
7. Paul Motta		Woodsville NH
8. Doreen Hubert	Doreen K. Hubert	Danville, VT
9. Donald Hubert	Donald R. Hubert	Danville, VT
10. Barbara A. Bullard	Barbara A Bullard	Woodsville, NH
11. Nicole Morris	Nicole Morris	Woodsville. NH
12. Jessica Darling	Jessica L Darling	S. Ryegate VT
13. STEPHEN WHITNEY	Stephen Whitney	Bath, NH
14. Valerie Blewey	Valerie Blewey	Woodsville, NH
15. Michael C. Lewis	Michael C. Lewis	E. Ryegate, VT
16. Tammy K Burley	Tammy K Burley	Woodsville NH
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Ammonoosuc Community Health Services, Inc.

25 Mt. Eustis Road • Littleton, NH 03561 • 603.444.2464 • Fax 603.444.3441 • www.ammonoosuc.org

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First, we are writing in appreciation for your continued bi-partisan support of Federally Qualified Health Centers in general and for Ammonoosuc Community Health Services, specifically.

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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Barbara Fullerton	Barbara Fullerton	N. Haverhill, N.H.
2.	SABRINA M. HADLEY	Sabrina M. Hadley	WOODSVILLE, N.H.
3.	Norman R Ingalls	Tom Ingalls	N. Haverhill, NH
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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Denise Crowley	DENISE CROWLEY	Twin Mt NH
2.	Thomas H. Campbell	Thomas H Campbell	Littleton NH
3.	Anne M. Smith	Anne M Smith	Bethlehem, NH
4.	Helen Brennan	Helen Brennan	Dalton, NH
5.	Sandra Hesseltine	SANDRA HESSELTINE	Littleton, N.H.
6.	Maelinda LaFrance	Maelinda LaFrance	Littleton NH
7.	Claire Houghton	Claire Houghton	Whitefield, N.H.
8.	~~Wm Houghton~~		~~Whitefield~~ - N H
9.	Wm Houghton	Wm Houghton	Whitefield
10.	MEGAN E. BROWN	Megan E Brown	TWIN MTN, NH
11.	~~JOHN D. STORTON~~		Bethlehem NH
12.	ROBIN ROGERS	Robin Rogers	Woodsville
13.	Richard H Jensen		Nashua
14.	Patricia Rothney	Patricia Rothney	Littleton, NH
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16.	Richard Blodgett	Richard Blodgett	Littleton NH
17.	DeAnne Blodgett	DeAnne Blodgett	
18.	Clifton D. Crosby	CLIFTON D. CROSBY	Bethlehem NH
19.	Joel Paventy	JOEL J. PAVENTY	Bethlehem N.H.
20.	Terence Gallagher	Terence Gallagher	Littleton N.H.
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PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1. Floyd GRAMMO	Floyd Grammo	Littleton, NH
2. ANN FABRIZIO	Ann Fabrizio	Twin Mt NH
3. CARMINE J. FABRIZIO	Carmine Fabrizio	Twin Mt. NH
4. Ronald Baillargeon	Ronald Baillargeon	Franconia NH
5. MARK DIMARZIO	Mark A. DiMarzio	FRANCONIA, NH
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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Kelly Marsh	Kelly Marsh	Warren NH
2.	Jerry Brown	Jerry Brown	Wentworth NH
3.	Melissa Barton	Melissa Barton	Wentworth, NH
4.	Bree McHugh	Bree McHugh	Warren, NH
5.	Charles J. Hall		Rumney N.H
6.	Nancy B. Chandler	Nancy B Chandler	Warren NH
7.	Eunice M. Ramsay	Eunice M Ramsay	Glendale, N.H.
8.	Cindy S Sites	← ic	Warren N.H
9.	Denise Brown	Denise Brown	Wentworth, N.H.
10.	Shirley Nicol	Shirley Nicol	Piermont, N.H.
11.	Susan D. Bliss	Sid Bliss	Wentworth, NH
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	PRINT LEGAL NAME	SIGNATURE	CITY & STATE
1.	Katelynn Wright	Katelynn Wright	Littleton NH.
2.	Wallace B Schwartz	Wallace B Schwartz	Whitefield, NH
3.	Melvin A. Colby, Jr	Melvin A. Colby, Jr	Woodsville, NH
4.	Marion Daignault	Marion Daignault	Littleton, NH.
5.	John Kennedy		Franconia
6.	Joan F Dexter	Joan F Dexter	Littleton, NH
7.	Fred Daignault	F Daignault	Littleton NH
8.	Marina Lopez		Littleton NH
9.	Victoria Lord		Woodsville, NH
10.	Timothy Randall		Lincoln, NH
11.	Seth Frank		Lancaster, NH
12.	Sheila Baciak	Sheila Baciak	Whitefield NH
13.	Donald MacArthur		Littleton NH
14.	Dwight D. Ferland		Warren NH.
15.	Cindy Pease		Franconia
16.	Karen SAFFIAN	Karen Saffian	Carroll
17.	Elena MATLOSZ	Elena Matlosz	Bethlehem, NH
18.	Sandra Godley	Sandra Godley	Littleton
19.	G.M. Chamberlain Jr.	G.M. Chamberlain Jr	Franconia NH.
20.	Annmarie Blodgett	Annmarie Blodgett	Littleton, NH
21.	Sarah Murray	Sarah Murray	Littleton, NH
22.	Susan Cooper	Susan Cooper	Littleton
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Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings

Robert S. Nocon, MHS, Sang Mee Lee, PhD, Ravi Sharma, PhD, Quyen Ngo-Metzger, MD, MPH, Dana B. Mukamel, PhD, Yue Gao, MPH, Laura M. White, MS, Leiyu Shi, DrPH, MBA, MPA, Marshall H. Chin, MD, MPH, Neda Laiteerapong, MD, MS, and Elbert S. Huang, MD, MPH

Objectives. To compare health care use and spending of Medicaid enrollees seen at federally qualified health centers versus non–health center settings in a context of significant growth.

Methods. Using fee-for-service Medicaid claims from 13 states in 2009, we compared patients receiving the majority of their primary care in federally qualified health centers with propensity score–matched comparison groups receiving primary care in other settings.

Results. We found that health center patients had lower use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care and 25% fewer admissions and 27% lower spending on inpatient care. Total spending was 24% lower for health center patients.

Conclusions. Our analysis of 2009 Medicaid claims, which includes the largest sample of states and more recent data than do previous multistate claims studies, demonstrates that the health center program has provided a cost-efficient setting for primary care for Medicaid enrollees. (*Am J Public Health.* 2016;106:1981–1989. doi:10.2105/AJPH.2016.303341)

A central pillar of the Affordable Care Act (ACA; Pub L No. 111–148) is the expansion of the Medicaid program to include adults younger than 65 years with incomes up to 133% of the federal poverty level. Roughly half of states have formally expanded their Medicaid programs, and even nonexpansion states have seen increased enrollment stemming from greater public awareness and streamlined enrollment processes.[1] Medicaid expansion has raised concerns about the financial sustainability of the program and the availability of health care providers to see the newly insured.[2] To improve access to care for the medically underserved, including the newly insured, the ACA also called for $11 billion in funding for federally qualified health centers.[3,4]

Federally qualified health centers receive grants under Section 330 of the US Public Health Service Act and currently provide comprehensive primary care to roughly 23 million patients[5] in medically needy areas and roughly 1 out of 7 Medicaid enrollees.[6] For brevity, we will use the term "health center" throughout this article to refer to these federally qualified health centers. Health centers are required to provide nonclinical enabling services that support access to primary care, such as case management and transportation. Health centers are required to be located in, or provide services to, medically underserved communities, and they are required to have more than half of their governing board be health center patients that represent the population served. Because of the likelihood of an expanded role for health centers in the Medicaid program and ongoing concerns regarding the costs of the program, it is critical to understand whether the setting of primary care for Medicaid recipients has any association with health service utilization and spending.

The design and requirements of the health center program may be particularly well suited to the complex social and primary care needs of Medicaid patients. For example, the enabling services provided by health centers may result in physical and mental health issues being addressed earlier and in a more coordinated manner, resulting in lower health care use and spending for other services. Although the conceptual underpinnings of the program are clear, the empirical evidence regarding the impact of health center care on use and spending has been conflicting. Previous studies of Medicaid enrollees receiving primary care in health centers have found some associations with lower health care use. A study of 2008 Colorado Medicaid data found health center use to be associated with lower likelihoods of emergency department (ED) visit, inpatient

ABOUT THE AUTHORS

At the time of this study, Robert S. Nocon and Sang Mee Lee were with the Department of Public Health Sciences, University of Chicago, Chicago, IL. Yue Gao, Marshall H. Chin, Neda Laiteerapong, and Elbert S. Huang were with the Department of Medicine, University of Chicago. Ravi Sharma is with the Bureau of Primary Health Care, Health Resources and Services Administration, US Department of Health and Human Services, Rockville, MD. Quyen Ngo-Metzger is with the Agency for Healthcare Research and Quality, Rockville. Dana B. Mukamel and Laura M. White were with the Department of Medicine, University of California, Irvine. Leiyu Shi is with the Johns Hopkins Bloomberg School of Public Health, Baltimore, MD.

Correspondence should be sent to Robert S. Nocon, Section of General Internal Medicine, Department of Medicine, University of Chicago, 5841 S. Maryland Ave, MC2007, Chicago, IL 60637 (e-mail: rnocon@medicinc.bsd.uchicago.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted June 18, 2016.

doi: 10.2105/AJPH.2016.303341

hospitalization, 90-day readmission, and preventable hospitalization.[7]

Two multistate Medicaid claims studies (a 4-state study using 1994–1995 data and a 5-state study of 1992 data) found health center use to be associated with fewer preventable ED visits and hospitalizations.[8,9] By contrast, other studies have found that health center care was associated with higher use and spending. A 3-state study of 2003–2004 Medicaid claims found greater outpatient and total spending for health center patients compared with physician office care,[10] and a study of 2004–2008 data from a national survey of adults included a subgroup analysis of Medicaid patients that found health center care to be associated with more ED visits than is non–health center care.[11] Overall, the literature on this topic is limited by analyses that capture varying or incomplete utilization and spending outcomes, study a small number of states, use older data that may not reflect current practice patterns, or use limited methods for adjusting for differences in health center and non–health center patient populations.

We compared utilization and spending between health center and non–health center Medicaid enrollees using data from a large number of US states, which can provide important insight because of the variability in Medicaid programs across states. We also examined a broader set of health care services than have previous studies, including primary care, other outpatient care, prescription drugs, ED use, and inpatient care. Finally, we compared health center and non–health center patients with a propensity score–matching approach, which can provide a more robust adjustment for observed differences between health center and non–health center patients.

Although our use of 2009 data does not allow us to analyze the effect of ACA Medicaid expansions that began in 2014, post-ACA claims are not yet available for this data set. Our data year allows us to examine a larger number of Medicaid patients and states than do more recent years. In more recent years of Medicaid claims, the increasing prevalence of Medicaid managed care inhibits cross-plan and cross-state comparison, because these claims do not contain service-level expenditures and vary in data quality across states.

METHODS

We examined the cross-sectional association between primary care setting and a set of utilization and spending outcomes among fee-for-service Medicaid enrollees in 13 states in 2009. The 13 states in our analysis were Alabama, California, Colorado, Connecticut, Florida, Iowa, Illinois, Mississippi, Montana, North Carolina, Vermont, Texas, and West Virginia (Table 1). We emphasized the following factors when choosing states to include in the analysis: geographic diversity, variation in size, presence of a large number of health centers and health center Medicaid patients, likelihood of claims data being available in a timely manner, and high prevalence of fee-for-service Medicaid claims. The number of states we included was limited by our funds available for data purchase.

Data Collection

We obtained claims from the Medicaid Analytic eXtract files. We constructed an analytic data set from Medicaid Analytic eXtract files that focused on adult, nonelderly (aged 18–65 years), fee-for-service users of ambulatory primary care services. We excluded all dental, transportation, and long-term care claims from our analysis. Because claims data for utilization and spending data may not be reliable for Medicaid managed care patients, we excluded all claims in months of data when an enrollee was in a medical managed care program. We also excluded single months of fee-for-service data that fell between 2 months of managed care enrollment. Other notable exclusions were patients with restricted benefits anytime during the year, those who delivered a baby during the year, and those who had changing eligibility over the year. (A full listing and description of exclusions are available as a supplement to the online version of this article at http://www.ajph.org.)

We examined use or spending for primary care, other (nonprimary) outpatient care, prescription drugs, ED care, inpatient care, and total health care spending, which represents the sum of the previously listed spending categories. Spending for each type of utilization represented the sum of total payments from Medicaid and third-party payers. Our spending variable did not include federal support to health centers that occurs outside the context of the Medicaid fee-for-service visit, such as federally backed loan guarantees for capital improvement projects and the ability to forgo purchase of private malpractice insurance because the federal government assumes responsibility for malpractice settlement and judgment costs.[12]

Our main independent variable of interest was the type of primary care setting. We categorized patients as either health center or non–health center patients on the basis of whether more than half of their primary care visits occurred in a health center. We also conducted analyses dividing non–health center patients into 3 subgroups: physician office patients, hospital outpatients, and mixed use patients, where the mixed use category comprised those who did not have a majority of primary care visits in any 1 setting. To determine primary care setting, we used the national provider identifier, claim type, and place of service in each claim. We created a listing of health center identifiers from Health Resources and Services Administration databases and Medicare and Medicaid cost reports and linked that information to the National Plan and Provider Enumeration System.[13]

Our adjusted analyses included covariates to account for factors that influenced health care utilization and spending. Covariates were patient demographics (age, race/ethnicity, gender), insurance characteristics (eligibility category, months of eligibility, Temporary Aid for Needy Families program indicator), disease burden, and US state. For disease burden, we used the Chronic Illness and Disability Payment System for Medicaid with the Medicaid Rx model and created binary variables for each category of diagnosis (e.g., cardiovascular, low) and medication group (e.g., diabetes) included in sufficient volume in our study sample.[14,15]

One barrier to adjustment in health center analyses is that Medicaid generally pays health centers on a per-visit (vs fee-for-service) basis. Although health centers are required to use diagnosis codes for billing and quality reporting, the lack of service-level (as opposed to encounter-level) claims may lead to health centers applying a lower volume of diagnosis codes and the potential for underdetection of disease burden for health center patients when using claims-based risk adjustment. Our adjustment method mitigates this risk by drawing from

TABLE 1—Medicaid Enrollee Characteristics by Primary Care Setting: United States, 2009

Characteristic	Health Center, No. (%) or Mean ±SD	Non–Health Center, No. (%) or Mean ±SD			
		Combined	Physician Office	Hospital Outpatient	Mixed Use[a]
Enrollees	144 076 (14)	894 898 (86)	460 198 (44)	95 599 (9)	339 101 (33)
Age, y	41.3 ±13.1	40.0 ±13.7	41.3 ±14.0	40.5 ±13.4	38.1 ±13.3
Female	(67.0)	(67.0)	(69.1)	(62.9)	(65.1)
Race/ethnicity					
Non-Hispanic White	(40.2)	(42.1)	(41.7)	(38.0)	(43.8)
Hispanic or Latino	(23.3)	(22.8)	(25.7)	(21.0)	(19.4)
Non-Hispanic Black	(20.1)	(19.9)	(18.9)	(22.9)	(20.5)
Non-Hispanic Asian	(2.5)	(2.2)	(2.9)	(1.8)	(1.5)
Hispanic or Latino and >1 race	(2.9)	(0.9)	(0.9)	(1.9)	(0.7)
Non-Hispanic Native Hawaiian	(2.2)	(2.5)	(3.0)	(1.7)	(2.1)
Non-Hispanic American Indian	(0.7)	(0.7)	(0.4)	(0.9)	(1.1)
Non-Hispanic and >1 race	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)
Unknown	(8.0)	(8.8)	(6.5)	(11.7)	(11.0)
State					
California	(51.4)	(39.2)	(33.1)	(44.0)	(46.1)
Illinois	(7.2)	(5.4)	(5.6)	(3.3)	(5.7)
West Virginia	(7.0)	(5.6)	(7.5)	(2.2)	(3.8)
Florida	(6.9)	(12.7)	(13.5)	(18.2)	(10.0)
Texas	(6.9)	(16.9)	(24.2)	(6.2)	(10.0)
Colorado	(6.0)	(4.9)	(0.7)	(10.3)	(9.3)
Connecticut	(5.9)	(2.4)	(2.5)	(4.7)	(1.7)
Mississippi	(4.9)	(7.7)	(7.3)	(4.0)	(9.3)
Iowa	(2.0)	(2.8)	(2.5)	(4.7)	(2.6)
Vermont	(1.2)	(1.0)	(1.4)	(0.4)	(0.6)
North Carolina	(0.5)	(1.3)	(1.6)	(1.6)	(0.9)
Alabama	(0.1)	(0.1)	(0.1)	(0.3)	(0.1)
Montana	(<0.1)	(<0.1)	(<0.1)	(0.2)	(<0.1)
Medicaid eligibility group					
Cash, adult	(34.7)	(26.4)	(22.4)	(33.0)	(30.0)
Cash, disabled	(42.6)	(51.1)	(51.8)	(44.2)	(52.1)
Medically needy, adult	(6.7)	(7.2)	(8.6)	(4.3)	(6.1)
Medically needy, disabled	(3.1)	(2.7)	(2.6)	(3.9)	(2.6)
Other, adult	(3.1)	(2.4)	(2.5)	(2.2)	(2.3)
Other, disabled	(4.4)	(2.8)	(2.8)	(3.8)	(2.4)
Poverty, adult	(4.3)	(6.5)	(8.6)	(6.9)	(3.5)
Poverty, disabled	(1.2)	(1.0)	(0.8)	(1.7)	(1.0)
TANF eligible[b]	(5.8)	(4.2)	(4.0)	(4.1)	(4.5)
Residing in MSA[c]	(82.2)	(79.9)	(82.2)	(89.2)	(74.2)
Eligible months	9.9 ±3.3	9.9 ±3.3	9.9 ±3.3	9.2 ±3.7	10.2 ±3.1
Minimum distance from nearest health center, km	4.8 ±6.7	9.7 ±13.1	9.3 ±12.2	7.7 ±11.8	10.9 ±14.4
CDPS risk score[d]	0.90 ±1.00	1.11 ±1.34	1.12 ±1.34	1.37 ±1.78	1.03 ±1.18
Use and spending					
Primary care					
Visits, no.	7.6 ±7.8	8.6 ±8.9	8.5 ±8.0	8.2 ±10.2	8.9 ±9.7
Spending, $	1 430 ±2 312	2 090 ±6 687	1 366 ±4 656	2 153 ±6 383	3 053 ±8 686

Continued

TABLE 1—*Continued*

Characteristic	Health Center, No. (%) or Mean ±SD	Non–Health Center, No. (%) or Mean ±SD			
		Combined	Physician Office	Hospital Outpatient	Mixed Use[a]
Other outpatient[e]					
Visits, no.	12.2 ±39.4	16.7 ±45.5	17.8 ±49.3	13.2 ±36.2	16.1 ±42.2
Spending, $	1 965 ±6 820	3 748 ±11 278	3 799 ±11 611	3 224 ±11 283	3 825 ±10 804
Prescription drug spending, $	2 324 ±5 457	2 765 ±14 540	2 805 ±9 469	2 986 ±36 839	2 649 ±7 324
Emergency department					
Visits, no.	1.2 ±3.0	1.4 ±3.4	1.1 ±2.8	2.7±5.6	1.3 ±3.2
Spending, $	216 ±634	236 ±713	181 ±559	492 ±1 229	240 ±686
Inpatient					
Visits, no. (SD)	0.2 ±0.8	0.3 ±1.2	0.3 ±1.0	0.6 ±2.0	0.3 ±1.0
Length of stay,[f] no. (SD)	0.8 ±5.3	1.4 ±7.5	1.2 ±6.3	3.1 ±13.1	1.2 ±6.6
Spending, $ (SD)	1 496 ±9 879	2 324 ±13 264	1 910 ±10 494	5 610 ±25 508	1 959 ±11 315
Total spending, $ (SD)	7 518 ±15 196	11 306 ±26 165	10 189 ±21 102	14 699 ±49 810	11 865 ±22 310

Note. CDPS = Chronic Disability Payment System; MSA = metropolitan statistical area; TANF = Temporary Aid for Needy Families. Characteristics are derived from the setting where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. The sample size was n = 1 038 974.

[a]Mixed use refers to enrollees for whom no single setting accounts for > 50% of primary care visits.

[b]Enrollee is eligible for TANF program in any month during the data year.

[c]Patient resides in a MSA.

[d]CDPS risk score derived from concurrent risk weights is shown here as an indicator of severity of illness. These values were not used in the model; rather, we used binary variables for 69 of the individual CDPS diagnoses.

[e]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[f]Total annualized inpatient length of stay in days.

claims across all service types (inpatient, nonprimary care outpatient, and prescription drugs) to characterize disease severity. We also controlled for 2 geographic variables: residing in a metropolitan statistical area[16] and the distance from where the patient lived (using the centroid of the residence zip code)[17] to the closest health center delivery site.

Statistical Analyses

We conducted basic descriptive analyses of patient characteristics, utilization, and spending by assigned primary care setting. Because the characteristics of health center patients are unlike those of patients seen in other settings, we used propensity score methods to balance potential observed confounders.[18] The propensity score–matching method is a technique for selecting non–health center users who are matched with health center users on potentially confounding covariates. This matching approach results in groups that are comparable on the basis of the covariates, regardless of correct model specification of outcomes and covariates, which is required in the standard generalized linear model.

We estimated propensity scores using a logistic regression model in which receiving treatment in a health center is predicted by the covariates we have described. We matched health center patients and non–health center patients with replacement using the nearest neighbor matching method. We then developed a series of generalized linear models to assess the effect of primary care setting on utilization and expense outcomes on the matched sample. We used a log link, assuming negative binomial distribution for utilization and γ-distribution for expenses. (Further details on the propensity score match and statistical models are available as a supplement to the online version of this article at http://www.ajph.org.)

We expressed our results in terms of the estimated mean of utilization or spending for each primary care setting and percentage difference in utilization or spending associated with the health center primary care setting relative to the non–health center comparison group. We conducted a main analysis with all states pooled, comparing health center to non–health center patients. In secondary analyses, we compared health center patients to physician office, hospital outpatients, and mixed use patients separately. Because Medicaid programs may vary significantly by state, we also performed separate state-by-state analyses. We conducted sensitivity analysis of a range of subgroup populations, including disabled beneficiaries and recipients of Temporary Aid for Needy Families benefits (not shown). We considered results to be statistically significant using a threshold of $P < .005$ on the basis of the Bonferroni method of correction for multiple comparisons.[19] We carried out all analyses with SAS version 9.4 (SAS Institute, Cary, NC). All reported P values are 2-sided.

RESULTS

Our final analyses included 144 076 health center Medicaid patients and 894 898 non–health center patients (Table 1). Roughly two thirds of patients were female, and they had an average age of 41 years. Most patients were from racial/ethnic minority groups. On an unadjusted basis, health center patients had lower levels of utilization and expense across all service types.

Before propensity score matching, health center and non–health center users differed substantially across several covariates, including state, Medicaid eligibility category, distance from the nearest health center site, and disease burden. After matching, observed confounders were balanced (data available as a supplement to the online version of this article at http://www.ajph.org).

When compared with non–health center patients, patients receiving most of their primary care in health centers experienced lower utilization and spending for all services examined (Table 2). The largest differences were in other outpatient visits (15.7 vs 12.2; –22% difference; CI = –21%, –24%) and spending ($2948 vs $1964; –33% difference; CI = –32%, –35%) as well as inpatient admissions (0.25 vs 0.19; –25% difference; CI = –22%, –27%) and spending ($2047 vs $1496; –27% difference; CI = –24%, –30%). Total spending was lower for health center patients ($9889 vs $7518; –24% difference; CI = –23%, –25%). Differences in ED services were smaller in magnitude, although health center patients still had lower ED use (1.3 vs 1.2 visits; –11% difference; CI = –10%, –13%) and spending ($244 vs $216; –11% difference; CI = –10%, –13%).

When compared with the physician office, hospital outpatient, and mixed use groups (Table 3), the pattern of consistently lower use and spending for all services held for health center patients in comparison with hospital outpatients and mixed use patients. When compared with physician office patients, there was no difference in primary care use for health center patients, and health center patients had higher primary care spending ($1184 vs $1430; 21% difference; CI = 18%, 24%), more ED visits (1.0 vs 1.2; 16% difference; CI = 14%, 18%), and more ED spending ($186 vs $216; 16% difference; CI = 13%, 18%). Health center patients had lower use and spending across other services and lower total spending.

When comparing health center patients to non–health center patients in each of the 13 study states, we found trends in findings that were generally consistent across states (Table 4). Total spending was lower for health center patients across all 13 states. In 3 states (Connecticut, Illinois, and Texas), health center patients had higher primary care use or spending, and in Illinois, health center patients had higher ED use.

DISCUSSION

In this study of fee-for-service adult Medicaid enrollees across 13 states, we found that patients who received the majority of their primary care in health centers had lower total health care use and spending than did matched patients who receive primary care in other settings. The finding of lower total spending for health center patients was robust across all primary care comparison settings and states that we examined.

When comparing the full range of outcomes across states, we found that most states had the same patterns as our main analyses that pooled all states. The general consistency of these findings suggests that there may be a distinct association between health center primary care setting and health care use and spending because each state administers the Medicaid program independently, with variation in financing, management, and care programs. Some individual states did have

TABLE 2—Use and Expense for Health Center Patients Compared With Matched Non–Health Center Patients: United States, 2009

Variable	Non–Health Center (n = 144 075), Estimate (95% CI)	Health Center (n = 144 075), Estimate (95% CI)	Difference,[a] % (95% CI)
Primary care			
Visits, no.	8.2 (8.2, 8.3)	7.6 (7.6, 7.7)	–7 (–8, –7)
Spending, $	1845 (1815, 1876)	1430 (1418, 1442)	–23 (–24, –21)
Other outpatient care[b]			
Visits, no.	15.7 (15.5, 15.9)	12.2 (12.0, 12.4)	–22 (–24, –21)
Spending, $	2948 (2900, 2996)	1964 (1930, 2000)	–33 (–35, –32)
Prescription drug spending, $	2704 (2664, 2744)	2324 (2296, 2352)	–14 (–16, –12)
Emergency department			
Visits, no.	1.3 (1.3, 1.4)	1.2 (1.2, 1.2)	–11 (–13, –10)
Spending, $	244 (240, 247)	216 (213, 219)	–11 (–13, –10)
Inpatient			
Admissions, no.	0.25 (0.25, 0.26)	0.19 (0.19, 0.20)	–25 (–27, –22)
Length of stay,[c] d	1.1 (1.1, 1.2)	0.8 (0.8, 0.9)	–26 (–29, –23)
Spending, $	2047 (1987, 2114)	1496 (1446, 1548)	–27 (–30, –24)
Total spending, $	9889 (9784, 9996)	7518 (7440, 7597)	–24 (–25, –23)

Note. CI = confidence interval. Primary care setting is determined by where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. Each health center patient was matched with 1 non–health center patient on the basis of the logit of propensity score, which was estimated using a logistic regression adjusting for patient demographics (age, race/ethnicity, gender), insurance characteristics (Medicaid eligibility category, months of eligibility, Temporary Aid for Needy Families program beneficiary indicator), disease burden (on the basis of binary disease diagnosis variables from the Chronic Illness and Disability Payment System), state, residence in a metropolitan statistical area, and distance from the closest health center delivery site.

[a]A negative percentage difference reflects lower health center utilization or spending.

[b]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[c]Total annualized inpatient length of stay in days.

TABLE 3—Use and Expense for Health Center Patients Compared With Matched Physician Office, Hospital Outpatient, and Mixed Use Patients: United States, 2009

Utilization or Cost	Health Center (n = 144 076), Estimate (95% CI)	Physician Office (n = 144 074)		Hospital Outpatient (n = 144 071)		Mixed Use[a] (n = 144 074)	
		Estimate (95% CI)	Difference From Health Center, % (95% CI)[b]	Estimate (95% CI)	Difference From Health Center, % (95% CI)[b]	Estimate (95% CI)	Difference From Health Center, % (95% CI)[b]
Primary care							
Visits, no.	7.6 (7.6, 7.7)	7.6 (7.6, 7.7)	0 (−1, 0)	7.7 (7.7, 7.8)	−1 (−2, −1)	8.6 (8.6, 8.7)	−12 (−12, −11)
Spending, $	1 430 (1 418, 1 442)	1 184 (1 158, 1 211)	21 (18, 24)	1 974 (1 944, 2 004)	−28 (−29, −26)	2 315 (2 283, 2 347)	−38 (−39, −37)
Other outpatient care[c]							
Visits, no.	12.2 (12, 12.5)	14.4 (14.2, 14.7)	−15 (−17, −13)	13.5 (13.3, 13.7)	−9 (−11, −7)	18.5 (18.2, 18.8)	−34 (−35, −32)
Spending, $	1 970 (1 935, 2 006)	2 842 (2 787, 2 897)	−31 (−32, −29)	3 066 (3 015, 3 117)	−36 (−37, −34)	3 170 (3 125, 3 217)	−38 (−39, −36)
Prescription drug spending, $	2 324 (2 296, 2 352)	2 716 (2 680, 2 752)	−14 (−16, −13)	3 051 (2 964, 3 140)	−24 (−26, −21)	2 709 (2 673, 2 746)	−14 (−16, −13)
Emergency department							
Visits, no.	1.2 (1.2, 1.2)	1 (1, 1)	16 (14, 18)	2.6 (2.5, 2.6)	−54 (−54, −53)	1.4 (1.4–1.4)	−13 (−15, −12)
Spending, $	216 (213, 219)	186 (184, 189)	16 (13, 18)	480 (473, 486)	−55 (−56, −54)	249 (245, 252)	−13 (−15, −11)
Inpatient							
Admissions, no.	0.19 (0.19, 0.20)	0.22 (0.21, 0.22)	−11 (−14, −8)	0.60 (0.59, 0.61)	−68 (−69, −67)	0.24 (0.24, 0.25)	−21 (−23, −19)
Length of stay,[d] d	0.8 (0.8, 0.9)	0.9 (0.9, 0.95)	−9 (−13, −4)	2.8 (2.7, 2.9)	−70 (−71, −69)	1.11 (1.1, 1.1)	−24 (−27, −20)
Spending, $	1 496 (1 446, 1 548)	1 757 (1 702, 1 814)	−15 (−19, −11)	4 908 (4 799, 5 018)	−70 (−71, −68)	1 893 (1 834, 1 953)	−21 (−24, −17)
Total spending, $	7 530 (7 452, 7 609)	8 791 (8 691, 8 891)	−14 (−16, −13)	13 629 (13 467, 13 793)	−45 (−46, −44)	10 439 (10 337, 10 542)	−28 (−29, −27)

Note. CI = confidence interval. Primary care setting is determined by where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. Each health center patient was matched with 1 patient from the physician office, hospital outpatient, and mixed use settings on the basis of the logit of propensity score, which was estimated using a multinomial logistic regression adjusting for patient demographics (age, race/ethnicity, gender), insurance characteristics (Medicaid eligibility category, months of eligibility, Temporary Aid for Needy Families program beneficiary indicator), disease burden (on the basis of binary disease diagnosis variables from the Chronic Illness and Disability Payment System), state, residence in a metropolitan statistical area, and distance from the closest health center delivery site.

[a]Mixed use indicates enrollees, where no single setting accounts for > 50% of primary care visits.

[b]The negative percentage difference reflects lower health center utilization or spending.

[c]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[d]Total annualized inpatient length of stay in days.

results that varied from the trend observed when all states were pooled. Connecticut, Illinois, and Texas had higher primary care use or spending for health center patients, and Illinois had higher ED use for non–health center patients.

When examining different forms of non–health center primary care settings (physician office, hospital outpatient, and mixed use), we found that most of our main findings held, except that health center patients had more primary care spending and ED use and spending than did physician office patients.

One potential interpretation of our results is that if health centers provide comparable or higher levels of quality, lower spending may mean that they are an efficient form of primary care. Two other recent studies of health center primary care have used data from the Medical Expenditure Panel Survey[11] and Medicare claims,[20] and they similarly found lower overall health care use or spending for health center patients. With respect to quality of care, short-term studies (most often 1–2 years) using administrative or survey data have generally found process-based measures of quality to be comparable or higher among health centers for similar patient populations.[11,21,22] Studies using ecologic designs have also demonstrated that the establishment or expansion of health centers in an area is associated with long-term declines in mortality.[23,24] Recent high-profile studies of Medicaid have brought intense controversy over the cost of the program.[25] States that are considering expansion of their Medicaid programs are engaged in discussions of how to manage health care spending for newly insured patients. If our observation of lower use and cost among health center patients is owing to health centers providing a more

TABLE 4—Adjusted Percentage Difference (95% CI) in Utilization and Spending, Health Center Patients Compared With Non–Health Center Patients, by State: United States, 2009

Variable	AL, % Difference (95% CI)	CA, % Difference (95% CI)	CO, % Difference (95% CI)	CT, % Difference (95% CI)	FL, % Difference (95% CI)	IA, % Difference (95% CI)	IL, % Difference (95% CI)	MS, % Difference (95% CI)	NC, % Difference (95% CI)	TX, % Difference (95% CI)	VT, % Difference (95% CI)	WV, % Difference (95% CI)
Matched health center patients, no.	132	74 028	8640	8481	9947	2945	10 371	7113	748	9909	1728	10 022
Primary care												
Visits	−16 (−36, 10)	−10 (−11, −9)	−17 (−19, −14)	35 (31, 40)	−23 (−25, −21)	−3 (−7, 1)	6 (4, 9)	−10 (−12, −8)	−20 (−27, −12)	−9 (−11, −7)	−1 (−7, 5)	−15 (−16, −13)
Spending	−38 (−60, −5)	−37 (−38, −35)	−11 (−16, −6)	5 (−1, 11)	−31 (−34, −28)	−34 (−40, −26)	11 (5, 18)	−23 (−29, −15)	−33 (−44, −20)	19 (15, 24)	−1 (−11, 12)	−13 (−17, −9)
Other outpatient[a]												
Visits	−48 (−77, 15)	−12 (−14, −9)	−25 (−32, −17)	−23 (−28, −18)	−44 (−49, −39)	−6 (−14, 2)	−4 (−11, 4)	1 (−7, 9)	−26 (−41, −6)	−37 (−42, −32)	−19 (−31, −5)	−15 (−20, −10)
Spending	−84 (−94, −51)	−37 (−39, −36)	−42 (−49, −34)	−33 (−40, −26)	−54 (−59, −48)	−26 (−39, −10)	−25 (−30, −19)	−32 (−41, −23)	−33 (−48, −13)	−38 (−42, −34)	−23 (−37, −5)	−24 (−31, −16)
Prescription spending	−30 (−64, 38)	0 (−2, 2)	−31 (−36, −25)	−5 (−9, 0)	−22 (−26, −16)	−12 (−22, −2)	−26 (−36, −14)	−3 (−10, 4)	−35 (−49, −17)	−20 (−26, −15)	−11 (−21, 1)	−18 (−21, −14)
Emergency department												
Visits	11 (−47, 132)	−6 (−9, −3)	−4 (−10, 2)	−1 (−7, 6)	−40 (−43, −36)	−40 (−45, −34)	16 (9, 25)	−3 (−8, 2)	21 (−2, 51)	−9 (−14, −3)	−9 (−21, 5)	−15 (−20, −10)
Spending	16 (−53, 184)	−5 (−8, −2)	−10 (−16, −3)	−3 (−9, 4)	−41 (−45, −37)	−45 (−50, −39)	1 (−7, 10)	−5 (−10, 0)	13 (−10, 41)	−4 (−10, 2)	−6 (−19, 9)	−18 (−23, −12)
Inpatient												
Admissions	No estimate	−17 (−21, −14)	−12 (−23, 1)	−24 (−32, −16)	−28 (−35, −19)	−45 (−56, −33)	−33 (−42, −24)	−19 (−28, −10)	−26 (−48, 6)	−1 (−11, 10)	−24 (−48, 11)	−6 (−15, 4)
Length of stay[b]	No estimate	−15 (−20, −10)	−3 (−23, 24)	−30 (−40, −19)	−24 (−35, −10)	−44 (−58, −27)	−44 (−53, −33)	−10 (−22, 4)	−9 (−42, 44)	−4 (−17, 11)	−13 (−41, 28)	−5 (−17, 10)
Spending	−5 (−24, 19)	−13 (−19, −8)	−9 (−28, 16)	−31 (−40, −20)	−29 (−39, −18)	−41 (−56, −20)	−50 (−59, −39)	−13 (−24, 0)	−23 (−49, 18)	−14 (−27, 1)	−21 (−46, 15)	−11 (−22, 2)
Total spending	−63 (−78, −37)	−22 (−23, −20)	−26 (−30, −21)	−19 (−23, −15)	−32 (−36, −29)	−27 (−32, −21)	−27 (−31, −22)	−19 (−24, −14)	−29 (−40, −15)	−22 (−26, −18)	−15 (−24, −6)	−18 (−21, −14)

Note. CI = confidence interval. "No estimate" means that models for that outcome did not converge and no estimate was reached. Primary care setting was determined by where > 50% of primary care visits occur. Use and spending is expressed in annual values per patient. Each health center patient was matched with 1 non–health center patient on the basis of the logit of propensity score, which was estimated using a logistic regression adjusting for patient demographics (age, race/ethnicity, gender), insurance characteristics (Medicaid eligibility category, months of eligibility, Temporary Aid for Needy Families program beneficiary indicator), disease burden (determined by binary disease diagnosis variables from the Chronic Illness and Disability Payment System), state, residence in a metropolitan statistical area, and distance from the closest health center delivery site. The negative percentage difference reflects lower health center utilization or spending.

[a]Other outpatient care is defined as all nonprimary care, nontransportation, and nondental outpatient claims activity.

[b]Total annualized inpatient length of stay in days.

efficient form of primary care, then health center program growth may provide an avenue for expanding Medicaid in a cost-efficient manner.

A second interpretation is that the patterns of utilization and cost reflect characteristics of the health care network accessed by health center patients—as opposed to aspects of care within the health center. If health center providers tend to refer patients to other care settings that have lower use rates or lower spending (because of access or practice patterns), the nature of those referral networks may lead to the observed differences in use and spending. Although utilization of lower cost specialty and inpatient care networks may be a desirable outcome, policymakers and Medicaid administrators must ensure that it does not limit access to high-quality care. For example, in a recent national survey of health centers conducted in 2009 and 2013, health center leaders reported increasing difficulty obtaining specialty or subspecialty appointments for their Medicaid patients.[26]

A third interpretation is that health center patients may be different from those in physician offices and hospital outpatient practices in ways that we are unable to account for with our data. Our propensity score–matching techniques adjust for confounding stemming from factors such as patient demographics, type of Medicaid insurance, and the disease burden observed in our data. However, we are unable to control for potential confounding because of factors that are not observed in our data set, and we are unaware of any studies that identify factors that drive Medicaid patients' choice of health centers for primary care. In particular, administrative claims data provide limited insight into important patient characteristics that may influence utilization and spending, such as healthy behaviors and lifestyle.

If our findings are driven by health center Medicaid patients being systematically healthier in ways not observable in claims data, this would highlight the importance of ongoing work to improve measurements of health and incorporate them into risk adjustment and payment schemes.[27,28] Health centers have long been known for serving vulnerable populations with high chronic disease burdens and health care needs. As health centers increasingly participate in accountable care organizations and shared savings arrangements with payers, it will be important for health centers and other providers to thoroughly document the health needs of their patients and communicate that information in a clear and compelling manner to payers and policymakers.

Other limitations in the scope of our analysis are also important to note. Our cross-sectional study cannot provide evidence of a causal relationship between health center care and health care use and spending. Although our study includes a large number of patients across several states, our study sample excludes important groups of enrollees (e.g., Medicaid managed care enrollees, Medicaid–Medicare dual eligible enrollees, long-term care recipients, and children), which limits the generalizability of findings across the Medicaid program. In particular, because Medicaid managed care has grown to become the dominant mode of administration for the Medicaid programs, ongoing study of the association between primary care setting and health care spending in the context of managed care is important.

We examined only Medicaid utilization and spending; we did not assess quality of care and cannot make conclusions about cost effectiveness or overall costs from a societal perspective. For example, health centers receive some federal financial support outside the scope of Medicaid fee-for-service payment, and some programs (such as the 340b drug pricing program, which is prevalent among health centers)[29] may lower Medicaid spending for health center patients. Health centers also receive federally supported technical assistance on quality improvement as well as federal grant funding outside Medicaid payments that we are unable to account for in our analyses. In addition, we cannot account for the unobserved heterogeneity across patients of different settings that is not captured with propensity score adjustment. Finally, although we classified settings of primary care into health center, hospital outpatient, and physician offices, it is important to acknowledge the wide variation in organizational structure and practices within these settings. Future work should analyze the role of organizational characteristics in the relationship between primary care setting and utilization, cost, and quality of care.

Cost reduction will continue to play an important role in ongoing efforts to improve the US health care system. Our analyses showed that Medicaid patients who obtain primary care at health centers had lower use and spending than did similar patients in other primary care settings. Although we hypothesize several potential causes for this association, future studies should work to empirically identify the mechanisms at work that lead to the compelling utilization and cost differences found in this study. As more Medicaid data become available for the years after the implementation of the ACA, it will also be critical to examine whether the associations we observed differ for more recent cohorts. AJPH

CONTRIBUTORS

R. S. Nocon drafted the article. R. S. Nocon, S. M. Lee, D. B. Mukamel, Y. Gao, and L. M. White conducted data analyses. R. S. Nocon, R. Sharma, Q. Ngo-Metzger, D. B. Mukamel, L. Shi, M. H. Chin, and E. S. Huang conceptualized the study. All authors interpreted results, provided critical revision, and approved the final version of the article.

ACKNOWLEDGMENTS

This work was funded under a contract to the Health Resources and Services Administration (HRSA), and R. Sharma is an HRSA employee. The work was also supported by the Chicago Center for Diabetes Translation Research (grant P30 DK20595) and the Diabetes Research and Training Center (grant P60 DK20595). R. S. Nocon. is supported by an Agency for Healthcare Research and Quality (AHRQ) training grant (T32 HS000084). M. H. Chin and E. S. Huang are supported by National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Midcareer Investigator Awards in Patient-Oriented Research (K24 DK071933, K24 DK105340).

Note. The views expressed in this article are solely the opinions of the authors and do not necessarily reflect the official policies of the US Department of Health and Human Services, HRSA, NIDDK, or AHRQ; nor does mention of any department or agency name imply endorsement by the US government.

HUMAN PARTICIPANT PROTECTION

This study was deemed exempt by the University of Chicago, Biological Sciences Division institutional review board.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Print-Friendly Version

Federally Qualified Health Center

RURAL HEALTH SERIES

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these Medicare-certified Federally Qualified Health Center (FQHC) topics:

- FQHC background
- FQHC certification
- FQHC services
- FQHC visits
- FQHC payment
- FQHC cost reports
- Lists of helpful websites and Regional Office Rural Health Coordinators

Note: The information in this publication does not necessarily apply to Grandfathered Tribal FQHCs.

FQHC BACKGROUND

The FQHC benefit under Medicare was added effective October 1, 1991, when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are safety net providers that primarily provide services typically furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program "look-alikes." They also include outpatient health programs or facilities operated by a tribe

ICN 006397 January 2017

or tribal organization or by an urban Indian organization. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically-necessary primary health services and qualified preventive health services furnished by a FQHC practitioner.

FQHC CERTIFICATION

To be certified as an FQHC, an entity must meet **one** of these requirements:

- Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements
- Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration
- Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990
- Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991

For certification as an FQHC, the entity must meet **all** of these requirements:

- Provide comprehensive services and have an ongoing quality assurance program
- Meet other health and safety requirements
- Not be concurrently approved as a Rural Health Clinic

FQHCs that receive a Section 330 grant or are determined to be a FQHC look-alike must meet **all** requirements contained in Section 330 of the PHS Act, including:

- Serve a designated medically-underserved area or medically-underserved population
- Offer a sliding fee scale to persons with incomes below 200 percent of the Federal poverty level
- Be governed by a board of directors, of whom a majority of the members receive care at the FQHC

FQHC SERVICES

FQHC services include:

- Physician services
- Services and supplies incident to the services of physicians
- Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services
- Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs
- Medicare Part B-covered drugs furnished by and incident to services of a FQHC practitioner
- Visiting nurse services to the homebound in an area where CMS determined there is a shortage of home health agencies
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for patients with diabetes or renal disease furnished by qualified practitioners of DSMT and MNT

FQHC VISITS

A FQHC visit is a medically-necessary face-to-face medical or mental health visit or a qualified preventive health visit between the patient and a physician, NP, PA, CNM, CP, or CSW during which time one or more qualified FQHC services are furnished. Transitional Care Management and Advance Care Planning can also be a FQHC visit. In certain limited situations, a FQHC visit may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound patient.

FQHC visits may take place in **any** of these locations:

- The FQHC
- The patient's residence (including an assisted living facility)
- A Medicare-covered Part A Skilled Nursing Facility
- The scene of an accident

FQHC visits may **not** take place in either of these locations:

- An inpatient or outpatient hospital (including a Critical Access Hospital)
- A facility that has specific requirements that preclude FQHC visits

FQHC PAYMENT

Medicare FQHC PPS

Section 10501(i)(3)(A) of the Affordable Care Act (Public Law 111-148 and 111-152) added Section 1834(o)(2) of the Act to establish the FQHC PPS for cost reporting periods beginning on or after October 1, 2014. FQHCs transitioned to the FQHC PPS between October 1, 2014, and December 31, 2015.

FQHCs must include a FQHC payment code on their claim for payment. They are paid 80 percent of the lesser of their charges based on the FQHC payment codes or the FQHC PPS rate (a national encounter-based rate with geographic and other adjustments). Beginning on January 1, 2017, the FQHC PPS base payment rate is updated annually using the FQHC market basket. For calendar year 2017, the market basket update under the FQHC PPS is 1.8 percent.

Per-Diem Payment and Exceptions

Encounters with more than one FQHC practitioner on the same day, regardless of the length or complexity of the visit or multiple encounters with the same FQHC practitioner on the same day, constitute a single visit, except when the patient has one of these:

- An illness or injury requiring additional diagnosis or treatment subsequent to the first encounter (for example, the patient sees the practitioner in the morning for a medical condition and later in the day has a fall and returns to the FQHC)
- A qualified medical visit and a qualified mental health visit on the same day

Payment Adjustments

These adjustments apply to the FQHC PPS payment rate:

- FQHC Geographic Adjustment Factor
- New patient adjustment
- Initial Preventive Physical Examination (IPPE) or Annual Wellness Visit (AWV) adjustment

Charges and Payment

FQHCs set their own charges for the services they provide and determine which services to include in the bundle of services associated with each FQHC G code. Charges must be uniform for all patients.

To find the specific FQHC payment codes to use when submitting claims under the PPS and a list of billable visits, visit the FQHC webpage.

Payment is for professional services only. Laboratory tests (excluding venipuncture) and the technical component of billable visits are paid separately. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, include the charges for the procedure on the claim with the visit.

Coinsurance

Coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate, except for certain preventive services. There is no Part B deductible in FQHCs for FQHC-covered services. Patient cost-sharing requirements for most Medicare-covered preventive services are waived, and Medicare pays 100 percent of the costs for these services. No coinsurance is required for the IPPE, AWV, and any covered preventive services recommended with a grade of A or B by the United States Preventive Services Task Force. For a complete list of preventive services and their coinsurance requirements, refer to the Federally Qualified Health Center (FQHC) Preventive Services Chart.

Influenza and Pneumococcal Vaccine

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. The cost is included in the cost report and no visit is billed. FQHCs must include these charges on the claim if they are furnished as part of an encounter. If the administration of the vaccine is the only service furnished on that day, no claim is filed. The beneficiary coinsurance is waived.

Hepatitis B Vaccine (HBV)

The HBV and its administration are included in the FQHC visit and are not separately billable. If a qualifying FQHC visit is furnished on the same day as the HBV, report the charges for the vaccine and related administration on a separate line item to ensure that coinsurance is not applied.

Telehealth Services

FQHCs are authorized to serve as an originating site for telehealth services if the FQHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

FQHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished. The cost of a visit may not be billed or included on the cost report.

Chronic Care Management (CCM) Services

As of January 1, 2016, FQHCs may receive an additional payment for the costs of CCM services when a minimum of 20 minutes of qualified CCM services are furnished to a Medicare patient who has two or more chronic conditions that:

- Are expected to last at least 12 months or until his or her death
- Place him or her at significant risk of death, acute exacerbation/ decompensation, or functional decline

CCM payment is based on the Medicare Physician Fee Schedule national average non-facility payment rate when Current Procedural Terminology (CPT) code 99490 is billed alone or with other payable services on a FQHC claim. Coinsurance is applied and the FQHC face-to-face requirements are waived for CCM services.

FQHC COST REPORTS

FQHCs must file a cost report annually and are paid for the costs of graduate medical education, bad debt, and influenza and pneumococcal vaccines and their administration through the cost report. FQHCs use Form CMS-224-14, Federally Qualified Health Center Cost Report, to file a cost report.

Provider-based FQHCs must complete the appropriate worksheet designated for FQHC services within the parent provider's cost report.

RESOURCES

This table provides FQHC resource information.

FQHC Resources

For More Information About...	Resource
FQHCs	CMS.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html Chapter 13 of the Medicare Benefit Policy Manual (Publication 100-02) Chapter 9 of the Medicare Claims Processing Manual (Publication 100-04)
FQHC PPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS
CCM Services	Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Chronic Care Management Services
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Provider-Specific Medicare Information	MLN Guided Pathways: Provider Specific Medicare Resources
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Grandfathered Tribal FQHCs	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Grandfathered-Tribal-FQHCs.html
Section 1861(aa) of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
42 United States Code Section 254a	https://www.gpo.gov/fdsys/pkg/USCODE-2015-title42/pdf/USCODE-2015-title42-chap6A-subchapII-partD.pdf
Section 1834(o)(2) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
FQHC webpage	https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html
Federally Qualified Health Center (FQHC) Preventive Services Chart	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-Preventive-Services.pdf
Form CMS-224-14	https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReduction Actof1995/PRA-Listing-Items/CMS-224-14.html
Chapter 13 of the Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
Chapter 9 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf
Chronic Care Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN Products/Downloads/ChronicCare Management.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MLN Guided Pathways: Provider Specific Medicare Resources	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_booklet.pdf

HELPFUL WEBSITES

American Hospital Association Rural Health Care
http://www.aha.org/advocacy-issues/rural

Critical Access Hospitals Center
https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospitals
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration
https://www.hrsa.gov

Hospital Center
https://www.cms.gov/Center/Provider-Type/Hospital-Center.html

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http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers
http://nachc.org

National Association of Rural Health Clinics
http://narhc.org

National Rural Health Association
https://www.ruralhealthweb.org

Rural Health Clinics Center
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Rural Health Information Hub
https://www.ruralhealthinfo.org

Swing Bed Providers
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

U.S. Census Bureau
http://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf.

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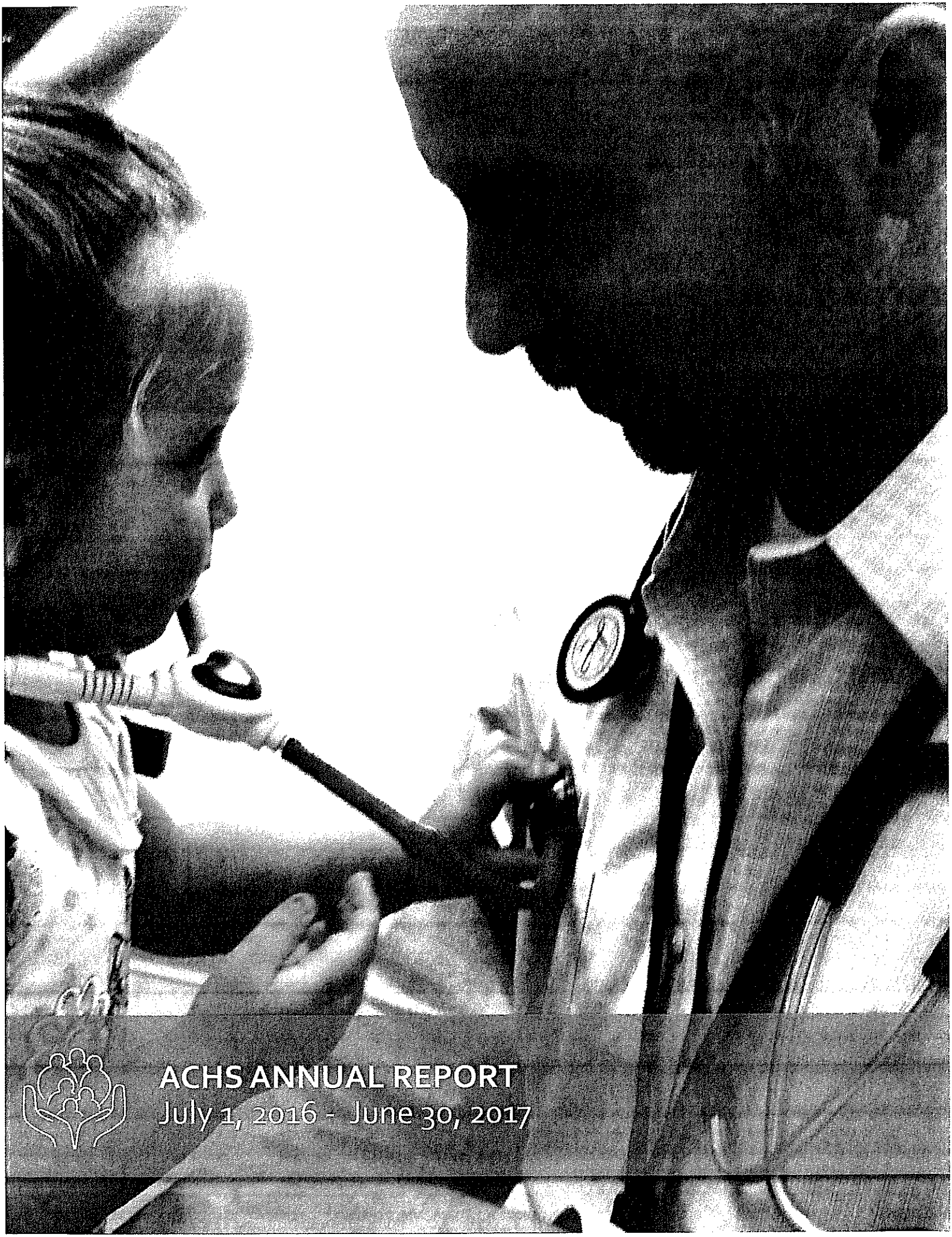
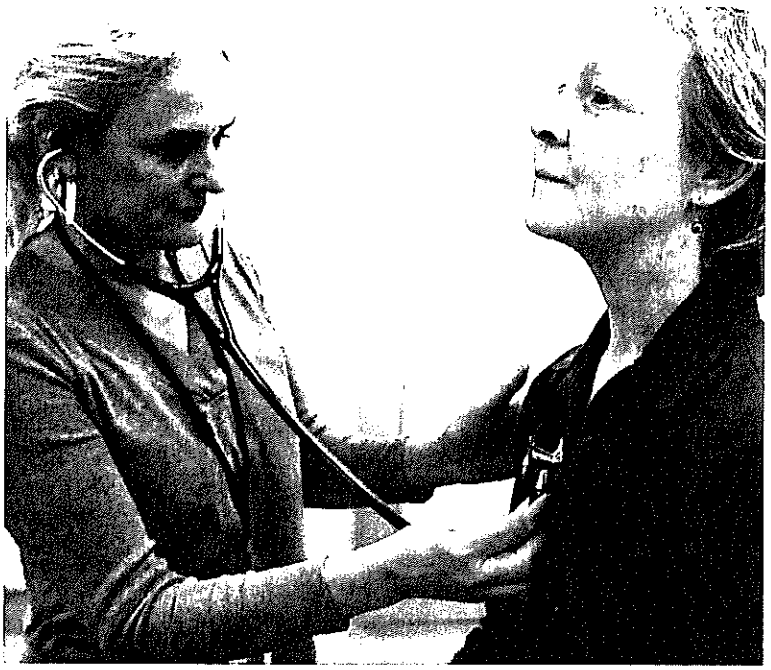
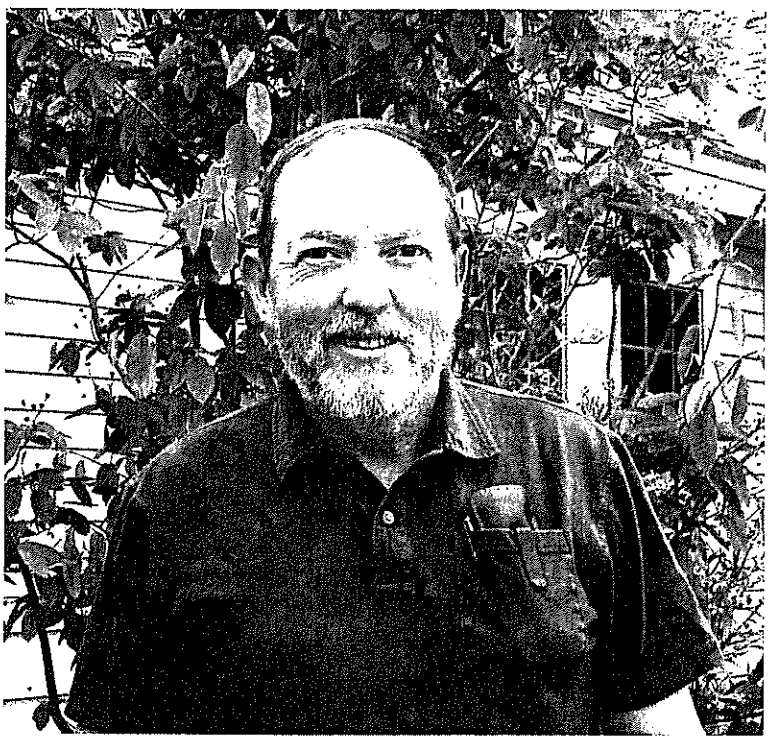


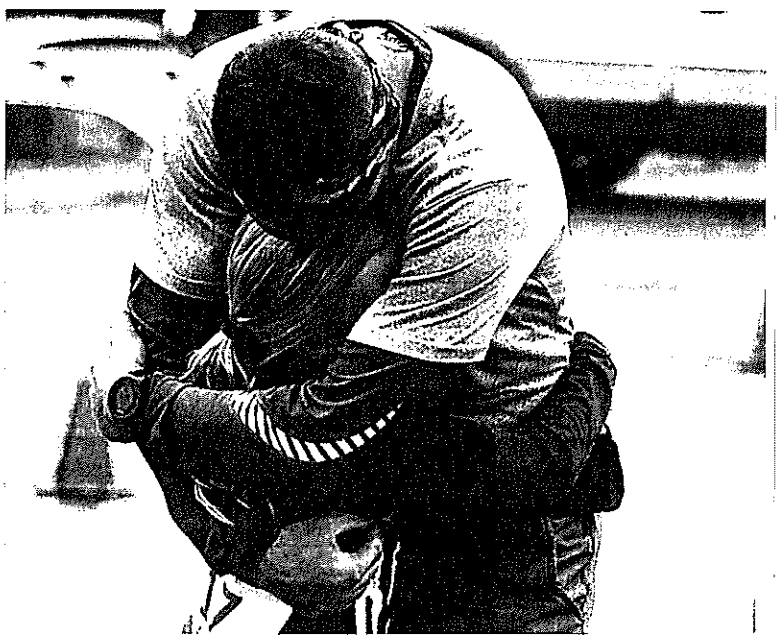
ACHS ANNUAL REPORT

July 1, 2016 - June 30, 2017




GAP





WE HEAR YOU...

You're worried about the changes in health care.
You need access to quality, affordable dental services.
You want programs and services that matter to you.

Your provider has to listen and understand your needs.
You want to feel like you belong, a part of the ACHS family... and that we're part of your community.

Throughout this past year, you've reached out to us. You've shared your stories and struggles. You've laughed and cried with us. You've hugged us and held our hands. We know you expect affordable, high-quality health care from people who truly care about what matters to you.
And, we aim to deliver.

ACHS hears you.

ACHS 2016
Annual Report to the Community

ACHS, Speaking on your behalf - locally and nationally

American's across the nation are concerned about their health care. The rising cost of insurance, the potential changes to the Affordable Care Act (Obama Care) and the availability of quality care are high on the priority lists of many. For New Hampshire residents it is no different.

In a recent poll, NH resident's listed health care and the opioid crisis among their top 5 concerns. ACHS is concerned, too. Changes to regulations in these arenas have the potential to effect policies, procedures and disrupt patient care.

Administration shifts at the nation's capital are always disconcerting and this term is particularly volatile as talk of sweeping changes threaten to impact millions. Many of those affected could be among the most in-need of the population - those on Medicare and Medicaid, and those who fall below the Federal Poverty level - patients who count on ACHS for their health care.

That's why we partner with agencies such as Bi-State Primary Care Association and community health centers throughout Vermont and New Hampshire to advocate on the state and national level. We travel to Concord, NH., Burlington, VT., Washington D.C. and beyond to be sure the voices of those in the north country are heard.

This year, ACHS CEO, Ed Shanshala traveled to D.C. with our Assistant Medical Director and members of the ACHS Board of Directors. They met with key members of the House and Senate working on health care issues. All parties came away with a better understanding of what is needed to protect precious services in the state.

On a local level, ACHS is working with the North Country Health Consortium and other area agencies, to help break the cycle of addiction, educate the community on opioid misuse and implement programs to aid those who are ready to make a change.

"I don't know what we'd do without Medicaid. My son is still a baby. He was diagnosed with Down's Syndrome. Even working two jobs... we struggle to make ends meet. I worry about losing coverage every day"

K.L. - ACHS Patient
Woodsville, NH

Data illustrates need in northern NH

ACHS serves over **10,000** patients in **26** north country towns, in **2** counties - Grafton and Coos. We see patients covered by private insurance, those who self-pay, and those on Medicaid and Medicare. We offer a sliding fee payment scale to those who qualify. Here's the breakdown:

22.8% are covered by Medicare - **14.5%** are covered by Medicaid - **47.2%** have private insurance - **10.5%** self pay.

ACHS provided $1.062 million in sliding fee discounts in 2016

Top: ACHS joins Bi-State Primary Care Association and Senator, Maggie Hassan in March 2017 to meet with the delegation on Health Committee changes. Top center - ACHS CEO, Ed Shanshala meets with Civil Rights leader and Congressman, John Lewis. Bottom: ACHS and Bi-State Primary Care delegates meet with U.S. Representative for NH, Annie Kuster.

ACHS - Listening and understanding each patient's unique health care story

Many believe the provider/patient relationship is a key to better health. Patients learn to trust and share. As a result, providers can better treat and heal. That's best for the patient and the community. According to Harvard Business Review, strengthening communication and enhancing provider bonds with patients may also result in reduced trips to Emergency Room and Specialist visits - decreasing overall costs to organizations and patients.

ACHS' providers understand how important it is to take the time to listen and fully understand their specific patient's needs. Our patient navigators are in place to help support their efforts, fielding questions related to outside issues that can impact care, such as transportation, food insecurities, insurance and legal issues.

For the third year in a row, ACHS has scored above the national average for patient satisfaction (97%) and recommendation (98%).

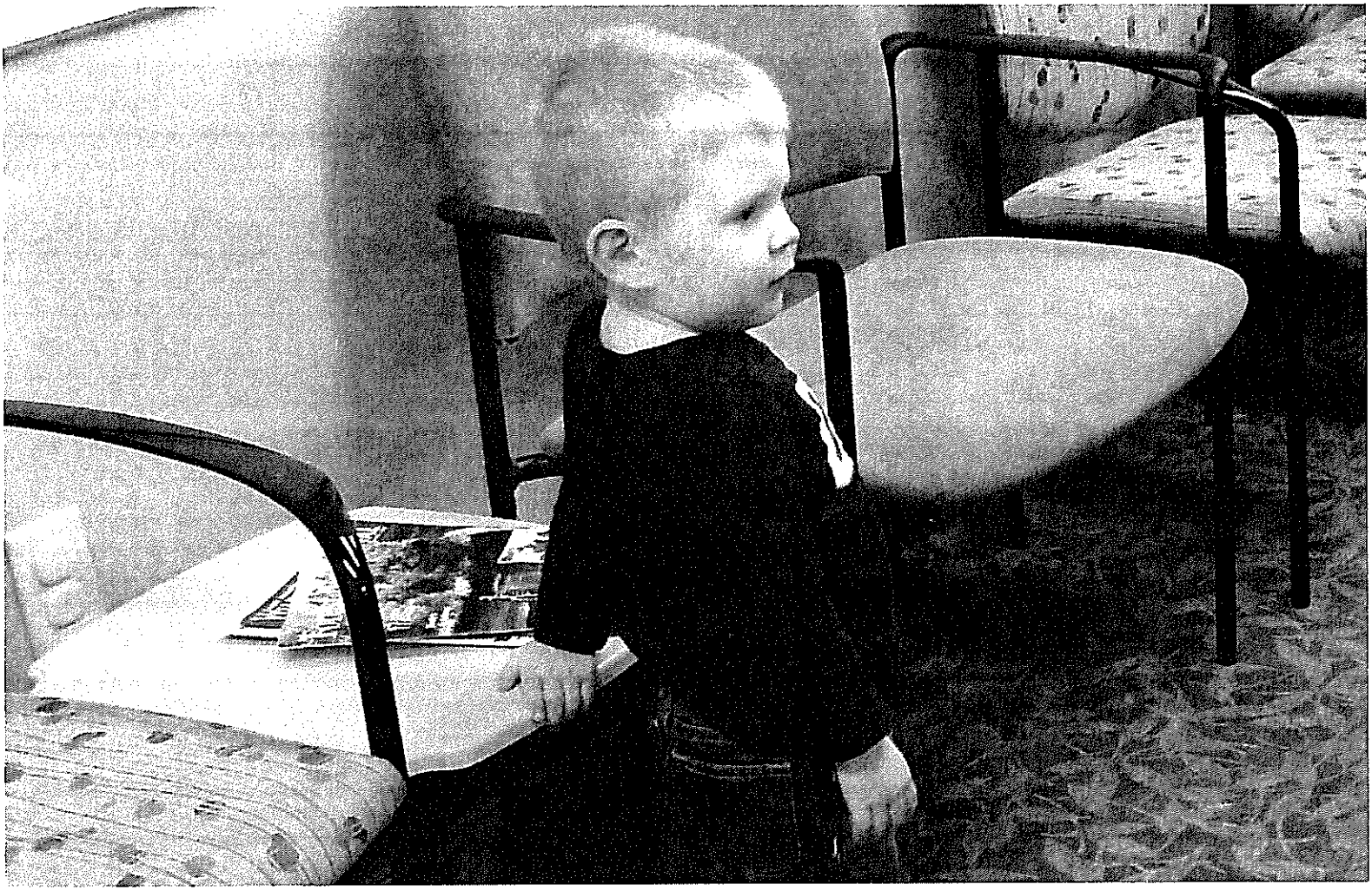
DID YOU KNOW?

40,000 women will die of **breast cancer** each year.

EARLY DETECTION SAVES LIVES

Elizabeth Story -

Elizabeth is an ACHS patient who felt comfortable enough with her provider to share a personal story about her mother's death from breast cancer. As a result, her provider recommended she have a free breast cancer screening through ACHS and New Hampshire's Department of Health & Human Services, Let No Woman Be Overlooked Program. The early detection of Elizabeth's breast cancer, helped save her life. With funds from the BCCP, we created a video to chronicle her success. Hear Elizabeth's story on the ACHS YouTube channel.



You requested quality, affordable dental care - ACHS listened

Above: ACHS- Dental Hygienist, Katie Latulip talks to one of our littlest patients about proper dental care, and coaxes him into his first dental cleaning.

Rural areas across the US face serious challenges in providing residents with oral health care. It is estimated that over the next 10 years, every state in the nation will face a dental shortage. Today, only 62% of New Hampshire's dental needs are currently being met. Compounding availability issues are expenses. Only about 1/3 of available dentists accept Medicaid or other public insurance. When patients can't access dental care their first stop may be the hospital emergency department. There they are often prescribed antibiotics or pain medication. ED dental is expensive and generally doesn't address the original problem.

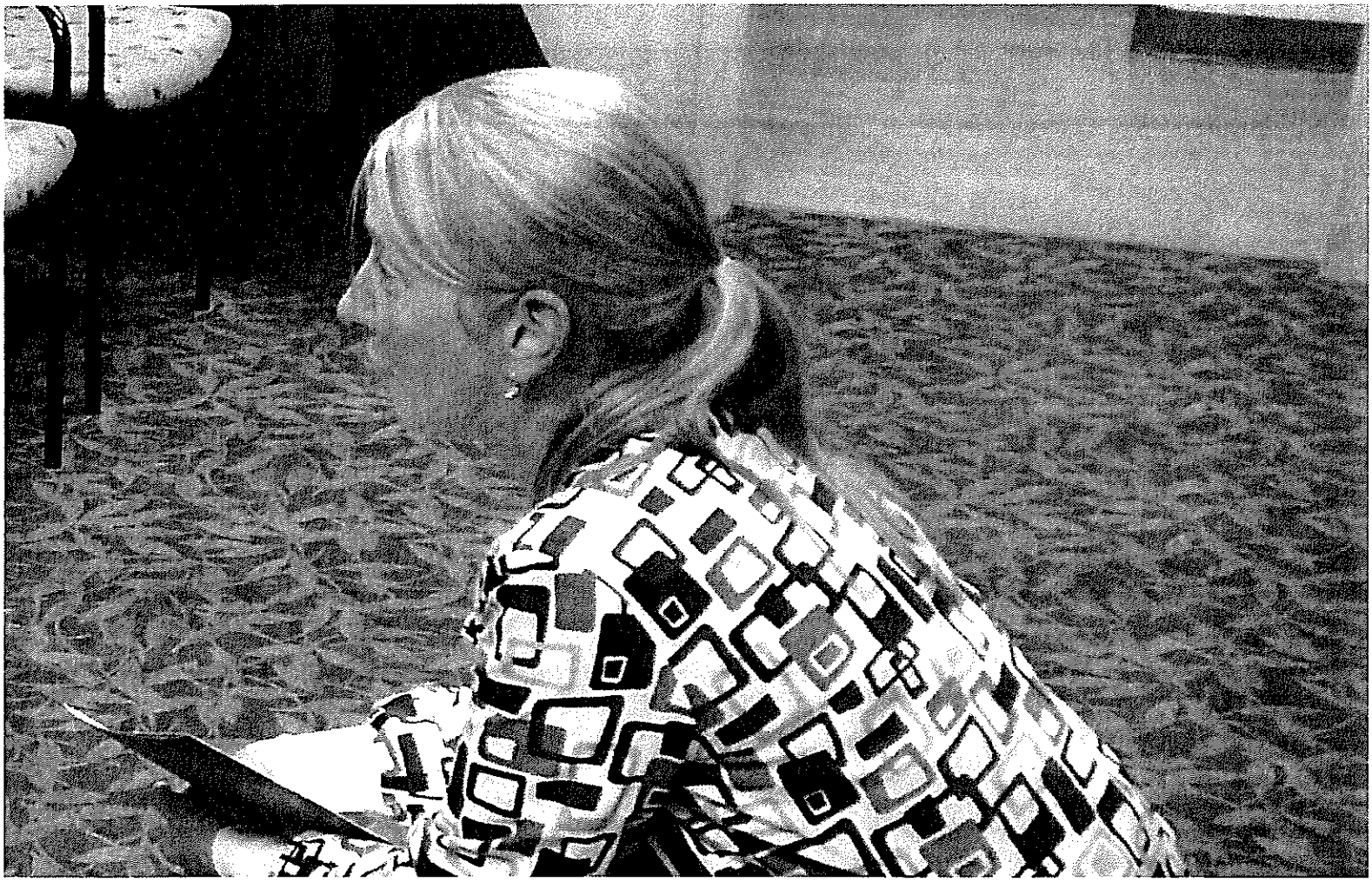
The correlation between dental health and overall health are well-known. Unhealthy mouths can lead to a variety of medical issues. In addition, it's hard to function day-to-day when you are in constant dental pain.

When ACHS Oral & Dental Health Center opened in January of 2015, we knew there was a need. How much of a need soon became apparent. Many of our patients had not seen a dentist in years, some had never had a dental cleaning. ACHS offered these patients care they otherwise couldn't afford.

In 2016, ACHS saw over 1,000 patients and delivered over $400,000 in discounted sliding fee services. The need for a second dentist is evident. ACHS is actively recruiting for an additional dentist to help address the continued need. In the interim, our dental staff continues to see a steady stream of patients.

"Thank you ACHS. I was faced with a decision, pay for a pressing home repair or fix my tooth. I can't thank you enough for your generosity"

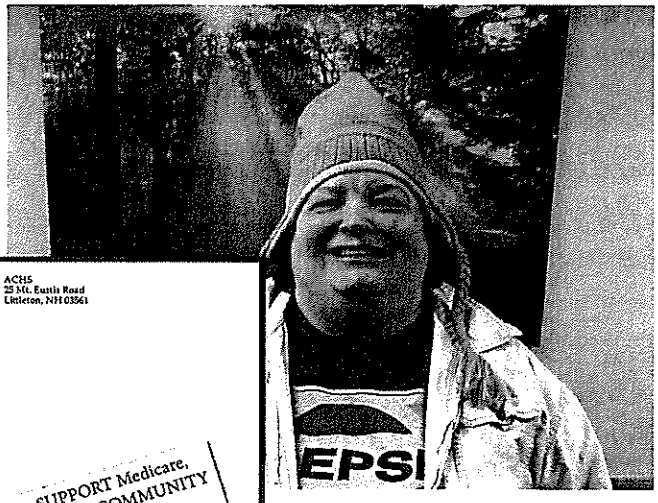
J.B. ACHS Dental Patient
North Haverhill, NH

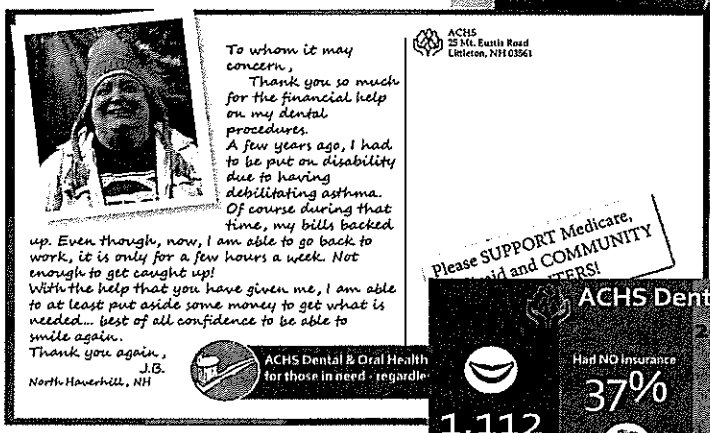


JB's story

A few years ago, JB from Haverhill, NH. was diagnosed with chronic, debilitating asthma. As a result, she was unable to work. During her disability, the bills backed up and she put off her dental checkups.

Fortunately, JB qualified for ACHS' sliding fee discount, and with some financial assistance she was able to fix the issues she was having with her teeth. She can now smile and has returned to work. She is ever grateful for the support she received from ACHS.





To whom it may concern,

Thank you so much for the financial help on my dental procedures.

A few years ago, I had to be put on disability due to having debilitating asthma. Of course during that time, my bills backed up. Even though, now, I am able to go back to work, it is only for a few hours a week. Not enough to get caught up!

With the help that you have given me, I am able to at least put aside some money to get what is needed... best of all confidence to be able to smile again.

Thank you again,

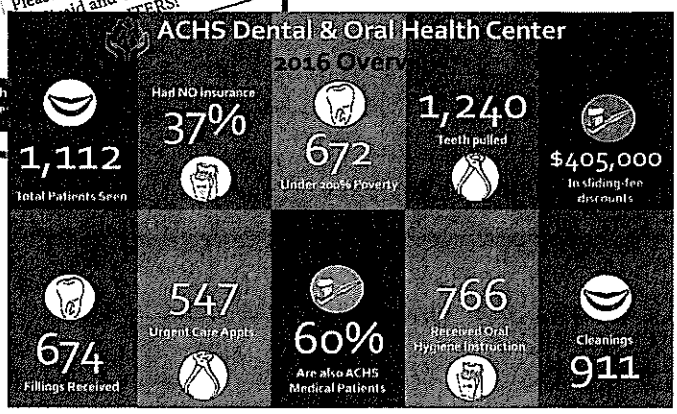
J.B.

North Haverhill, NH

ACHS
22 Mt. Eustis Road
Littleton, NH 03561

Please SUPPORT Medicare, ...id and COMMUNITY ...TERS!

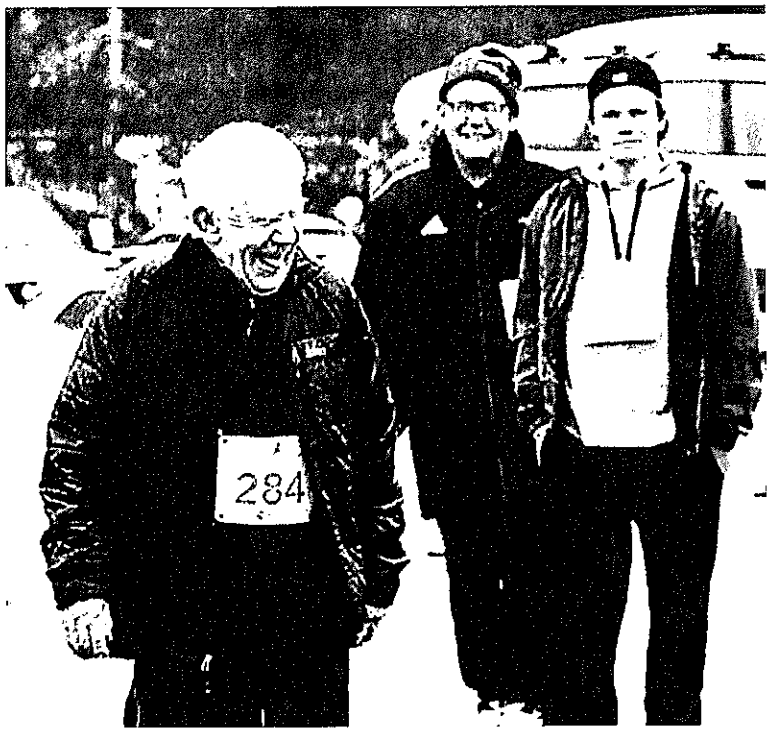
ACHS Dental & Oral Health for those in need - regardle...



Roughly 37% of ACHS dental patients have no insurance. Our sliding fee service for those who qualify helps those who need us most.

Right: Infographics, such as this overview of dental services, are used to provide a snapshot of our services at the state and local level.


JUST ME IN THE TUB
GOOD DOG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ACHS - Integrated with Community

Without the communities we serve, ACHS would not exist. At our six sites throughout northern New Hampshire, we serve over 10,000 residents. These folks are not just our patients, they are our friends and neighbors.

We strive to let those we serve know we are in their corner. By delivering educational and beneficial programs we promote improved health and nutrition, better dental and vision care, behavioral health services and an overall healthier lifestyle.

Whether we're participating in a health fair, promoting the works of local artists, supporting the Warren-Wentworth Food Pantry, or celebrating our "most senior" participant at the Ammonoosuc Amble, we're part of the community. Just like the local Mom and Pop shop, ACHS is also a small business that depends on the success of the town's we serve. We support the efforts of our community partners and appreciate the support of like-minded organizations.

Despite the rainy weather, this year's Ammonoosuc Amble was a hit. With nearly 200 participants we raised over $10,000 for our Healthy Smiles Program - which helps support those who need assistance with their dental care.

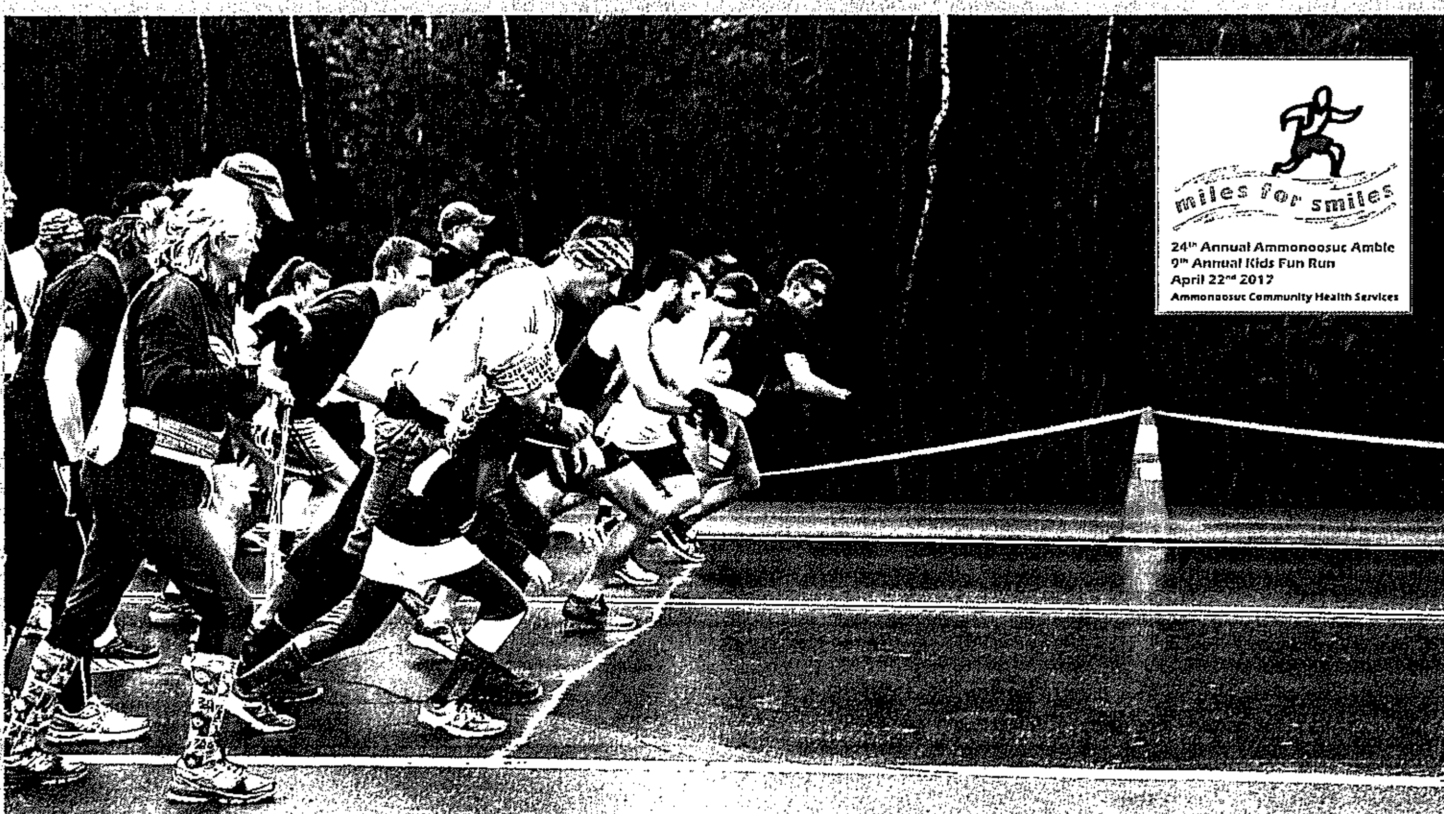
Thank you to our 2017 Ammonoosuc Amble sponsors:

Ammonoosuc Community Health Services

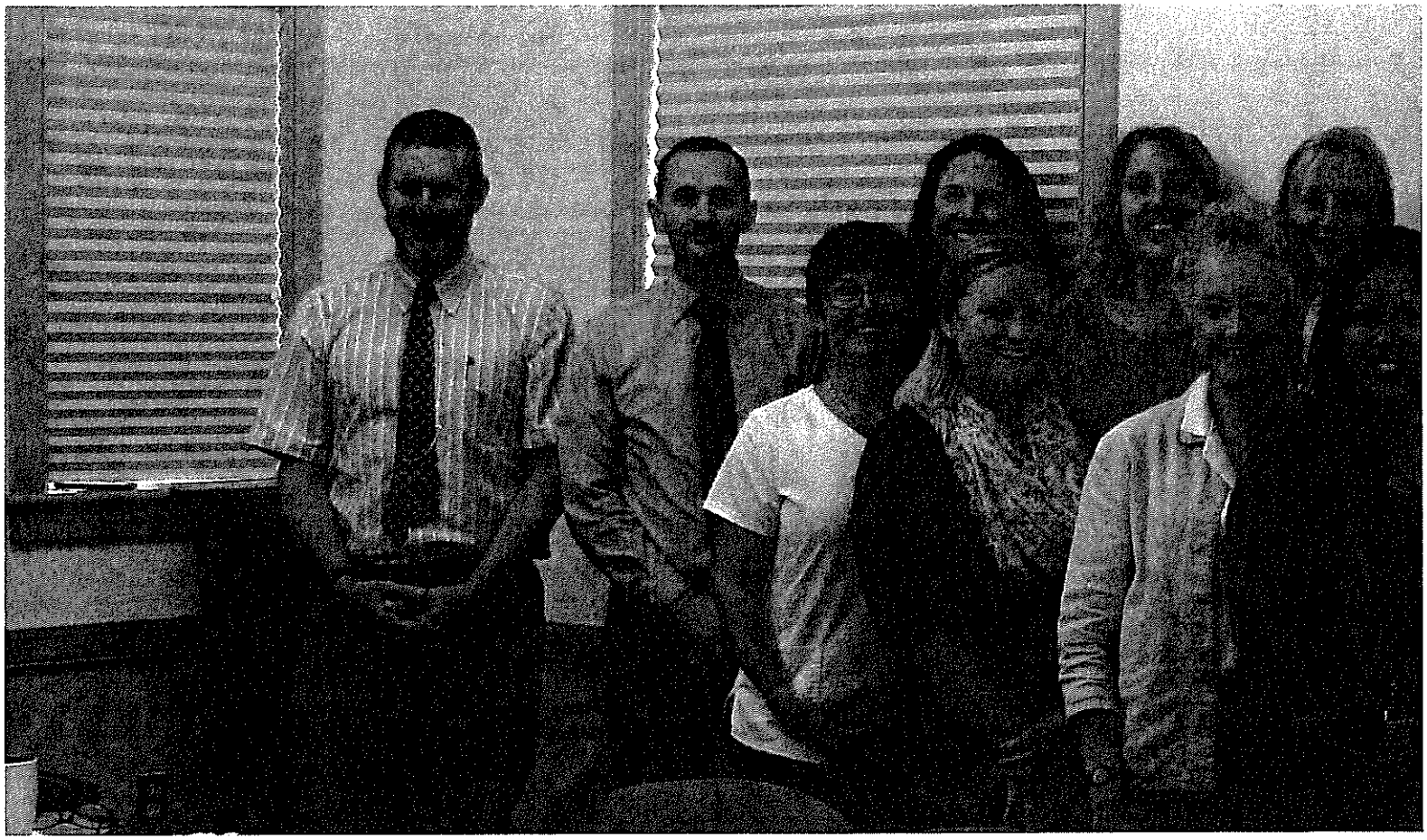
24th Annual Ammonoosuc Amble • 9th Annual Kids' Fun Run • 4•22•2017

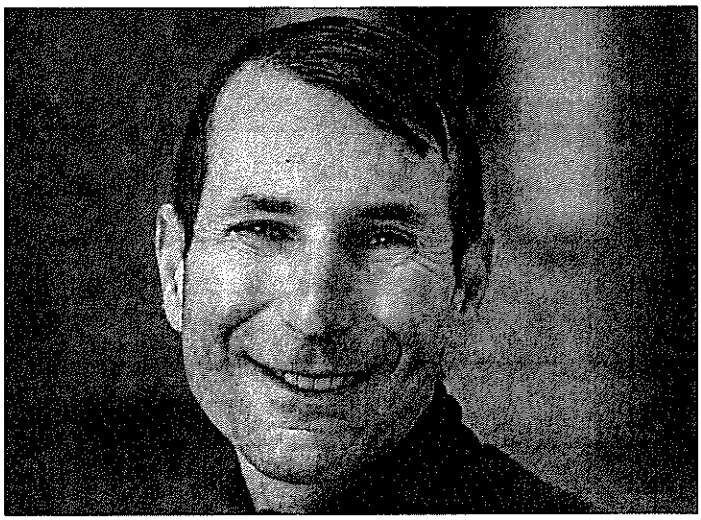
Abbott Rental	Foto Factory	McLure's Honey & Maple Products
ACHS Staff	Franconia Hardware	Mountain View Grand
Alburrito's Restaurant	Fresh Salon & Day Spa	North Country Local
Ammonoosuc Massage & Nutrition	Frost Place	Pentimento
Bank of New Hampshire	George M. Stevens Insurance	Pete & Gerrys Organics
Beal House Inn & Restaurant	Gold House Pizza	Polly's Pancake Parlor
Bethlehem Police Department	Harman's Cheese & Country Store	Porfido's Market & Deli
Bethlehem Emergency Services	Hunkins & Eaton Insurance	Profile School
Bretton Woods Ski Area	The Inn at Whitefield	Salmon Press
Bridge Weekly Sho-Case	Jax Jr. Cinemas	Shaws of Littleton
Chang Thai Cafe	Lahout's Clothing & Ski Shop	Sherwin Dodge Printers
Cherry Blossom Florist	Little Village Toy & Book Shop	Subway of Littleton
Coca-Cola of Northern NH	Littleton Athletic Department	The Coffee Pot
Dunkin Donuts of Littleton	Littleton Bike & Fitness	The Inn at Whitefield
Embroidery By Everything Personal	Littleton Healing Arts Studio	Topic of the Town Restaurant
Emma & Co. Consignment Boutique	Littleton Pet Center	Walgreen's
Fireside Hearth & Leisure	Maple Grove Farms	

Join us for the 25th Annual Ammonoosuc Amble Saturday - April 28, 2018



Left - Right to Left: Young runner at Kids Fun Run, Artist Amy [illegible] smiles & exhibits her work, Mikayla Fahey interns at ACHS, [illegible] is Ammonoosuc Amble's oldest runner, Warren-Wentworth Food Pantry receives a check from Bishop's Charitable Trust, ACHS Dental Hygienist, [illegible] visits Boys & Girls Club of the North Country. Above: Runners take their mark at the 24th Ammonoosuc Amble.





You're only as good as the company you keep!

At ACHS we are known for our offer high-quality, affordable health care and integrated primary care services. These are not the only reasons area residents come to us time and time again for their health care needs. For many, it comes down to the relationships they build with their providers and our professional staff.

Patients have many choices for their care - primary, behavioral health, dental and pharmacy services, yet they choose ACHS. The reason? If you ask them, they'll say it's all about the people.

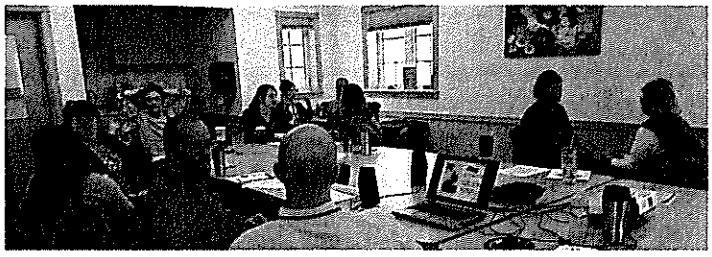
According to on the Consumer Assessment of Healthcare Providers & Systems, ACHS has a patient promotion rating of 95%. We also scored the highest of over 900 like organizations in: Over-all Doctor Rating, Office Staff Quality, Office Recommendation, Access to Care, and Provider Communication Quality. These statistics are indicative of our employee's commitment to quality - from patient interactions at reception and visits, to customer service in the pharmacy or with our billing team. ACHS keeps the customer (our patient) at the fore-front of everything we do.

*Above Left: **ACHS - Littleton's Melanie Childs and Tasha Martin,***
*Below left: **David Ferris, DO joins the ACHS family of providers.***

How do we continue to keep these ratings high? It starts with taking good care of our employees. ACHS provides over 121 area residents a welcoming place to work where they can contribute to their communities, care for its people and be recognized for their efforts. Many of our employees have been at ACHS for decades.

The very culture of the organization is to care for one another. For folks who work here, their coworkers become friends and family.

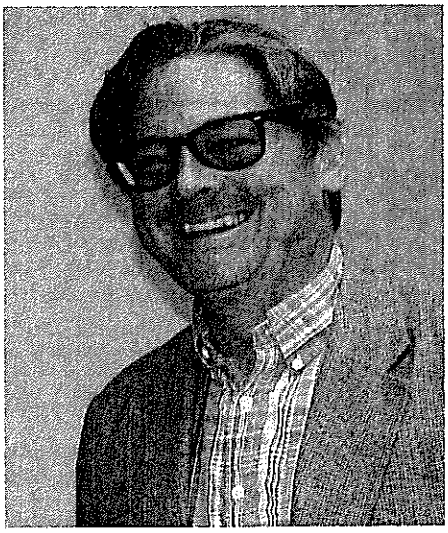
ACHS employees receive competitive pay, medical and dental benefits, a health reimbursement incentive, education support and more. We treasure our staff and will continue to keep our employees satisfied, so they can continue to do what they do best - care for our patients and our communities.



Top: *ACHS- Providers left to Right: Aaron Solnit, MD, Brandon Jolley, DDS, Glenda Reynolds, DDS. Backrow: Caitlyn O'Donnell, MD, Nicole Fischler, APRN, Natalya Sudinaya, PA, David Nelson, DO, MBA, Josh Gleiner, PA, Jessica Thibodeau, APRN, Medical Director, Sarah Young-XU, MD, Lisa Bujno, APRN* ***Front Row:*** *Elizabeth Newton, APRN, Kate Smith, MD, Imelyn Fernandez, MD, Alley Noble MD, Barbara Ford, APRN, Evelyn Hagan, MD.* ***Above:*** *ACHS Littleton employees participate in a session on Motivational Interviewing.*

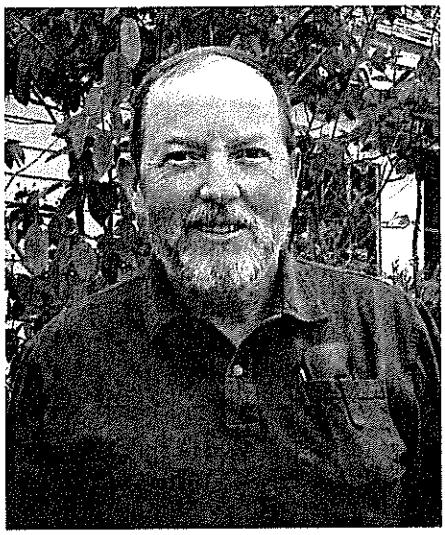
"I visited ACHS yesterday. As usual this appointment, was warm, welcoming, and informative. The staff at the desk, the nurse that greeted me, and of course the beloved Dr. Kate Smith couldn't have been more approachable or helpful. It's nice to know that ACHS is available when I call them in need and that I leave there feeling really cared for. Thank you and kudos to you and the whole staff."

M.K., ACHS Primary Care Patient
Bethlehem, NH



ACHS CEO, Ed Shanshala

ACHS COO, Teresa Brooks



ACHS Board of Directors President, Doug Harmon

A word from ACHS senior leaders

As a Federally Qualified Community Health Center with roots steeped in America's quest for Civil Rights and the War-on-Poverty, it's no surprise that ACHS remains committed to advocating for patients. Speaking on behalf of those who can't is as important to us today as it was when we began in 1975.

This year brought the promise of significant changes to health care. Cuts to funding, modifications of federal programing and a variety of other implications threatened to impact the services we offer to our patients.

To that end, we rolled up our sleeves and partnered with other health care organizations to monitor an speak up about the changing health care environment locally and nationally.

We remain connected to key supporters, monitored changing legislation and advocated for policies that could impact care. After all, it's these issues - affordable health care, surging insurance premiums, access to care, and pharmaceutical changes - which directly affect our patients.

In February, at a health care session in Berlin, NH with Senators Jeanne Shaheen, Maggie Hassan and U.S. Rep Annie Kuster, we delivered our message at a health care round table. We must continue to push for affordable health care and Medicaid expansion.

Time and time again, ACHS is recognized as an organization who is not afraid to face issues head on. We are not afraid to take chances, to think outside of the box, to be innovative.

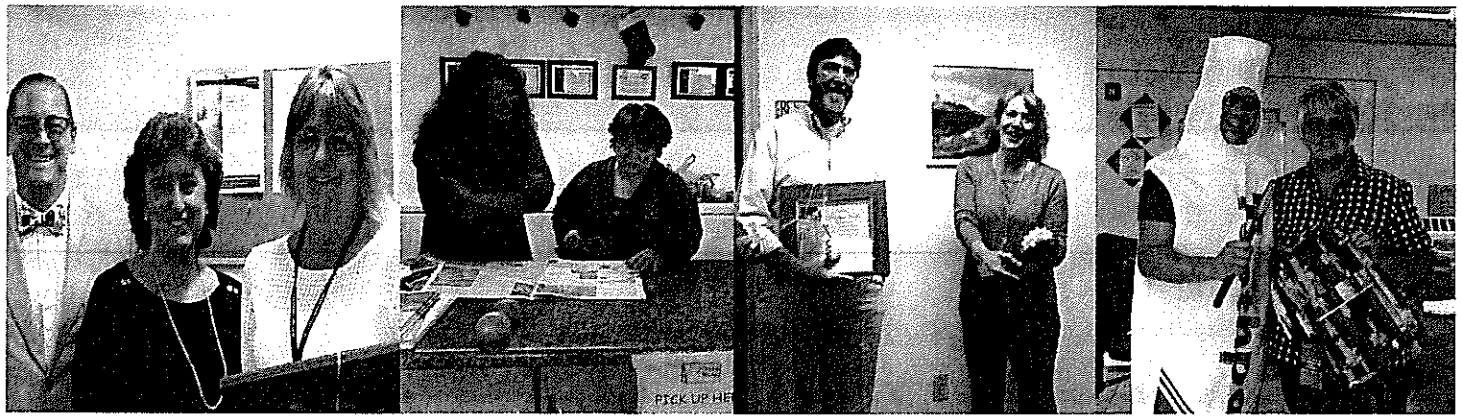
This way of thinking is ingrained in our culture and shared by our employees. We are all committed to doing what is right by our patients, our organization and our community.

As we move forward in navigating this new health care territory, you can be sure ACHS will continue to evolve and modify as needed to ensure our long-term success.

Be Mindful, Active, and Well.

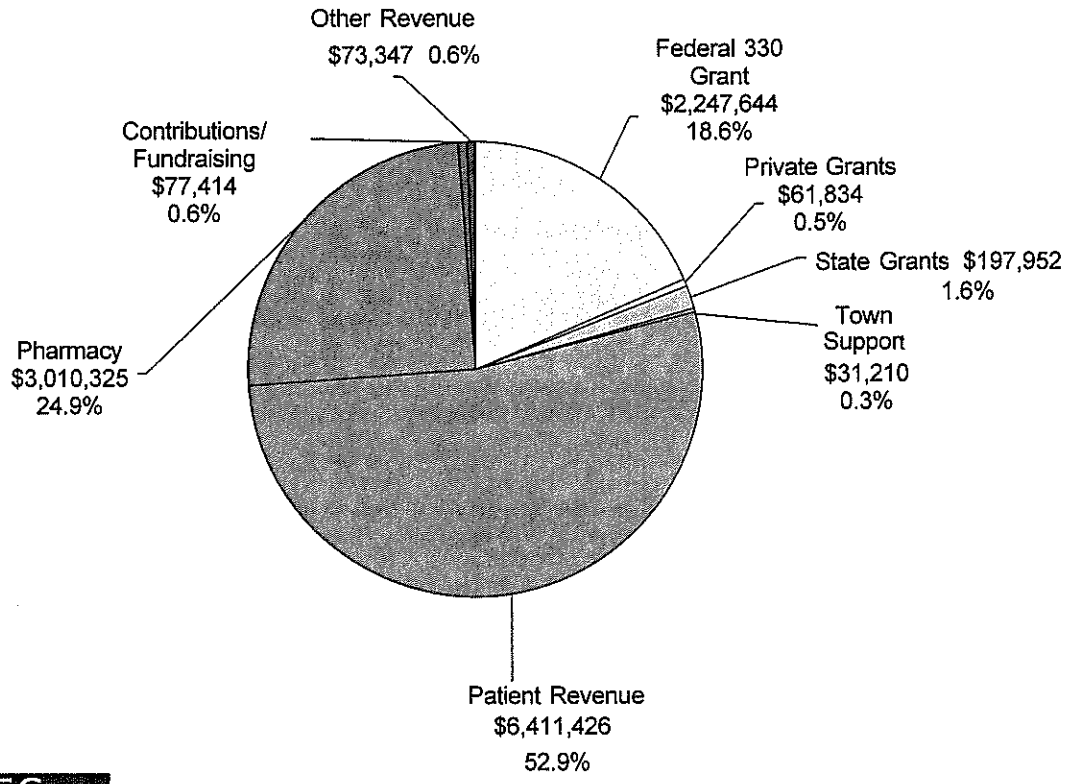
Above: *Ed Shanshala delivers a presentation on the changing aspects of health care at a round table meeting. (Senator Shaheen, Senator Hassan and Congresswoman Kuster were present.) Right: ACHS activities throughout the year.*


Community
Health Services

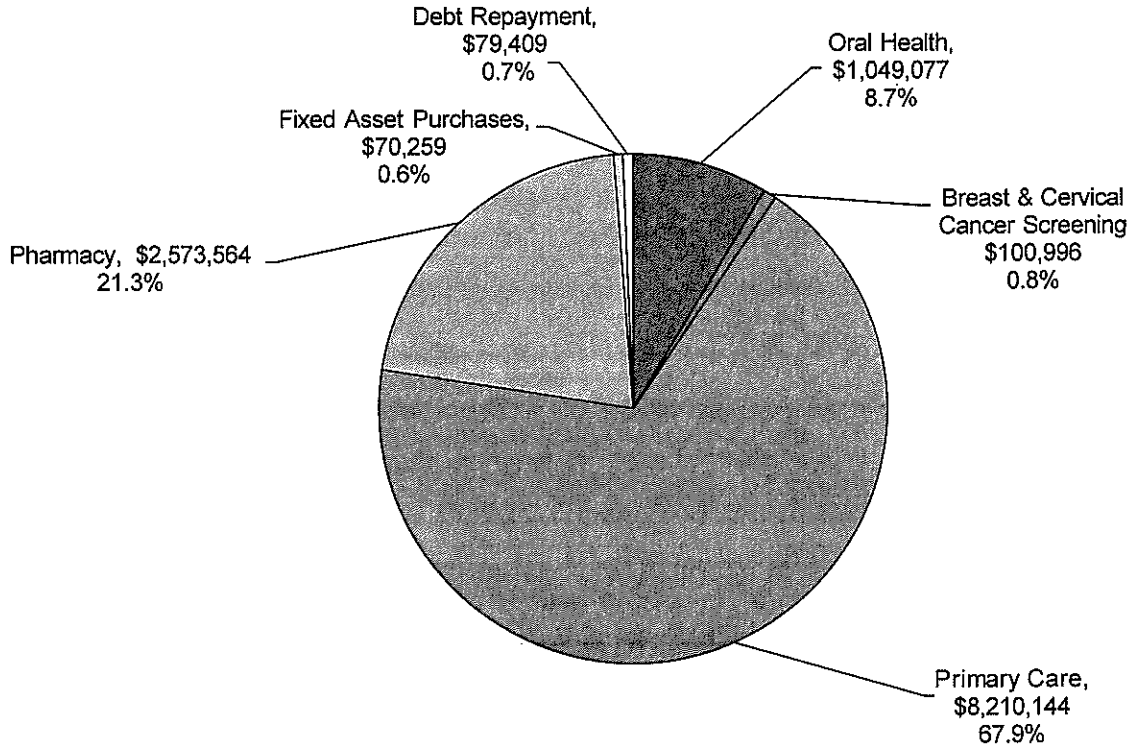


July 1, 2016 - June 30, 2017

REVENUE



EXPENSES



Our Mission...

To provide a network of comprehensive Primary Health Care and Support Services to individuals and families throughout the communities we serve. In support of this mission, ACHS provides evidence-based, outcome-specific, systemic care that is: patient-centered, prevention-focused, accessible and affordable for all.

FY 2016-2017

ACHS Board of Directors

Doug Harman, President • Mark Secord, Vice President
John Rapoport, Treasurer • Ned Densmore, Secretary
Erik Becker, Rick Christofferson, Judy Day, Natch Greyes, Blaine Hall,
Elizabeth Harman, Sandy Laleme, Gary Merchant
Alan Smith, Ron Spaulding, DDS

ACHS Senior Leadership Team

Edward Shanshala, CEO • Ken Riebel, CFO • Teresa Brooks, COO
Damian Anthony Canuto, Pharmacy Director,
Dr. Melissa Buddensee, Chief Quality Director • Lisa Bujno, Asst. Medical Director,
Jill Kimball, Community Relations Manager,
Stephen Noyes, Director of Integrated Behavioral Health,
Dr. Sarah Young-Xu, Chief Medical Director • Crystal Rutledge, HR Director

Services Provided

- Primary Preventive Medical Care – Family Practice - Prenatal Care through Geriatrics
- Prenatal Care – Childbirth Education, Nurse/Midwife Service and Newborn Care
- Family Planning – Birth Control, STD and HIV Testing and Counseling
- Breast & Cervical Cancer Screening Program • Nutrition Counseling
- Behavioral Health • Dental & Oral Health Care • Patient Navigation Services
- Pharmacy Services – In-house Pharmacy, Medication Management, Low-Cost Drug Program
- Vision Program – Comprehensive eye exams and affordable glasses for those who qualify
- Nutrional Counseling – Free guidance for eating better to aid in improved health
- Financial Services – Sliding Fee Scale for eligible patients

ACHS Statistics

- Number of Unduplicated Clients Served: Medical - 9,450, Dental - 1,234, Behavioral Health - 539, Enabling - 65, Vision - 143
- Number of Visits: Medical - 32,810, Dental - 3,904, Behavioral Health - 3,559, Enabling - 95, Vision - 160
- Client/Payor Mix: Medicaid - 14.5%, Medicare - 22.8%, Uninsured - 10.5%, Insured - 47.2%
- Value of free medications provided to our patients: $272,371 • Value of discounted health care services provided to our patients: $1,061,670 - total; Medical - $360,166 Dental - $456,205, Behavioral Health - $15,614, Pharmacy - $229,684

ACHS Supporters

Thank you for your support - it is a great investment in the health of our community and furthers our mission to provide quality, affordable health care for all regardless of one's ability to pay. We rely on the continued commitment of our community partners, through donations, volunteer efforts and collaborations. We make every effort to ensure the accuracy of this list.

AMMONOOSUC AMBLE SPONSORS

Abbott Rental
ACHS Board of Directors
ACHS Dental
ACHS Front Desk Staff
ACHS MIS Department
ACHS PN & NPC
ACHS Senior Leadership
Alburritos Restaurant
Ammonoosuc Massage & Nutrition
Badger Company
Bank of New Hampshire
Beal House
Bear Images
Beth Harwood
Bethlehem EMS
Bethlehem Police Department
Bretton Woods Ski Area
Chang Thai
Cherry Blossom Florist
Coca Cola of Northern New England
Connors Footwear
Community Financial Services
Cyndi Keller
Dayna Flumerfelt Photography
Dunkin Donuts
Ellen Scarponi
Emma & Co.
Fairpoint Communications, Inc.
Fireplace Hearth & Leisure
Foto Factory
Fresh Salon & Day Spa
Frost Place
Garnet Hill, Inc.
George M Stevens
GM Fotography & Framing
Gold House Pizza
Hampton Inn
Harman's Cheese & Country Store
Hunkins & Eaton Insurance
Inn at Whitefield
Jax Junior Cinemas
Joan Dexter
Katie Latulip
Ken Kimball Art
Lahout Country Clothing & Ski
Linda Shulda
Little Village Toy & Book Shop
Littleton Athletic Department
Littleton Bike & Fitness Littleton Chevrolet, Buick, Inc Littleton Coin Company, LLC Littleton Diner
Littleton Food Coop
Littleton Healing Arts Studio
Littleton Regional Healthcare
Littleton Rotary Club
Littleton Subway
Loren Solnit
Maple Grove Farms
Mascoma Savings Bank
McLure's Honey & Maple Product
Mountain View Grand
North Country Health Consortium
New England Wire
NH Healthy Families
North Country Community Radio
North Country News
Northeast Delta Dental
Omni Hotels & Resorts
Passumpsic Savings Bank
Peabody & Smith Realty, Inc
Pentimento

Pete and Gerry's Organics
Polly's Pancake Parlor
Point FM
Porfido's Market & Deli
Racewire
Salmon Press
Sally Crossley
Santilli Family Dentistry
Secured Network Solutions, Inc.
Stephen Noyes
Shaws
Sherwin Dodge Printers
Stephen Noyes
Team O'Neil
Tender Corporation
Topic of the Town
Trahan's Cleaning Service
Union Bank
Walgreens
Walmart
Wellsense
White Mountain Footwear
Woodsville Guaranty Savings Bank
Dr. & Mrs. Charles Wolcott
WYKR-Puffer Broadcasting

ACHS DONORS

Patricia Ahearn
Mr. & Mrs. Dudley Bailey
Mr. & Mrs. Damian A. Canuto Mr. & Mrs. Philip R. Chase
Mr. & Mrs. John Cloran
Colin Comi
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Ms. Sally Crossley
Mr. & Mrs. Joseph Cushing
Mr. Edward D. Densmore
Ms. Catherine Emery
Ms. Patricia Exley
Ms. Santa Rita Ferrante
Mr. & Mrs. Michael J. Ford
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Mr. & Mrs. John P. Mumley
Mr. & Mrs. Richard C. Nelson
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Mr. & Mrs. John Rapoport
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Ms. Crystal Rutledge
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Mark Secord
Linda Shulda
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Mr. & Mrs. Michael Talotta
Mr. & Mrs. Chris Thoma
Mr. & Mrs. Robert Tortorice
Betsy Vanderwater-Fuller
Dr. Deborah Warner
Dr. & Mrs.Charles J. Wolcott
Mr. & Mrs.Frank S. Woodruff
Dr. Sarah Young-Xu

ACHS WARREN

Mr. Paul R. Belyea
Ms. Virginia Burnham
Mr. Ronald A. Chase
Mr. & Mrs. Rick Christoffersen
Cornell Family Foundation
Mr. & Mr. William Gove
Mr. & Mrs. Alfred Hannett
Ms. Christine Healy
Favor Jenkins
Ann Katan
Jean Marston-Dockstader
Mr. & Mrs. Lyle Moody
Lori Mooney
Marshall Moulton
Lisa F. Palmer
Mr. & Mrs. William F. Sommerfeld
Susan Barlow
Ms.Margaret Whitcher
Mr. & Mrs. David R. Whitcher
Patricia M.Wilson

TOWN SUPPORT

Town of Bath
Town of Bethlehem
Town of Carroll
Town of Dalton
Town of Dorchester
Town of Easton
Town of Franconia
Town of Haverhill
Town of Landaff
Town of Lincoln
Town of Littleton
Town of Lisbon
Town of Lyman
Town of Monroe
Town of Piermont
Town of Rumney
Town of Sugar Hill
Town of Thornton
Town of Warren
Town of Wentworth
Town of Whitefield

SPECIAL THANKS

Bi-State Primary Care Association
Community Health Access Network
Coos County Family Health Services, Inc.
Cottage Hospital
Littleton Regional Healthcare
NH Department of Health & Human Services
North Country Health Consortium
US Department of Health & Human Services - Health Resouces & Services Administration

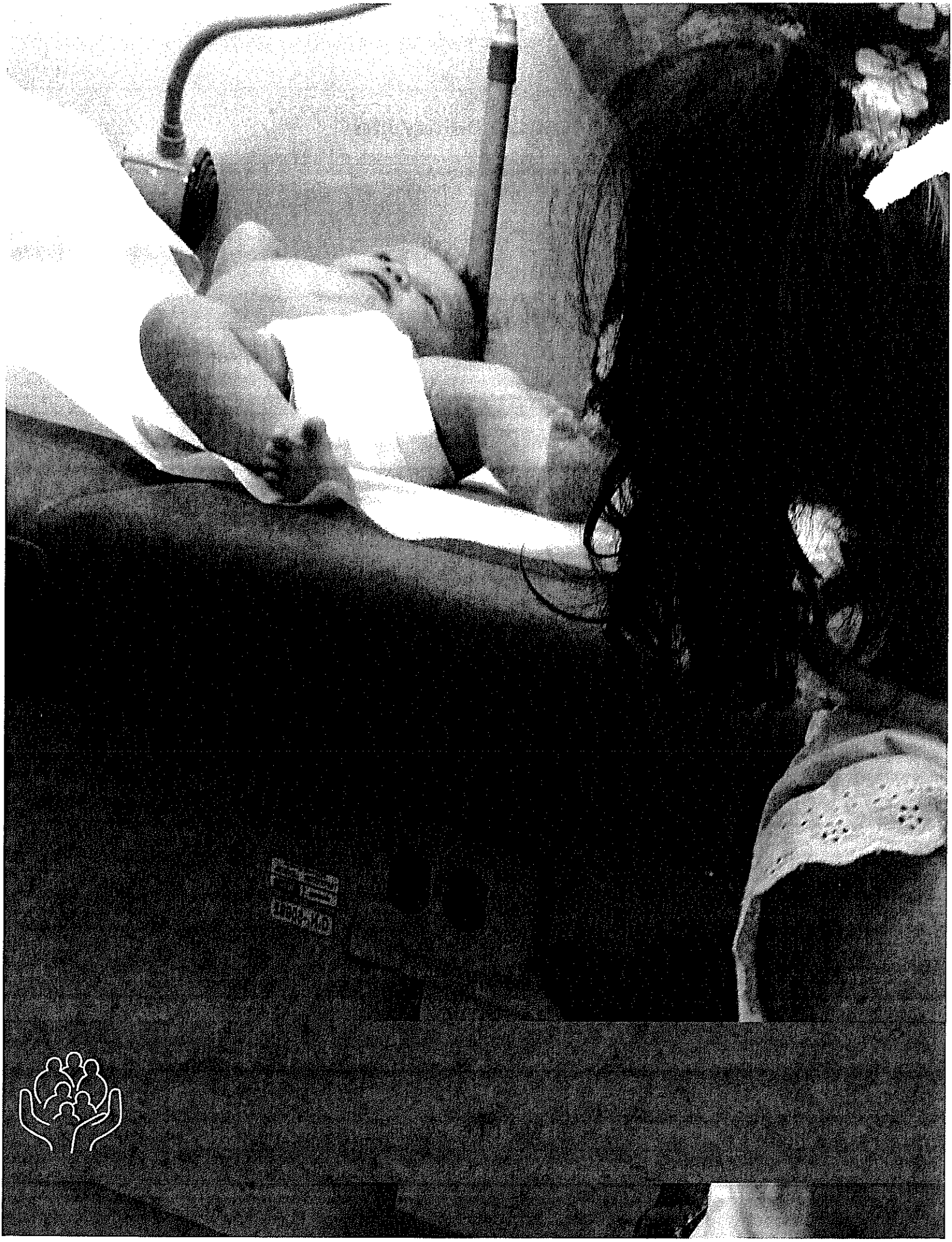
FairPoint communications

Mascoma Savings Bank

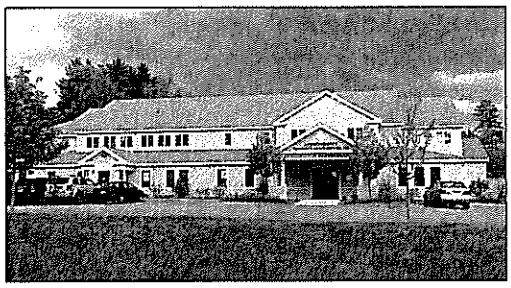
Passumpsic Savings Bank
Your Bank, Your Way of Life.

Delta Dental
Northeast Delta Dental Foundation

NEW HAMPSHIRE CHARITABLE FOUNDATION
NORTH COUNTRY REGION

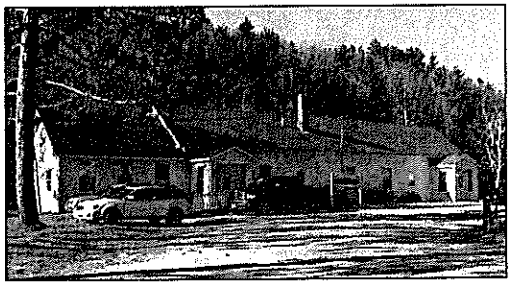


ACHS Care Delivery Sites



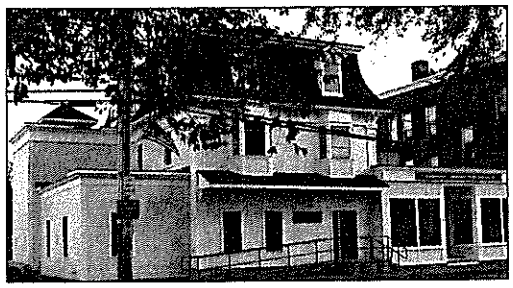
ACHS-LITTLETON
(Administrative Offices, Clinic, Pharmacy, Dental & Oral Health Center)
25 Mt. Eustis Road • Littleton, NH 03561
603.444.2464 • www.ammonoosuc.org

ACHS-FRANCONIA
1095 Profile Rd. Suite B. • Franconia, NH 03580
603.823.7078



ACHS-WARREN
Route 25, Main St. • Warren, NH 03279
603.764.5704

ACHS-WOODSVILLE
79 Swiftwater Road • Woodsville, NH 03785
603.747.3740



ACHS-WHITEFIELD
14 King's Square • Whitefield, NH 03598
603.837.2333

ACHS' Federally Designated Service Area encompasses the following 26 towns:

Bath • Benton • Bethlehem • Carroll • Dalton • Dorchester • Easton • Ellsworth • Franconia • Groton
Haverhill • Landaff • Lincoln • Lisbon • Littleton • Lyman • Monroe • Orford • Piermont • Rumney
Sugar Hill • Thornton • Warren • Wentworth • Whitefield • Woodstock

Amendments

Rep. Knirk, Carr. 3
Rep. W. Marsh, Carr. 8
Rep. J. Edwards, Rock. 4
March 23, 2018
2018-1216h
01/03

Not adopted

Amendment to SB 313-FN

Amend RSA 126-AA:2, I(a) as inserted by section 1 of the bill by replacing it with the following:

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

Amend RSA 126-AA:2, I(d) as inserted by section 1 of the bill by replacing it with the following:

(d) Prior to submitting the waiver or state plan amendment to the Centers for Medicare and Medicaid Services (CMS), the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

Bill as Introduced

SB 313-FN - AS AMENDED BY THE SENATE

03/08/2018 0984s
03/08/2018 1022s

2018 SESSION

18-2956
01/03

SENATE BILL ***313-FN***

AN ACT reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

SPONSORS: Sen. Bradley, Dist 3; Sen. Morse, Dist 22; Rep. S. Schmidt, Carr. 6; Rep. Umberger, Carr. 2; Rep. Danielson, Hills. 7; Rep. Kotowski, Merr. 24

COMMITTEE: Finance

AMENDED ANALYSIS

This bill:

I. Establishes the New Hampshire granite advantage health care program which shall replace the current New Hampshire health protection program. Under this program, those individuals eligible to receive benefits under the Medicaid program and newly eligible adults shall choose coverage offered by one of the managed care organizations contracted as vendors under the Medicaid program.

II. Establishes the granite workforce pilot program.

III. Increases the amount of liquor revenues to be deposited into the alcohol abuse prevention and treatment fund and provides that moneys deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund for substance use disorder prevention, treatment, and recovery.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eighteen

AN ACT reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, less the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV, less all federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs attributable to the program, and taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver of the requirement to provide 90-day retroactive coverage. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a

cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all pre-existing authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. The commissioner shall also include in the MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance. Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g).

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment, including nonprofit organizations.

(2) Subsidized private sector employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph refuses to engage in work or community engagement activities required in accordance with this subparagraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.

(c) This subparagraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i). In this subparagraph, "childless" means an adult who does not live with a dependent child which includes a child under 19 years of age or under 20 years of age if the child is a full-time student in a secondary school or the equivalent.

(d) This subparagraph shall not apply to:

(1) A person who is temporarily unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A parent or caretaker of a dependent child under 13 years of age or a child with developmental disabilities who is residing with the parent or caretaker.

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R section 440.315(f), and as defined in the alternative benefit plan in the state plan.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Those rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care physicians. The wellness visit shall include appropriate assessments of both physical and mental health,

including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity to cure and for re-activation following noncompliance.

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, and to pay for the administrative costs for the program. The commissioner may accept any gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund. No state general fund appropriations shall be deposited into the fund. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to managed care organizations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30, 2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before September 30, the commissioner shall calculate the estimated final

remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before September 30 of each subsequent year, the commissioner shall calculate the estimated final remainder amount for the prior fiscal year. If the actual remainder amount is greater than the prior calculated estimated remainder for any fiscal year, the difference shall be retained in the trust fund and shall be used in the calculation of future estimated remainder amounts.

VI. The commissioner of the department of health and human services, in accordance with the most current available information, shall be responsible for determining, every 6 months commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next 6-month period. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS.

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the speaker of the house of representatives.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the chairperson of the committee.

(11) A licensed physician, appointed by the governor.

(12) A licensed mental health professional, appointed by the governor.

(13) A licensed substance use disorder professional, appointed by the governor.

(14) An advanced practice registered nurse (APRN), appointed by the New

Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the commissioner concerning recommended monitoring and evaluation requirements for work and community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members.

The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Ten members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report together with its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022.

126-AA:5 Evaluation Report Required.

I. The program shall employ an outcome-based evaluation of its Medicaid program annually to:

(a) Provide accountability to patients and the overall program.

(b) Ensure that patients are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care.

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs.

II. The results of the evaluation conducted under this section shall be in the form of a report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF) program to end the dependence of needy parents and low income childless adults ages 18 through 24 on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be

provided to eligible participants through Granite Workforce. The total cost of the pilot program shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) Parents aged 18 through 64 with a child under age 18 in the household;

(c) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(d) Childless adults between 18 and less than 25 years of age.

III. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

IV. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program, adopted under RSA 541-A as chapter He-W 600, shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. Upon placement of a participant into a paying job and receiving verification of employment and wages from the employer, the department of employment security shall pay the employer a subsidy of $2,000.

II. After at least 3 full months of the continued employment of the participant and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a second subsidy of $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications (RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence. Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire;

(b) Referring individuals to the department of business and economic affairs to utilize available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures.

Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] ***126-AA*** shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3.*** The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration of the New Hampshire granite advantage health care program, established in RSA 126-AA.***

10 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5-e, I(b), less the amount made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5-b~~] ***the lesser of the remainder amount or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-***

A:1, IV and taxes attributable to premiums written for medical and other medical-related services for the newly eligible Medicaid population, as defined in RSA 126-AA:1, V. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.

11 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016,13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under [~~RSA 126-A:5, XXIV-XXV between July 1, 2014—December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] *RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby* repealed 180 days after the event under this [~~subparagraph~~] *paragraph* occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services. The commissioner shall immediately issue notice to program participants of the program's pending repeal *consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program.*

12 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.4~~] *Five* percent of the previous fiscal year gross profits derived by the commission from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

13 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding alcohol education and abuse prevention and treatment programs. *The commissioner of the department of health and human services may accept gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund.* The state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys *received from all other sources other than the liquor commission pursuant to RSA 176:16, III* shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3.

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

14 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program established in RSA 126-AA.*

15 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] *126-AA*, and the federally qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

16 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health

Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program under RSA 126-AA*** in which case all provisions of this chapter shall apply.

17 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII~~] ***New Hampshire granite advantage health care program under RSA 126-AA***. If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

18 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

19 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

20 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the date of certification by the commissioner of the department of health and human services to the director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

21 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d (y)(1) to eliminate the state's share of funding for the New Hampshire granite advantage health care program, or if the federal government allows the use

of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

22 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

23 Effective Date.

I. Paragraph II of section 22 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 22 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 20 of this act.

V. Section 3-8 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

Fiscal Note

LBAO
18-2956
Revised 1/25/18

SB 313-FN- FISCAL NOTE
AS INTRODUCED

AN ACT reforming New Hampshire's Medicaid and Premium Assistance Program.

FISCAL IMPACT: [X] State [ ] County [X] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Appropriation	$0	$0	$0	$0
Revenue	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Expenditures	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Funding Source:	[ ] General [ ] Education [ ] Highway [X] Other - Insurance premium tax, voluntary contributions, insurer assessment, federal funding.			

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable Decrease	Indeterminable Decrease	Indeterminable Decrease	Indeterminable Decrease

METHODOLOGY:

This bill creates a new chapter, RSA 126-AA, establishing the New Hampshire Granite Advantage Health Care Program (Granite Advantage Program), which will become effective on December 31, 2018 and replace the New Hampshire Health Protection Program (NHHPP), scheduled by law to terminate on that date. The Granite Advantage Program will differ from the NHHPP in that, rather than making coverage available by purchasing health plans certified for sale on the federally facilitated marketplace, it will offer coverage via Medicaid managed care organizations (MCO). As with the NHHPP, the Granite Advantage Program will make coverage available to individuals with incomes up to 138% of the federal poverty level.

The existing NHHPP is funded via: (1) federal funds, which as of January 1, 2018 cover 94% of program costs, declining to 90% on January 1, 2020, (2) insurance premium tax revenue attributable to premiums purchased under the NHHPP, and (3) other non-general fund revenue sources. These other non-general fund revenue sources consist of an assessment on insurers under RSA 404-G, as well as voluntary contributions accepted under RSA 126-A:5, d. This bill retains funding source (1), since federal funds will remain available regardless of delivery type, as well as funding source (2), since MCO coverage will remain subject to the state's insurance premium tax. The bill modifies funding source (3) by removing the requirement that a

"remainder amount" (i.e., costs remaining after funding sources (1) and (2) have been exhausted) be calculated and split evenly between the insurance assessment and voluntary contributions. While the bill allows for the possibility of using gifts, grants, and donations to fund the Granite Advantage Program, it does not specify that they be used to fund any particular share of program costs. Likewise, the bill allows for an insurer assessment under RSA 404-G, but, as noted by the Insurance Department, does not specify what level of financial support the assessment is expected to provide. Given this, it is unclear how remaining program costs will be funded if federal revenue and State Insurance Premium Tax Revenues are not sufficient. The bill does, however, make clear that State General Funds shall not be used to support the program.

The Department of Health and Human Services states that, due to limited detail about the design and operation of the Granite Advantage Program, it is unable to provide a detailed analysis of the bill's fiscal impact. For informational purposes, the Department's contracted actuary prepared a report in October 2017 on the cost effectiveness of an MCO model versus that of the existing model, and concluded reimbursement rates to providers would, on average, be lower under an MCO model, resulting in lower overall program costs. Using assumed expenditures of $378 million for the non-medically frail population served by the NHHPP in FY 2018, the analysis projected that expenditures for the same period under an MCO model would be approximately $167 million. Since the State's share of program costs in FY 2018 is 6% of the total, the actuary projected that State expenditures under the MCO model would be approximately $10 million versus $22.7 million under the existing NHHPP. These numbers do not include the cost of the medically frail population, which is currently served by MCOs and would continue to be served by MCOs under this bill. The report did not address such factors as the impact on uncompensated care claims, disproportionate share payments to hospitals, Medicaid Enhancement Tax revenue, or Insurance Premium Tax Revenue.

The Insurance Department projects that, once federal funding drops to 90% in calendar year 2020, federal funds plus Insurance Premium Tax Revenue will collectively fund 92% of program costs. The Department based this projection on an estimated enrollment of 46,000 and an estimated per member per month cost of $350, as well as assumed Insurance Premium Tax revenues attributable to the program of $2.6 million in FY20, $2.7 million in FY21, and $2.8 million in each of FY22 and FY23. The Department estimates that if the insurer assessment under RSA 404-G is expected to fully fund the remaining State share of program costs (which, as noted above, is not specified by the bill itself), the assessment will need to raise approximately $15 million per year. The assessment needed to raise this amount will be approximately $2.75 per member per month on the base of approximately 475,000 covered lives.

"remainder amount" (i.e., costs remaining after funding sources (1) and (2) have been exhausted) be calculated and split evenly between the insurance assessment and voluntary contributions. While the bill allows for the possibility of using gifts, grants, and donations to fund the Granite Advantage Program, it does not specify that they be used to fund any particular share of program costs. Likewise, the bill allows for an insurer assessment under RSA 404-G, but, as noted by the Insurance Department, does not specify what level of financial support the assessment is expected to provide. Given this, it is unclear how remaining program costs will be funded if federal revenue and State Insurance Premium Tax Revenues are not sufficient. The bill does, however, make clear that State General Funds shall not be used to support the program.

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The New Hampshire Municipal Association assumes the bill will reduce expenditures by an indeterminable amount due to a decrease in costs for local welfare assistance.

The Department of Corrections is unable to determine the bill's fiscal impact.

The New Hampshire Association of Counties assumes the bill will have no impact on county finances.

AGENCIES CONTACTED:

Departments of Health and Human Services, Administrative Services, Corrections, and Revenue Administration, Insurance Department, New Hampshire Municipal Association, and New Hampshire Association of Counties

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AGENCIES CONTACTED:

Departments of Health and Human Services, Administrative Services, Corrections, and Revenue Administration, Insurance Department, New Hampshire Municipal Association, and New Hampshire Association of Counties

Committee Report

REGULAR CALENDAR

April 25, 2018

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on Finance to which was referred SB 313-FN,

AN ACT (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. David Danielson

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**Finance**
Bill Number:	**SB 313-FN**
Title:	**(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**
Date:	**April 25, 2018**
Consent Calendar:	**REGULAR**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT 2018-1769h**

STATEMENT OF INTENT

SB 313 seeks to continue the state's expanded Medicaid program to be known as the New Hampshire granite advantage health care program. The committee amended the bill to include new language to strengthen several areas of the Senate's bill, such as the work requirement, by removing uncompensated self-employment and the carry-over of significant hours to fulfill the requirement for participation in expanded Medicaid. The committee was also very careful to include suitable exemptions to the work requirements in the case of single parents with children younger than 6 years of age. The committee's amendment includes clarification of the calculations showing the solvency of the health care trust fund that contains the financial resources for the expanded Medicare program by limiting funding sources and expenditures that can be made from this fund. The committee amendment also establishes a medical loss ratio (MLR) which is an actuarially determined value of the minimum spending on patient care by the managed care organizations (MCO). The MLR ensures that the state is protected against overspending on administrative costs by MCOs. The "medically frail" classification was better defined to require the diagnosis of frailty by a medical professional rather than self-certification and to also require annual recertification by a doctor to maintain that classification. The amended bill requires that the commissioner of department of health and human services (DHHS) apply for a state plan amendment that will allow for Medicaid coverage for the treatment of incarcerated individuals on the state and county level. The original bill included the creation of the state's granite workforce program which was not connected to the New Hampshire granite advantage health care program. The amendment links these programs and makes the Granite Workforce Program an integral part of the New Hampshire granite advantage health care program to satisfy the work requirements and to move people out of the poverty level and into paying jobs and self-sufficiency. The Granite Workforce Program utilizes Temporary Aid to Needy Families (TANF) funding obtained from the Federal government as part of a match. A $40M floor was established below which the TANF funds spending will not occur. This is to ensure a reserve of TANF funds in case of a downturn in the economy. The voting composition of the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program is changed to authorize only the legislative members to vote and all other member to be consultative but fully participative. Lastly, the amendment changes the sunset period of the original bill from 5 years to two automatically renewing 2 ½ year programs. The program continues after the first 2 ½ years unless the commission determines it should end or the federal government block grants Medicaid to the state.

Original: House Clerk
Cc: Committee Bill File

Vote 24-2.

Rep. David Danielson
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Finance

SB 313-FN, (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds. **OUGHT TO PASS WITH AMENDMENT.**

Rep. David Danielson for Finance. SB 313 seeks to continue the state's expanded Medicaid program to be known as the New Hampshire granite advantage health care program. The committee amended the bill to include new language to strengthen several areas of the Senate's bill, such as the work requirement, by removing uncompensated self-employment and the carry-over of significant hours to fulfill the requirement for participation in expanded Medicaid. The committee was also very careful to include suitable exemptions to the work requirements in the case of single parents with children younger than 6 years of age. The committee's amendment includes clarification of the calculations showing the solvency of the health care trust fund that contains the financial resources for the expanded Medicare program by limiting funding sources and expenditures that can be made from this fund. The committee amendment also establishes a medical loss ratio (MLR) which is an actuarially determined value of the minimum spending on patient care by the managed care organizations (MCO). The MLR ensures that the state is protected against overspending on administrative costs by MCOs. The "medically frail" classification was better defined to require the diagnosis of frailty by a medical professional rather than self-certification and to also require annual recertification by a doctor to maintain that classification. The amended bill requires that the commissioner of department of health and human services (DHHS) apply for a state plan amendment that will allow for Medicaid coverage for the treatment of incarcerated individuals on the state and county level. The original bill included the creation of the state's granite workforce program which was not connected to the New Hampshire granite advantage health care program. The amendment links these programs and makes the Granite Workforce Program an integral part of the New Hampshire granite advantage health care program to satisfy the work requirements and to move people out of the poverty level and into paying jobs and self-sufficiency. The Granite Workforce Program utilizes Temporary Aid to Needy Families (TANF) funding obtained from the Federal government as part of a match. A $40M floor was established below which the TANF funds spending will not occur. This is to ensure a reserve of TANF funds in case of a downturn in the economy. The voting composition of the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program is changed to authorize only the legislative members to vote and all other member to be consultative but fully participative. Lastly, the amendment changes the sunset period of the original bill from 5 years to two automatically renewing 2 ½ year programs. The program continues after the first 2 ½ years unless the commission determines it should end or the federal government block grants Medicaid to the state. **Vote 24-2.**

Original: House Clerk
Cc: Committee Bill File

SB 313-FN

OTPA

24-2

(1769h)

Danielson

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The voting composition of the Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program is changed to authorize only the legislative members to vote and all other member to be consultative but fully participative. Lastly, the amendment changes the sunset period of the original bill from 5 years to two automatically renewing 2 ½ year programs. The program continues after the first 2 ½ years unless the commission determines it should end or the federal government block grants Medicaid to the state.

Voting Sheets

HOUSE COMMITTEE ON FINANCE

EXECUTIVE SESSION on SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: April 25, 2018

LOB ROOM: 210-211

MOTIONS: **OUGHT TO PASS WITH AMENDMENT**

Moved by Rep. Danielson	Seconded by Rep. Kurk	AM Vote: VV
Amendment # 1769h		
Moved by Rep. Danielson	Seconded by Rep. Kurk	Vote: 24-2

CONSENT CALENDAR: NO

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep Kenneth Weyler, Clerk

HOUSE COMMITTEE ON FINANCE

EXECUTIVE SESSION on SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: 4/25/18

LOB ROOM: 210-211

MOTION: (Please check one box)

☐ OTP ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # 1769 (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. Danielson Seconded by Rep. Kurk Vote: VV

MOTION: (Please check one box)

☐ OTP ☑ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # _____ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. Danielson Seconded by Rep. Kurk Vote: 24-2

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # _____ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # _____ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

CONSENT CALENDAR: ____ **YES** X **NO**

Minority Report? ____ Yes ____ No If yes, author, Rep: _____ Motion_____

Respectfully submitted: Kenneth J. Weyler

Rep Kenneth Weyler, Clerk

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/5/2018 10:28:56 AM
Roll Call Committee Registers Report

2018 SESSION

FINANCE

Bill #: SB 313 Title: _____

PH Date: ___/___/___ Exec Session Date: 4/25/18

Motion: OTP-A Amendment #: 1769

MEMBER	YEAS	NAYS
Kurk, Neal M. Chariman	25	
Ober, Lynne M. Vice Chairman	1	
Weyler, Kenneth L. Clerk	2	
Allen, Mary M.	3	
Umberger, Karen C.	4	
Twombly, Timothy L.	5	
Byron, Frank A.	6	
Danielson, David J.	7	
Emerick, J. Tracy	8	
Spanos, Peter J.	9	
Renzullo, Andrew	10	
Theberge, Robert L.	11	
Bates, David M.		1
~~Hennessey, Erin~~ T. Lang	12	
Griffin, Gerald		2
Wallner, Mary Jane	13	
Nordgren, Sharon	14	
Eaton, Daniel A.	15	
Smith, Marjorie K.	16	
Rosenwald, Cindy	17	
Leishman, Peter R.	18	
Buco, Thomas L.	19	
Hatch, William A.	20	
Rogers, Katherine D.	21	
~~Walsh, Robert M.~~ O'Brien	22	
Lovejoy, Patricia T.	23	
TOTAL VOTE:	24	2

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 25, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 8:36**

Time Adjourned: 8:47

(please circle if present)

Committee Members: **Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers, Lang**

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

Reforming NH's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Present: Byron, Kurk, Danielson, Bates, Renzullo, Lang, Wallner, Nordgren, Rosenwald, Rogers

Absent: Hennessey

Chairman Byron called the work session to order at 8:36am and asked that
LBA's distributed Amendment # 2018 - 1761h

LBA's Kevin Ripple overview
Commission to evaluate

Page 2 - line 4 and 5 leg members only voting members
Page 3 - line 5-6 4 of 6. Voting members =quorum
Report on 2022 line 10 -11 added continue
Remaining all new
17-21 if report recommends not continue initiate leg to repeal program
22-31 block grant by Feds will be repealed

Wallner - line 22-31 page 3 - block grant - do we have any idea when Feds block grant something how much notice given prior to event

LBA - depend on Fed legislation

Byron - by act of congress large amounts of press on that

Motion by Byron on 2016h, seconded by Danielson,

Vote
Yes - 9 (Byron, Lang, Kurk, Danielson, Bates, Renzulo, Wallner, Nordgren, Rogers)
No - 1 (Rogers)

Vote being 9 to 1 motion carries

Byron -

Danielson motion to OTP/A
1736 - large omnibus amendment
,1706 - children under 6 years of age and DD
1761 - amendment re: Commission to evaluate

Vote
Yes - 10 (Byron, Lang, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald, Rogers)
NO - 0

Vote being 10-0 motion carries

Byron business before being concluded work session Adjourned at 8:47am

Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/5/2018 10:29:31 AM
Roll Call Committee Registers Report

2018 SESSION

FIN-DIV3

Bill #: SB- 313 **Title:** Reforming

PH Date: ___/___/___ Exec Session Date: 4/25/2018

Motion: OTP/A - Danielson, Kurk Amendment #: 2018-1736, 1706, 1761

MEMBER	YEAS	NAYS
Byron, Frank A. Chariman	10	
~~Hennessey, Erin T. Vice Chairman~~ Lang	1	
Kurk, Neal M.	2	
Danielson, David J.	3	
Bates, David M.	4	
Renzullo, Andrew	5	
Wallner, Mary Jane	6	
Nordgren, Sharon	7	
Rosenwald, Cindy	8	
Rogers, Katherine D. Clerk	9	
TOTAL VOTE:		
	10	0

motion carries
10-0

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/5/2018 10:29:31 AM
Roll Call Committee Registers Report

2018 SESSION

FIN-DIV3

Bill #: Amendment 1761h **Title:**

PH Date: ___/___/___ Exec Session Date: 1/25/18

Motion: OTP - Byron, Danielson Amendment #: 1761h

MEMBER	YEAS	NAYS
Byron, Frank A. Chariman	9	
~~Hennessey, Erin T. Vice Chairman~~ Lang	1	
Kurk, Neal M.	2	
Danielson, David J.	3	
Bates, David M.	4	
Renzullo, Andrew	5	
Wallner, Mary Jane	6	
Nordgren, Sharon	7	
Rosenwald, Cindy		1
Rogers, Katherine D. Clerk	8	
TOTAL VOTE:		
	9	1

9 yes
1 no

motion rules

Rep. Byron, Hills. 20
April 24, 2018
2018-1761h
01/10

Draft Amendment to SB 313-FN

Amend RSA 126-AA:4 as inserted by section 1 of the bill by replacing it with the following:

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New

Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Of the commission members listed in this paragraph, only the 6 legislative members shall be voting members. All other members shall serve in an advisory capacity only.

(c) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the commissioner concerning recommended monitoring and evaluation requirements for work and

community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Four of the 6 voting members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report, together with its findings and any recommendations for proposed legislation, to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022. Both reports shall contain the commission's recommendation regarding whether the program should continue.

Amend the bill by inserting after section 22 the following and renumbering the original section 23 to read as 24:

23 Applicability.

I. If the commission, established pursuant to RSA 126-AA:4 in section 1 of this act, issues an interim report recommending the New Hampshire granite advantage health care program's discontinuation, the speaker of the house of representatives and the president of the senate shall initiate legislation as soon as practicable to repeal the New Hampshire advantage health care program established in section 1 of this act.

II. If the federal government converts the Medicaid program from a program funded jointly by the federal government and the states into a block grant the New Hampshire granite advantage health care program shall be repealed effective upon the implementation of such conversion, consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program. In the event of a repeal under this paragraph, the commissioner of the department of health and human services shall within 48 hours after the event has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of the fiscal committee, the secretary of state, and the director of legislative services of the program's pending termination and within 10 business days after the event under this paragraph has occurred, notify program participants of the program's pending termination.

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: April 25, 2018

ROOM: 210-211 **Time Work Session Called to Order:** 8:36 am

Time Adjourned: 8:47 am

(please circle if present)

Committee Members: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers, Lang

Bill Sponsors:

Sen. Bradley	Sen. Morse	Rep. S. Schmidt
Rep. Umberger	Rep. Danielson	Rep. Kotowski

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Amendment #2018-1761h
Byron, Danielson 9-yes
1-no
motion carries

OTP/A - Danielson, Kurk 10-yes
0-no
motion carries

SB 313 work session Finance Div III

April 25, 2018

Reforming NH's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Present: Byron, Kurk, Danielson, Bates, Renzullo, Lang, Wallner, Nordgren, Rosenwald, Rogers

Absent: Hennessey

Chairman Byron called the work session to order at 8:36am and asked that
LBA's distributed Amendment # 2018 - 1761h

LBA's Kevin Ripple overview
Commission to evaluate

Page 2 - line 4 and 5 leg members only voting members
Page 3 - line 5-6 4 of 6. Voting members =quorum
Report on 2022 line 10 -11 added continue
Remaining all new
17-21 if report recommends not continue initiate leg to repeal program
22-31 block grant by Feds will be repealed

Wallner - line 22-31 page 3 - block grant - do we have any idea when Feds block grant something how much notice given prior to event

LBA - depend on Fed legislation

Byron - by act of congress large amounts of press on that

Motion by Byron on 2016h, seconded by Danielson,

Vote
Yes - 9 (Byron, Lang, Kurk, Danielson, Bates, Renzulo, Wallner, Nordgren, Rogers)
No - 1 (Rogers)

Vote being 9 to 1 motion carries

Byron -

Danielson motion to OTP/A
1736 - large omnibus amendment
,1706 - children under 6 years of age and DD
1761 - amendment re: Commission to evaluate

Vote
Yes - 10 (Byron, Lang, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald, Rogers)
NO - 0

Vote being 10-0 motion carries

Byron business before being concluded work session Adjouned at 8:47am

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 24, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 1:36**

Time Adjourned: 4:25

(please circle if present)

Committee Members: Byron, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers)

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

Chairman Byron called the work session to order at 1:36pm
1st order of business is amendment 1736h dated April 24 distributed by LBAS Kevin Ripple

Ripple overview of Amendment

Base document from HHS Committee Original bill

Page 1 remainder amount laid out in A, B, C format line 21-23

Page 2 line 1-3 state plan amendment county corrections

Page 3 line 18-23

Page 4 Roman III-A

Page 5 line 1 -

Page 5 - lines 4-8

Page 5. Lines 20-24

Page 5 line 29 temporarily removed

Page 6 lines line 7

Page line 19-21 medical fragility annually added

Line 26-30 rule language added

Page 7 line 3-4

Lines 7-11 waiver request with Sever ability

Lines 16-17 added

Page 8 lines 10-14 rule making added

15-21 trust fund language

Line 26 spelled out

Line 36 not included is now

37 f cost of coverage

Page 9 -22-28 revised commissioners protected remainder amount

Line 30 comm responsible stuff in fund previously 6 months

Page 9 -10

Page 10 line 2 10 business days

Page 12 line 20 goals 18-64

Page 13. Line 7-13 add of language increase in income

Page 13 line 19-21 also in Medicaid program

Lines 26-33

Page 15 line 30 page 16 line 7 termination of program

Page 17 line 6-10

10-17

Line 16 ten business days

Page 18 line 6-9 funds received shall not be used for
advantage or trust fund

Page 19 line 33-34 Sever ability

Byron - that covers everything we discussed

Danielson motion, seconded by Kurk approval of 1736h to SB 313-FN

Rosenwald - have to vote against this because we have made young children more at risk then we had previously our youngest children in the state and those with developmental disabilities are portents ally at trick of neglect by exempting only one parent from work requirement net we are now talking about children between 0 and 5 and second parent not being exempt these youngest children and those with disabilities do not have the good cause exemption if they arcane not find child care and only one parent can have access to the exemption I know there will be some amendments to fix this but without that change leaving infants and children with disabilities I can't make the choice between the adults

and the babies

Wallner - I would agree and in this day and age children do move back and forth between family members and to have different custody members you leave some children in very difficult positions

Bates - we had a protracted discussion about emotions but we didn't prohibit exemptions about younger children so the conditions you are taking about could have exemptions if a child is going to be at risk that could qualify as an exemption

Nordgren - could we have a comment from the Commissioner

Byron - no in the voting mod - recess until 2 pm

Byron - called work session back into order at 2:02pm

Byron - there is an ability to have good cause exemptions in the bill

Rosenwald - I do not believe language on lines 5-7 is anything but exemptions for anything but one parent or caretaker at a time I do not read it as giving the commissioner to have flexibility and if we wanted the Commissioner to have that flexibility we would have written it as we did for parents of babies as we did for children between ages 12. These are children who are most vulnerable.

Vote on motion in front of us adopt of amendment 1273h show f hands

Yes - 6
No - 4 (Wallner, Nordgren, Rosenwald, Rogers)

Motion to adopt carries 6 to 4

Amendment #2018-1706h Byron custodial parent or caretaker of a dependent child under 6 of developmental disabilities residing with parent or caretaker provided that the exemption shall only apply to one parent or caretaker in the case of a 2-parent household

LBA-review
This would replace page 6 line 5-7 by referring to custodial parent or caretaker in case of 2 parent household

Byron - my understanding Rosenwald has similar amendment

Rosenwald. Only difference is word custodial and I am fine with that language

Motion by Byron, seconded by Rosenwald to adopt 1706h

Rosenwald - yes this addresses earlier concerns I will stop there

Vote
Yes - 10
No -0

Motion carries by 10 yes to 0 no

Rogers motion on Amendment 1730h, seconded by Rosenwald,and eliminate Page 1 line 21-21, page 3 line 18-23 and page 8 line 30-32

Kurk if we amended the SB 313 with this and the previous amendment which prevails

LBA. Suggest one amendment

Wallner - this did not get talked about in HHS committee we added at last moment and did not do the kind of study we did not need to do gives us time to take a serious look at this

Kurk - if as I first read this was to add another obligation on the Commission to study the medical loss ratio on medical loss rates and if we adopt it is different we are undoing what we passed on 1776 I can't support

Byron - doesn't

Rosenwald - support and the amendment and elimination of takes out all of the incentives to lower claims cost by improving efficient delivery of quality claim care

Lang - can't support anything not in writing

Kurk - i

Vote -
Yes - 4
No - 6

Rogers Amendment #2018-1729h and elimination of page 1 line 21-23, page 3 line 18-23, page 8 line 30-32

Rogers - Mr Lipman could this assist in helping to negotiate with the MCO's and prevent dis incentivizing their managing end and savings of the managed care

Kurk - this is a wholesale revision of the concept we have already voted on we set rates in the Medicaid program I don't understand what we are trying to do it doesn't serve the program we want to do -

Byron - there are other parts of the program that deal with the Medical loss ratio

Lipman as Kurk - described that would be a problem
Byron - hearing no further discussion vote

Vote -

Yes- 4 (Wallner, Nordgren, Rosenwald, Rogers)

No - Kurk says for Republicans to vote no so they do

Motion fails 4 to 6

Byron recesses work session at 2:40pm

Byron called the work session back into order at 4:25pm

Byron recessed until April 25 at 8:30am

Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

Rep. Byron, Hills. 20
April 24, 2018
2018-1736h
01/03

Amendment to SB 313-FN

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, minus the following:

(a) The amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) All federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs related to the program;

(c) Any surplus funds generated as a result of the managed care organizations managing the cost of their services below the minimum medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter; and

(d) Taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver

of the requirement to provide 90-day retroactive coverage and a state plan amendment allowing state and county correctional facilities to conduct presumptive eligibility determinations for incarcerated inmates to the extent provided under federal law. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all preexisting authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total

cost of care within the Medicaid managed care program. The commissioner shall also include in the MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance. Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures. >insert here

(3) The commissioner shall establish for the managed care program beginning on July 1, 2019 and thereafter a minimum medical loss ratio that is actuarially sound and that encourages cost efficiency in the delivery of care to the entire Medicaid population. Any surplus funds generated from the MCOs managing the cost of their services below the established minimum medical loss ratio for the beneficiaries of the program shall be transferred to the fund and shall be included in the calculation of the remainder amount.

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g). »

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency,

citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment including by nonprofit organizations.

(2) Subsidized private sector employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph fails to comply with the work or community engagement activities required in accordance with this paragraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. Following approval by the joint health care reform oversight committee, pursuant to RSA 161:11, to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.

(5) The beneficiary is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the commissioner on a monthly basis, is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor.

(c) This paragraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i).

(d) This paragraph shall not apply to:

(1) A person who is unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A parent or caretaker of a dependent child under 6 years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker.

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Following approval by the joint health care reform oversight committee, pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules. The rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

(7) Annual certification of medical frailty pursuant to 42 C.F.R. section 440.315(f), including proof and duration of such condition on a form supplied by the department.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. The waiver request submitted by the commissioner shall be consistent with all the terms of this chapter. In the event that the final approved waiver is inconsistent with any of the terms of this chapter, the commissioner shall provide written notification to the governor, speaker of the house of representatives, and president of the senate, informing them of the differences between the terms of this chapter and the approved waiver. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management. The MCOs shall work collaboratively with the department and any outside contractor in encouraging and monitoring work and community engagement activities.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity to cure and for re-activation following noncompliance. Following approval by the joint health care reform oversight committee, pursuant to RSA 161:11, to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules.

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, to pay for the administrative costs for the program, and reimburse the federal government for any over payments of federal funds. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to MCOs. No state general funds shall be deposited into the fund. Deposits into the fund shall be limited exclusively to the following:

(a) Revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) Federal Medicaid reimbursement for program costs and administrative costs attributable to the program;

(c) Surplus funds generated as a result of MCOs managing the cost of their services below the medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019;

(d) Taxes attributable to premiums written for medical and other medical related services for the newlyeligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b);

(e) Funds received from the assessment under RSA 404-G;

(f) Funds recovered or returnable to the fund that were originally spent on the cost of

coverage of the granite advantage health care program; and

(g) Gifts, grants, and donations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30, 2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before August 15, 2020, the commissioner shall calculate the projected final remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before August 15 of each subsequent year, the commissioner shall calculate the projected final remainder amount for the prior fiscal year. If the amount deposited from the high risk pool exceeds the limit on contributions established by RSA 404-G:5-a, IV(d), then any excess difference shall be retained in the fund and the next estimated remainder amount calculated by the commissioner shall be reduced by the amount of the difference.

VI. The commissioner, in accordance with the most current available information, shall be responsible for determining, quarterly commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next 6-month period. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS. Upon making a determination that a projected shortfall exists, the commissioner shall:

(a) Within 48 hours of making the determination, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the fiscal

committee of the general court of the program's pending termination; and

(b) Within 10 business days of making the determination, notify program participants of the program's pending termination.

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Legislative members of the commission shall receive mileage at the legislative rate

when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the commissioner concerning recommended monitoring and evaluation requirements for work and community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Ten members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report together with its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022.

126-AA:5 Evaluation Report Required.

I. The program shall employ an outcome-based evaluation of its Medicaid program annually to:

(a) Provide accountability to patients and the overall program.

(b) Ensure that patients are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care.

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

II. The results of the evaluation conducted under this section shall be in the form of a report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF) program to end the dependence of needy parents ages 18 through 64 and low income childless adults ages 18 through 24 on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be provided to eligible participants through Granite Workforce. The total cost of the pilot program

shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) Parents aged 18 through 64 with a child under age 18 in the household; or

(c) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(d) Childless adults between 18 and less than 25 years of age.

III. An eligible recipient, whose wages subsequently cause the household to exceed 138 percent of the federal poverty level shall continue to receive Granite Workforce program services as needed, including the subsidy for employers under section 4 of this act, provided the recipients wages do not cause the household to exceed 250 percent of the federal poverty level. After the second employer subsidy is paid on behalf of a Granite Workforce recipient, the recipient shall no longer be eligible for Granite Workforce services as long as household income exceeds 138 percent or the federal poverty level.

IV. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

V. No person shall participate in the Granite Workforce program unless he or she is also enrolled in the New Hampshire Granite Advantage Health Care Program, as established in RSA 126-AA.

VI. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program, adopted under RSA 541-A , shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. After 3 months of the employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's wages for the prior month, not to exceed $2,000.

II. After 9 months of the continued employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's wages for the prior month, not to exceed $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications

(RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence. Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire;

(b) Referring individuals to the department of business and economic affairs to utilize available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures. Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, the president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Termination of Granite Workforce Program.

I. The commissioner of the department of health and human services shall be responsible for determining, every 3 months commencing no later than December 31, 2018, whether available TANF reserve funds total at least $40,000,000. If at any time the commissioner determines that available TANF reserve funds have fallen below $40,000,000, the commissioners of the departments of health and human services and employment security shall, within 20 business days of such determination, terminate the Granite Workforce program. The commissioners shall notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of

the fiscal committee of the general court, and Granite Workforce participants of the program's pending termination.

II. If at any time the New Hampshire granite advantage health care program, established under RSA 126-AA, terminates, the commissioners of the departments of health and human services and employment security shall terminate the Granite Workforce program. The date of the Granite Workforce program's termination shall align with that of the New Hampshire granite advantage health care program.

10 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] ***126-AA*** shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3***. The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration of the New Hampshire granite advantage health care program, established in RSA 126-AA.***

11 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5-c, I(b), less the amount made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5-b~~] ***the lesser of the remainder amount, as defined in RSA 126-AA:1, V, or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV and taxes attributable to premiums written for medical and other medical-related services for the newly eligible Medicaid population. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.***

12 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016,13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible

adults under [~~RSA 126-A:5, XXIV XXV between July 1, 2014 – December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] ***RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby*** repealed 180 days after the event under this [~~subparagraph~~] ***paragraph*** occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services ***and consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program.*** The commissioner shall [~~immediately issue notice to program participants of the program's pending repeal~~]***:***

(a) Within 48 hours after the event under this paragraph has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the legislative fiscal committee of the program's pending termination; and

(b) Within 10 business days after the event in this paragraph has occurred, notify program participants of the program's pending termination.

13 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.4~~] ***Five*** percent of the previous fiscal year gross profits derived by the commission from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

14 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding alcohol education and abuse prevention and treatment programs. ***The commissioner of the department of health and human services may accept gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund.*** The state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys *received from all other sources other than the liquor commission pursuant to RSA 176:16, III* shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3*; provided, however, that funds received from any source other than the liquor commission, pursuant to RSA 176:16, III, shall not be used to support the New Hampshire granite advantage health care program and shall not be deposited into the fund established in RSA 126-AA:3.*

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

15 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program established in RSA 126-AA.*

16 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] *126-AA*, and the federally qualified high risk pool, including articles, bylaws and operating rules, procedures and

policies adopted by the association.

17 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program under RSA 126-AA*** in which case all provisions of this chapter shall apply.

18 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII~~] ***New Hampshire granite advantage health care program under RSA 126-AA***. If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

19 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

20 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, or is not approved by the Centers for Medicare and Medicaid Services, the invalidity or nonapproval does not affect other provisions or applications of the act which can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

21 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the

date of certification by the commissioner of the department of health and human services to the director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

22 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d(y)(1) to eliminate the state's share of funding for the New Hampshire granite advantage health care program, or if the federal government allows the use of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

23 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

24 Effective Date.

I. Paragraph II of section 23 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 23 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 21 of this act.

V. Section 3-9 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 24, 2018**

ROOM: **210-211** Time Work Session Called to Order:

Time Adjourned: 4:25pm

(please circle if present)

Committee Members: **Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers**

Bill Sponsors:

Sen. Bradley	Sen. Morse	Rep. S. Schmidt
Rep. Umberger	Rep. Danielson	Rep. Kotowski

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Recessed until April 25 @ 8:30am

SB 313 Work Session Finance Div III

April 24, 2018

Reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the Granite workforce pilot program, and relative to certain liquor funds.

Present: Byron, Kurk, Danielson, Bates, Renzullo, Lang (sitting in for Hennessey), Wallner, Nordgren, Rosenwald, Rogers

Absent: Hennessey

Chairman Byron called the work session to order at 1:36pm 1st order of business is amendment 1736h dated April 24 distributed by LBAS Kevin Ripple

Ripple overview of Amendment

Base document from HHS COmmittee Original bill

Page 1 remainder amount laid out in A,B,C format line 21-23

Page 2 line 1-3 state plan amendment county corrections

Page 3 line 18-23

Page 4 Roman III-A

Page 5 line 1 -

Page 5 - lines 4-8

Page 5. Lines 20-24

Page 5 line 29 temporarily removed

Page 6 lines line 7

Page line 19-21 medical fragility annually added

Line 26-30 rule language added

Page 7 line 3-4

Lines 7-11 waiver request with Sever ability

Lines 16-17 added

Page 8 lines 10-14 rule making added

15-21 trust fund language

Line 26 spelled out

Line 36 not included is now

37 f cost of coverage

Page 9 -22-28 revised commissioners protected remainder amount

Line 30 comm responsible stuff in fund previously 6 months

Page 9 -10

Page 10 line 2 10 business days

Page 12 line 20 goals 18-64

Page 13. Line 7-13 add of language increase in income

Page 13 line 19-21 also in Medicaid program

Lines 26-33

Page 15 line 30 page 16 line 7 termination of program

Page 17 line 6-10

10-17

Line 16 ten business days

Page 18 line 6-9 funds received shall not be used for
advantage or trust fund

Page 19 line 33-34 Sever ability

Byron - that covers everything we discussed

Danielson motion, seconded by Kurk approval of 1736h to SB 313-FN

Rosenwald - have to vote against this because we have made young children more at risk then we had previously our youngest children in the state and those with developmental disabilities are portents ally at trick of neglect by exempting only one parent from work requirement net we are now talking about children between 0 and 5 and second parent not being exempt these youngest children and those with disabilities do not have the good cause exemption if they arcane not find child care and only one parent can have access to the exemption I know there will be some amendments to fix this but without that change leaving infants and children with disabilities I can't make the choice between the adults and the babies

Wallner - I would agree and in this day and age children do move back and forth between family members and to have different custody members you leave some children in very difficult positions

Bates - we had a protracted discussion about emotions but we didn't prohibit exemptions about younger children so the conditions you are taking about could have exemptions if a child is going to be at risk that could qualify as an exemption

Nordgren - could we have a comment from the Commissioner

Byron - no in the voting mod - recess until 2 pm

Byron - called work session back into order at 2:02pm

Byron - there is an ability to have good cause exemptions in the bill

Rosenwald - I do not believe language on lines 5-7 is anything but exemptions for anything but anything but one parent or caretaker at a time I don not read it as giving the commissioner to have flexibility and if we wanted to ave the Commissioner to have that flexibility we would have written it as we did for parents of babies as we did for children between. And 12. These are children who are most vulnerable.

Vote on motion in front of us adopt of amendment 1273h show f hands

Yes - 6
No - 4 (Wallner, Nordgren, Rosenwald, Rogers)

Motion to adopt carries 6 to 4

Amendment #2018-1706h Byron custodial parent or caretaker of a dependent child under 6 of developmental disabilities residing with parent or caretaker provided that the exemption shall only apply to one parent or caretaker in the case of a 2-parent household

LBA-review
This would replace page 6 line 5-7 by referring to custodial parent or caretaker in case of 2 parent household

Byron - my understanding Rosenwald has similar amendment

Rosenwald. Only difference is word custodial and I am fine with that language

Motion by Byron, seconded by Rosenwald to adopt 1706h

Rosenwald - yes this addresses earlier concerns I will stop there

Vote
Yes - 10
No -0

Motion carries by 10 yes to 0 no

Rogers motion on Amendment 1730h, seconded by Rosenwald,and eliminate Page 1 line 21-21, page 3 line 18-23 and page 8 line 30-32

Kurk if we amended the SB 313 with this and the previous amendment which prevails

LBA. Suggest one amendment

Wallner - this did not get talked about in HHS committee we added at last moment and did not do the kind of study we did not need to do gives us time to take a serious look at this

Kurk - if as I fist read this was to add another obligation on the Commission to study the medical loss ratio on medical loss rates and if we adopt it is different we are undoing what we passed on 1776 I can't support

Byron - doesn't

Rosenwald - support and the amendment and elimination of takes out all of the incentives to lower claims cost by improving efficient delivery of quality claim care

Lang - can't support anything not in writing

Kurk - i

Vote -
Yes - 4
No - 6

Rogers Amendment #2018-1729h and elimination of page 1 line 21-23, page 3 line 18-23, page 8 line 30-32

Rogers - Mr Lipman could this assist in helping to negotiate with the MCO's and prevent dis incentivizing their managing end and savings of the managed care

Kurk - this is a wholesale revision of the concept we have already voted on we set rates in the Medicaid program I don't understand what we are trying to do it doesn't serve the program we want to do -

Byron - there are other parts of the program that deal with the Medical loss ratio

Lipman as Kurk - described that would be a problem
Byron - hearing no further discussion vote

Vote -

Yes- 4 (Wallner, Nordgren, Rosenwald, Rogers)

No - Kurk says for Republican's to vote no so they do

Motion fails 4 to 6

Byron recesses work session at 2:40pm

Byron called the work session back into order at 4:25pm

Byron recessed until April 25 at 8:30am

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 23, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 10:12**

Time Adjourned: 2:03

(please circle if present)

Committee Members: Byron, Kurk, Danielson, Renzullo, Wallner, Nordgren, Rosenwald and Rogers, Lang (for Hennessey)

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

Chairmen Byron opened the work session at 10:12am and announced Rep Tim Lang from Ways and Means Committee would be replacing Rep Hennessey for the week. The schedule for the week is as follows today until 3pm on SB 313. Tuesday 9am voter SB 592, 11am SB 313. Wednesday 9am SB 590,

Today several items unresolved;
1 - Rosenwald look back amendment
2- reduction in work exemption age from 13 down to 6
3 - sever ability clause
4 - constructing a sliding scale - consider that monies that go to employers
5 - decision on determine the loss ration for MCOS

Rosenwald - I had a note that said when the premium tax is calculated is that still hanging out there

Byron - there is a general discussion as to weather we wanted to have a formal calculated amount or a rolling case going forward

The last version was April 18 that was a draft version with the yellow notes LBA will be coming with a new draft shortly

First item would be the construction of a sliding scale of the granite workforce program up to 250% of the poverty level

Commissioner Jef Meyers - we worked on some language this morning an attempt to address a Kurk request how to deal with recipient experience an income gain

Into the Byron amendment of April 18, page 12 after line 24 insert 2-A subsection
"an eligible receptive whose wages subsequently causes the household to exceed 138% of the federal poverty level as a result of participation in Granite Workforce but not more than 250% shall continue to receive Granite Workforce program services as needed, including subsidy for employers. After the

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/5/2018 10:29:31 AM
Roll Call Committee Registers Report

2018 SESSION

FIN-DIV3 SB 313
Amendment 1293h
Bill #: _____ **Title:** Reforming Medicaid

PH Date: ____/____/____ Exec Session Date: 4 / 23 / 2018

Motion: OTP Amendment #: 1293h

MEMBER	YEAS	NAYS
Byron, Frank A. Chariman	~~5~~	6
~~Hennessey, Erin L. Vice Chairman~~ Lang		5
Kurk, Neal M.		1
Danielson, David J.		2
Bates, David M.		3
Renzullo, Andrew		4
Wallner, Mary Jane	1	
Nordgren, Sharon	2	
Rosenwald, Cindy	3	
Rogers, Katherine D. Clerk	4	
TOTAL VOTE:		

6 no
4 - yes

motion fails

second subsidy is paid to an employer on behalf of a Granite Workforce recipient will no longer be eligible for Granite Workforce services as long as the household income exceeds 138% of the federal poverty level"

Kurk - that means if income is higher once you meet nine months you are over

Myers - yes

Meyers - have given to the LBA

Byron - any comments on the paragraph And this would allow us to make the final payment to the employer and complete the 9 months of work?

Meyers - yes

Byron - lets go on to the 90 day look back requirement - there was a proposal given to us by Rep Rosenwald

Rosenwald - Amendment #1293h would give confidence to community providers that they could begin treatment right away it would cost between a quarter to a half less than what DHHS had projected to the non-federal portion of the claim for the year. DHHS suggested 2.4 million for the non-federal portion of the year. The state is not paying any portion of this. (I am trying to continue to not use any state monies) that would be a total claim of 34 million next year.

Lipman told me hospital portion btw 40-60 % of total claim projected the MET revenue on the 30% and more aggressive 60% . If 30% $500,550, if 60%, $1million that is an offset of the 2.4 million at the bottom not able to figure if all of those claims subject to uncompensated care and federal match but we looked at what they could possibly be at the 30% and the 60%.

If hospital claims were 30% of the 34 million claims and we had that the cap on uncompensated claims we would set aside additional for DSH if 60% we would have to save 64million so it is a more favorable match rate.

Meyers - raise a question - today under current state plan hospitals and are able to do presumptive eligibility the hospital is authorized to so presumptive eligibility and can be compensated for those services. question is do these numbers reflect that hospital do undertake that presumptive eligibility

Rosenwald - I got the 30% and 60% from DHHS so I am not sure but other community providers are not able to do presumptive eligibility and it is helpful for them. I am not suggesting there is no cost to them just that there is less cost

Byron - I suggest we recess for 15 minutes to get LBA in the room so we are more effective
Recess at 10:35am

Rosenwald - if committee decides to adopt this and incorporates language with inmates would need to be redrafted

Kurk - if we change this the problem that caused us to put in language for Correction Dept is not necessary

Rosenwald - we got language about inmates that is a little bit different

Meyers - you wouldn't need it if you kept the 90 day retro coverage not for the state Dept but potentially for the counties

Byron - recess until 10:55 at 10:37am

Byron - recovered the work session at 10:55am and LBA distributed April 23, 2018 draft of the Byron amendment of SB 313 with highlighted changes of April 18 draft amendment

LBA - Kevin Ripple - overview of changes

Page - only things highlighted are changes from previous draft

Page 5 line 17 - temporary has been removed

Page 8 - line 23-24 - "funds recovered or returnable to the Granite Advantage Health Care Trust Fund that were originally spent on the cost of coverage of the Granite Advantage Health Care Program; and"

Page 9 - line 25 - 5 business days changed to 10

Page 12 - line 1 - 18

Page 12 - line 25-31 - new language - continued participation in Granite workforce with increase in income

Page 13- line 1-3 - relates to Granite workforce participants reference to ten days removed

Page 13 Line 10 & 14 - wages

Page 16 - line 29 - 5 business days changed to 10

Byron - back to 90 day look back

Kurk - on change on page 12 - I yellow if you want to discuss now or later

Byron - we covered but will come back but trying to finish look back discussion on Rosenwald amendment

Byron - cost of program conservative Vs Aggressive - 6 million vs 11 million

LBA - impact on DSH was the less clear of all variables assuming we are already hitting the CAP, if not there might be a significant impact

Rosenwald - we didn't know if we were hitting the CAP

LBA - FY18 - $241.9 million CAP on hospitals. The maximum amount paid to hospitals to compensate them for their uncompensated care costs

Byron - if we hit the CAP no more payment, if 6.1 and 11.3 could be payable or not payable depending on the CAP

Kurk - I am comfortable with what we have now

Byron - if you are comfortably with what we have now I have to maintain the request to get an amendment with Commissioner to get amendment to state plan for corrections

Wallner - Rosenwald brought a good amendment I am comfortable with the 90 day look back

Rogers - I believe we should go with the Rosenwald amendment she has shown a clear cost saving and it is a wise move no one has shown a reason not to go in this direction

Byron - my proposal is we stay with what we have in the bill not having the 90 day look back I think there is a cost to the amendment that is somewhat ambiguous It is open to interpretation

Rosenwald - I would like to move the amendment 1293h,seconded by Wallner

Lang - are we hitting the DSH cap

LBA - that is unclear

Byron - recess for a caucus until 11:20am

Byron called the work session back into order at 11:28am and asked for vote on amendment #2018-1293h on Rosenwald amendment

Vote - yes(Wallner, Nordgren, Rosenwald, Rogers) - 4- NO (Byron, Kurk, Danielson, Bates, Renzullo, Lang) 6 - motion fails

Kurk - Page 12 - line 26 delete as a result of participation in the Granite workforce program
Should be regardless of the reason that the source of income the commissioner has no problem with this

Byron - can I assume the committee has no problem with this - seeing no problem I would ask that the LBA remove that language - "as a result..."

Kurk - I have a question With the change on page 13 - I thought before one could enter the Granite Work force one had to be in expanded Medicaid. This seems to say one can enter without being in expanded Medicaid

Meyers - I agree if committee wants to change the language I have no problem

Kurk - yes no person shall participate in granite workforce unless he or sheets a participant in expanded Medicaid

Meyers - DHHS has no problem with that concept

Byron - any concerns on the part of the committee with that wording - hearing no objection we will consider that as a committee change - next I want to go over the age requirement and change from 13 to six that section is on page 5 line 29 -

Byron - I propose when we drop the age requirement from 13 to 6 there was a concern that possibly summer vacation or school recess would create a problem in fulfilling the work requirement and child care at the time - we incorporate an ability on Commissioner part on the waiver granted by Commissioner for good cause that participant not be able to fulfill their work requirement

Meyers - that is helpful I still have a concern that an exemption that is that young but if what the committee decides to have it in there then having a good cause exemption is helpful

Byron - is the ability on your part to generate rules helpful

Meyer - page 6 line 26 is already there for good cause exemptions

Byron - then we don't need a change to incorporate in there

Meyers - I don't think there is space in the bill to put in every good cause exemption

Kurk - that suggests you can put in any where you want to determine on your own

Meyers - There are many committees with rule making authority to establish that

Kurk - administratively to decide what good cause is

Meyers - that is not true there is guidance with CMC to determine what good cause is and there is guidance in the bill that is decided to be address I.E page 5 line 1 that determines at a minimum so the senate at least at this point has contemplated that these come directly fro the CMC guidance

Kurk - but you are suggesting that administratively the good cause language you suggested allows you to do that

Meyers - subject to rule making guidance legislatively

Kurk - but JALCR doesn't have authority

Sen Bradley - if you want to add this as a good cause exemption add to Page 5 under 13 and goes back to the exemptions a good cause exemption

Byron - on page 5 around line 34 put good cause there

Bradley - no line 13

Meyers - end on line 12 new subsection line 5

Byron - any objection to adding good cause exemption

Lang - relative to child care is that narrowly defined

Byron - relating to the work requirement

Rosenwald - the other day the DHHS said they would expect an increase of about 20% that would potentially qualify and that would cost about 20 million

Byron - if there would be an exemption why would there be a cost and a scholarship issued

Rosenwald - that depends if a scholarship were issued

Kurk - Rosenwald offered an amendment on the 18th where we talked about the exemption so you could put in the section where it talks about the age of the child or in the good cause section if you put in the statute it is a statutory exemption rather that a good cause one

Meyers - a good cause exemption with a child older than 6 that does not allow why not put on page 5

Kurk - that is one place but in the Rosenwald amendment section 4 providing the exemption only one parent or caretaker per household for a scholarship is not available when the child is not in school is a statutory exemption

Meyers - the difference is if it is a statutory exemption there is no discretion

Kurk - could we put the Rosenwald language in that same section as the good cause language

Meyers - Rosenwald working looks more like a good cause exemption then a statutory language that would imply that someone has to make decision if the scholarship is available

Rosenwald - good cause exemption is like I didn't make my hours last night because I had to work nights and my child care wasn't open a statutory exemption would be someone going to night school so

for this entire period I don't have child care how do we true this up with the fact there is a 12 month child care eligibility now what is someone's child care gets changed do we want the DHHS to interact with these 1400 families that often

Meyers - the word may imply that there is discretion involved so the amendment drafter introduces the idea of discretion under fed law when you qualify you have to do so for 12 months of the scholarship

Wallner - if we are going to have a reason we have to include not just that the scholarship is available that there is also a provider available

Meyers - if what geographic range

Bates - hold off on a decision of where to put this until we have language of what this is going to say

Byron - we have to decide today

Rosenwald - does the DHHS have language about appropriate providers from the child care program

Meyers - I don't

Wallner - if in TANF there is a work exemption that talks about if appropriate child care is not available

Lang - sounds like if under statutory it is exhaustive but if good cause it is exhausted list

Byron - next topic determination and use of medical loss ration now contains a medical loss ration the question is whether it should be removed is there a reason senate did not put it in

Sen Bradley - it was never discussed

Meyers - page 3 lines 11 & 12 includes MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

Byron - that was in the last draft

Rosenwald - I don't think we should go forward with it if we heard from the DHHS and the MCOS it is problematic

Danielson - is it necessary to address

Meyers -we don't believe so. The other point being as it appears in the point now there is no incentive for the MCOS to mange they have no potential to manage for less they have no incentive

Kurk - that money should go back into the pot and without this it won't

Byron - Rosenwald. You are against going forward with that

Byron - in favor of retaining:
Retaining - 5 (Byron, Kurk, Bates, Renzullo, Lang)
Not Retaining - 5 (Wallner, Rosenwald, Nordgren, Rogers, Danielson)
Fails - so it stays in

Byron - Sever ability

Kurk - you told us CMS will retain changes from the house why is this necessary

Meyers - you are saying the legislature will do what it wants it will hold us the issue of the waiver

Kurk - I suggested we put in the 1696 language

Rosenwald - would we be replacing the 1696 for the current language in the bill

Meyers - essentially yes

Byron. The Sever ability clause as it exists today is on page 18 line 36

Rosenwald - last week commissioner suggested on line 30 add "or not approved by CMS..."

Meyers - could read if any provision of this act is held in laid or not approved by CMS does not effect other provisions of the act

Byron - so is everybody accepting or in approval of inclusion of language by the Commissioner of this language

Byron - recess at 12:7pm until 1pm

Chairman Byron called the work session back into order at 1:15pm and announced there was a copy of language for page 5 line 12 regarding custodial parent;

"The beneficiary is a custodial parent of a child aged 6-12 who is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance or other related factor."

Meyers - this would be another good cause exemption part of the rules that would go thru the entire rule making process

Nordgren - so down on line 29 that section would this replace that

Meyers - it doesn't have to replace you could have both the statutory for the months of July and August and the good cause for the other months of the year

Rosenwald - it seems to make more sense to eliminate the one and keep the good cause because they are in some conflict

Nordgren - it adds the confusion

Danielson - could you explain the difference between the two

Meyers - the statutory exemption refereed to months of July and August that means that you could decide during those months the exemption is expanded automatically provided they apply only once for those two months the good cause exemption is creating a mechanism for lack of funding or provided the custodial parent would be given a good cause exemption that could not expand 12 months

Danielson - so under July and August they would not be required to work and flexibility to other parents

Kurk - how often would a person have to demonstrate they could not access child care

Meyers - when you are determined eligible you have to be determined every 12 months but at maximum could only be 12 months if it would be weekly determinations it is an administrative impossibility probably monthly and that would be in rules

Kurk - could we put that in this section

Meyers - how many positions will I be getting to do this

Kurk - your thought at this time would be monthly

Meyers - I would think maybe monthly

Rosenwald - you said one parent per household it says one parent or caretaker even if there is more than one custodial what kind of employer is going to hire if not going to work in July or August - I think there is conflict - it seems to also address nights and weekends-

Wallner - if looking at folks on a monthly basis - if two months later you could say I have a Summer camp then you lose that exemption if I find child care you would take away the exemption - the whole thing about July and August doesn't make sense to me

Byron - strike July and August and insert 5

Meyers - if the committee wants to include it

Rosenwald - if this language were a substitute for lines 23 if that

Byron - line 31-33 substitute

Nordgren - is it a problem with substitute language says custodial parent but line 30 says parent or caretaker

Meyer - fix it hat way

Nordgren - better to be consistent

Byron - drop it in there

Kurk - can we put in language about frequency

Meyers - I have to submit a plan to the Gov and Council, President of the Senate and Speaker of the House by Jan 1

Kurk - 1st line after who, as determined on a monthly basis

Byron - any objections

Rosenwald - I am confused about that if put in on line 12 are we still having conflicting language below

Kurk - no

Byron -lines 23-33 comes out

Kurk - lines 31-33 come out

Rosenwald - that is problematic one is talking about custodial and one is talking about only one parent - I would change line 3 that shall apply to only one parent or care talker

Lang - my concern is that courts are issuing dual custody parents so both parents are exempt from work requirement

Rosenwald - DHHS is not going to make these decisions as to who has custody

Danielson - wouldn't all this come under the discretion of the Commissioner it makes it simpler

Meyers - it comes under the rule making of at least 4 Committees

Byron - paragraph 5 between 12 and 3 with custodial parent or caretaker as determined on a monthly basis cross out lines 31-33

Kurk - so what we are creating is one standard for custodial parent in the rules that must comply with the statute which says one parent

Nordgren -we should put in statute monthly

Meyers - it will be done at a cost it has got to be paid

Wallner - Rosenwald why not in favor

Rosenwald - this would mean that one parent of a 6 year old can't find child care and half the time when living with other custodial parent if they have to work 3-11 what happens to that child

Nordgren - the solution is to just have the age 13

Byron - next item is Commissioners concerned with the calendar schedule

LBA - distribution of document

Henry Lipman - Medicaid Director DHHS - page 9 section 5 discussion on Line 7 -15 suggestion if remainder amount is less should there be language how it could work. Remainder amount greater than estimated and alcohol tax and premium fund line 7 aligns date to August.

Byron - what is the intention of Committee to incorporate into the draft -

Kurk - listening to Mr. Lipman it is convincing but it is not absorbed I would say yes let's put it in but for Tuesday's amendment yes

Byron - so without objection we will incorporate this in - this cover the issues I have

Byron -The MCOS have asked to address the loss ratio

Chris Kennedy - NHHealthy Families - for Profit
Richard Siegal - Wellsense not for Profit
we understand the issue with the MLR and the language the concern we have is the language as prevented flips the premise of managed care a shared risk between the state and the MCO and that price on the per member per months to manage this population if the MCO do a good job they make money if not then they eat it and that is why there is a benefit to the state in part they assume the risk. If you inset a provision that the MLR (a target number determine how much of the spending goes out the door to providers used by the accurate to determine the number per month negotiated by the MOC) when you say any amount below is returned to the state you are taken away the MCO ability to manage effectively if you take away and say the money will return to the state that is a problem to the MCO .

Kennedy - I agree. I will add there is an effect that it will stymie the MCOs to innovate within the program we have worked to innovate with in substance use disorder targeted to address this crisis that type of innovative program drives cost savings to keep our members healthy that will be cost savings

recognize in the enterprise. Our problem with this provision says anything over this hits the fundamental balance of the program as it was intended.

Siegel - we understand the committee wants to achieve more stability on the state side the cost of managed care while health care cost is going up between 3 - 8% I would add that saving assumption is built in to the rate so I would turn to the commissioner to speak in more detail to speak to this but for us this type of premise is very problematic and ask for you to remove this

Kurk - where does this money go if assumed rate of 90% is dripped to 85%

Siegel - that is money that is reinvested into organization the NH operation we are not for profit it is one of mort efficient of the organizations most of what we are taking in is going out the door

Kennedy - it behooves us to improve the program as much as possible I spoke to our substance abuse program

Kurk - all of this would go back directly to improve programs or is there a administrative operations

Sigel - if the financial is that MCO manages poorly or unexpected situations they eat that if they succeed if the MCO is financially healthy that benefits the state as its financial partner

Byron recess at 2:02pm until 11am Tuesday April 23

Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

House Finance
April 25, 2018
2018-1769h
01/03

Amendment to SB 313-FN

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, minus the following:

(a) The amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) All federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs related to the program;

(c) Any surplus funds generated as a result of the managed care organizations managing the cost of their services below the minimum medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter; and

(d) Taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver

of the requirement to provide 90-day retroactive coverage and a state plan amendment allowing state and county correctional facilities to conduct presumptive eligibility determinations for incarcerated inmates to the extent provided under federal law. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all preexisting authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total

cost of care within the Medicaid managed care program. The commissioner shall also include in the MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance. Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

(3) The commissioner shall establish for the managed care program beginning on July 1, 2019 and thereafter a minimum medical loss ratio that is actuarially sound and that encourages cost efficiency in the delivery of care to the entire Medicaid population. Any surplus funds generated from the MCOs managing the cost of their services below the established minimum medical loss ratio for the beneficiaries of the program shall be transferred to the fund and shall be included in the calculation of the remainder amount.

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g).

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency,

citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment including by nonprofit organizations.

(2) Subsidized private sector employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph fails to comply with the work or community engagement activities required in accordance with this paragraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. Following approval by the joint health care reform oversight committee, pursuant to RSA 161:11, to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.

(5) The beneficiary is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the commissioner on a monthly basis, is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or another related factor.

(c) This paragraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i).

(d) This paragraph shall not apply to:

(1) A person who is unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A custodial parent or caretaker of a dependent child under 6 years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker in the case of a 2-parent household.

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Following approval by the joint health care reform oversight committee, pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules. The rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

(7) Annual certification of medical frailty pursuant to 42 C.F.R. section 440.315(f), including proof and duration of such condition on a form supplied by the department.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. The waiver request submitted by the commissioner shall be consistent with all the terms of this chapter. In the event that the final approved waiver is inconsistent with any of the terms of this chapter, the commissioner shall provide written notification to the governor, speaker of the house of representatives, and president of the senate, informing them of the differences between the terms of this chapter and the approved waiver. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management. The MCOs shall work collaboratively with the department and any outside contractor in encouraging and monitoring work and community engagement activities.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity to cure and for re-activation following noncompliance. Following approval by the joint health care reform oversight committee, pursuant to RSA 161:11, to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules.

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, to pay for the administrative costs for the program, and reimburse the federal government for any over payments of federal funds. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to MCOs. No state general funds shall be deposited into the fund. Deposits into the fund shall be limited exclusively to the following:

(a) Revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) Federal Medicaid reimbursement for program costs and administrative costs attributable to the program;

(c) Surplus funds generated as a result of MCOs managing the cost of their services below the medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019;

(d) Taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b);

(e) Funds received from the assessment under RSA 404-G;

(f) Funds recovered or returnable to the fund that were originally spent on the cost of

coverage of the granite advantage health care program; and

(g) Gifts, grants, and donations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30, 2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before August 15, 2020, the commissioner shall calculate the projected final remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before August 15 of each subsequent year, the commissioner shall calculate the projected final remainder amount for the prior fiscal year. If the amount deposited from the high risk pool exceeds the limit on contributions established by RSA 404-G:5-a, IV(d), then any excess difference shall be retained in the fund and the next estimated remainder amount calculated by the commissioner shall be reduced by the amount of the difference.

VI. The commissioner, in accordance with the most current available information, shall be responsible for determining, quarterly commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next 6-month period. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS. Upon making a determination that a projected shortfall exists, the commissioner shall:

(a) Within 48 hours of making the determination, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the fiscal

committee of the general court of the program's pending termination; and

(b) Within 10 business days of making the determination, notify program participants of the program's pending termination.

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Of the commission members listed in this paragraph, only the 6 legislative members

shall be voting members. All other members shall serve in an advisory capacity only.

(c) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the commissioner concerning recommended monitoring and evaluation requirements for work and community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first

meeting of the commission shall be held within 45 days of the effective date of this section. Four of the 6 voting members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report, together with its findings and any recommendations for proposed legislation, to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022. Both reports shall contain the commission's recommendation regarding whether the program should continue.

126-AA:5 Evaluation Report Required.

I. The program shall employ an outcome-based evaluation of its Medicaid program annually to:

(a) Provide accountability to patients and the overall program.

(b) Ensure that patients are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care.

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

II. The results of the evaluation conducted under this section shall be in the form of a report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF) program to end the dependence of needy parents ages 18 through 64 and low income childless adults ages 18 through 24 on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an

initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be provided to eligible participants through Granite Workforce. The total cost of the pilot program shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) Parents aged 18 through 64 with a child under age 18 in the household; or

(c) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(d) Childless adults between 18 and less than 25 years of age.

III. An eligible recipient, whose wages subsequently cause the household to exceed 138 percent of the federal poverty level shall continue to receive Granite Workforce program services as needed, including the subsidy for employers under section 4 of this act, provided the recipients wages do not cause the household to exceed 250 percent of the federal poverty level. After the second employer subsidy is paid on behalf of a Granite Workforce recipient, the recipient shall no longer be eligible for Granite Workforce services as long as household income exceeds 138 percent or the federal poverty level.

IV. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

V. No person shall participate in the Granite Workforce program unless he or she is also enrolled in the New Hampshire Granite Advantage Health Care Program, as established in RSA 126-AA.

VI. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program, adopted under RSA 541-A , shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. After 3 months of the employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's wages for the prior month, not to exceed $2,000.

II. After 9 months of the continued employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's wages for the prior month, not to exceed $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount

upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications (RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence. Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire;

(b) Referring individuals to the department of business and economic affairs to utilize available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed

alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures. Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, the president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Termination of Granite Workforce Program.

I. The commissioner of the department of health and human services shall be responsible for determining, every 3 months commencing no later than December 31, 2018, whether available TANF reserve funds total at least $40,000,000. If at any time the commissioner determines that available TANF reserve funds have fallen below $40,000,000, the commissioners of the departments

of health and human services and employment security shall, within 20 business days of such determination, terminate the Granite Workforce program. The commissioners shall notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of the fiscal committee of the general court, and Granite Workforce participants of the program's pending termination.

II. If at any time the New Hampshire granite advantage health care program, established under RSA 126-AA, terminates, the commissioners of the departments of health and human services and employment security shall terminate the Granite Workforce program. The date of the Granite Workforce program's termination shall align with that of the New Hampshire granite advantage health care program.

10 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] *126-AA* shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3.*** The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration of the New Hampshire granite advantage health care program, established in RSA 126-AA.***

11 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5-e, I(b), less the amount made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5-b~~] ***the lesser of the remainder amount, as defined in RSA 126-AA:1, V, or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV and taxes attributable to premiums written for medical and other medical-related services for the newly eligible Medicaid population. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.***

12 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016,13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under [~~RSA 126-A:5, XXIV-XXV between July 1, 2014 – December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] ***RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby*** repealed 180 days after the event under this [~~subparagraph~~] ***paragraph*** occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services ***and consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program.*** The commissioner shall [~~immediately issue notice to program participants of the program's pending repeal~~]***:***

(a) Within 48 hours after the event under this paragraph has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the legislative fiscal committee of the program's pending termination; and

(b) Within 10 business days after the event in this paragraph has occurred, notify program participants of the program's pending termination.

13 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.4~~] ***Five*** percent of the previous fiscal year gross profits derived by the commission from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

14 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding alcohol education and abuse prevention and treatment programs. ***The commissioner of the department of health and human services may accept gifts, grants, donations, or other***

funding from any source and shall deposit all such revenue received into the fund. The state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys *received from all other sources other than the liquor commission pursuant to RSA 176:16, III* shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3*; provided, however, that funds received from any source other than the liquor commission, pursuant to RSA 176:16, III, shall not be used to support the New Hampshire granite advantage health care program and shall not be deposited into the fund established in RSA 126-AA:3.*

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

15 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program established in RSA 126-AA.*

16 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] ***126-AA***, and the federally qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

17 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program under RSA 126-AA*** in which case all provisions of this chapter shall apply.

18 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII~~] ***New Hampshire granite advantage health care program under RSA 126-AA***. If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

19 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

20 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, or is not approved by the Centers for Medicare and Medicaid Services, the invalidity or nonapproval does not affect other provisions or applications of the act which can be

given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

21 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the date of certification by the commissioner of the department of health and human services to the director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

22 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d(y)(1) to eliminate the state's share of funding for the New Hampshire granite advantage health care program, or if the federal government allows the use of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

23 Applicability.

I. If the commission, established pursuant to RSA 126-AA:4 in section 1 of this act, issues an interim report recommending the New Hampshire granite advantage health care program's discontinuation, the speaker of the house of representatives and the president of the senate shall initiate legislation as soon as practicable to repeal the New Hampshire advantage health care program established in section 1 of this act.

II. If the federal government converts the Medicaid program from a program funded jointly by the federal government and the states into a block grant the New Hampshire granite advantage health care program shall be repealed effective upon the implementation of such conversion, consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program. In the event of a repeal under this paragraph, the commissioner of the department of health and human services shall within 48 hours after the event has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of the fiscal committee, the secretary of state, and the director of legislative services of the program's pending termination and within 10 business days after the event under this paragraph has occurred, notify program participants of the program's pending termination.

24 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

25 Effective Date.

I. Paragraph II of section 24 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 24 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 21 of this act.

V. Section 3-9 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: April 23, 2018

ROOM: 210-211 **Time Work Session Called to Order:** 10:12

Time Adjourned: 2:03pm

(please circle if present) Rep Tim Lang (Rep Hennessey)

Committee Members: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers

Bill Sponsors:

Sen. Bradley	Sen. Morse	Rep. S. Schmidt
Rep. Umberger	Rep. Danielson	Rep. Kotowski

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Comm Jef Meyers DHHS

vote on Amendment 2018-1293h - 4yes - 6NO amendment fails

vote on Retaining medical loss ratio 5yes 5NO motion fails

Recessed at 2:30pm
Until Tuesday April 24, 2018
at 11am

SB 313 WORKSession

Finance Div III

April 23, 2018

Reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Present:Byron, Kurk, Danielson, Bates, Renzullo, Lang (replacing Hennessey),Wallner, Nordgren, Rosenwald, Rogers

Absent: Hennessey

Chairmen Byron opened the work session at 10:12am and announced Rep Tim Lang from Ways and Means Committee would be replacing Rep Hennessey for the week. The schedule for the week is as follows today until 3pm on SB 313. Tuesday 9am voter SB 592, 11am SB 313. Wednesday 9am SB 590,

Today several items unresolved;
1 - Rosenwald look back amendment
2- reduction in work exemption age from 13 down to 6
3 - sever ability clause
4 - constructing a sliding scale - consider that monies that go to employers
5 - decision on determine the loss ration for MCOS

Rosenwald - I had a note that said when the premium tax is calculated is that still hanging out there

Byron - there is a general discussion as to weather we wanted to have a formal calculated amount or a rolling case going forward

The last version was April 18 that was a draft version with the yellow notes LBA will be coming with a new draft shortly

First item would be the construction of a sliding scale of the granite workforce program up to 250% of the poverty level

Commissioner Jef Meyers - we worked on some language this morning an attempt to address a Kurk request how to deal with recipient experience an income gain

Into the Byron amendment of April 18, page 12 after line 24 insert 2-A subsection
"an eligible receptive whose wages subsequently causes the household to exceed 138% of the federal poverty level as a result of participation in Granite Workforce but not more than 250% shall continue to receive Granite Workforce program services as needed, including subsidy for employers. After the second subsidy is paid to an employer on behalf of a Granite Workforce recipient will no longer be eligible for Granite Workforce services as long as the household income exceeds 138% of the federal poverty level"

Kurk - that means if income is higher once you meet nine months you are over

Myers - yes

Meyers - have given to the LBA

Byron - any comments on the paragraph And this would allow us to make the final payment to the employer and complete the 9 months of work?

Meyers - yes

Byron - lets go on to the 90 day look back requirement - there was a proposal given to us by Rep Rosenwald

Rosenwald - Amendment #1293h would give confidence to community providers that they could begin treatment right away it would cost between a quarter to a half less than what DHHS had projected to the non-federal portion of the claim for the year. DHHS suggested 2.4 million for the non-federal portion of the year. The state is not paying any portion of this. (I am trying to continue to not use any state monies) that would be a total claim of 34 million next year.

Lipman told me hospital portion btw 40-60 % of total claim projected the MET revenue on the 30% and more aggressive 60% . If 30% $500,550, if 60%, $1million that is an offset of the 2.4 million at the bottom not able to figure if all of those claims subject to uncompensated care and federal match but we looked at what they could possibly be at the 30% and the 60%.

If hospital claims were 30% of the 34 million claims and we had that the cap on uncompensated claims we would set aside additional for DSH if 60% we would have to save 64million so it is a more favorable match rate.

Meyers - raise a question - today under current state plan hospitals and are able to do presumptive eligibility the hospital is authorized to so presumptive eligibility and can be compensated for those services. question is do these numbers reflect that hospital do undertake that presumptive eligibility

Rosenwald - I got the 30% and 60% from DHHS so I am not sure but other community providers are not able to do presumptive eligibility and it is helpful for them. I am not suggesting there is no cost to them just that there is less cost

Byron - I suggest we recess for 15 minutes to get LBA in the room so we are more effective Recess at 10:35am

Rosenwald - if committee decides to adopt this and incorporates language with inmates would need to be redrafted

Kurk - if we change this the problem that caused us to put in language for Correction Dept is not necessary

Rosenwald - we got language about inmates that is a little bit different

Meyers - you wouldn't need it if you kept the 90 day retro coverage not for the state Dept but potentially for the counties

Byron - recess until 10:55 at 10:37am

Byron - recovered the work session at 10:55am and LBA distributed April 23, 2018 draft of the Byron amendment of SB 313 with highlighted changes of April 18 draft amendment

LBA - Kevin Ripple - overview of changes

Page - only things highlighted are changes from previous draft

Page 5 line 17 - temporary has been removed

Page 8 - line 23-24 - "funds recovered or returnable to the Granite Advantage Health Care Trust Fund that were originally spent on the cost of coverage of the Granite Advantage Health Care Program; and"

Page 9 - line 25 - 5 business days changed to 10

Page 12 - line 1 - 18

Page 12 - line 25-31 - new language - continued participation in Granite workforce with increase in income

Page 13- line 1-3 - relates to Granite workforce participants reference to ten days removed

Page 13 Line 10 & 14 - wages

Page 16 - line 29 - 5 business days changed to 10

Byron - back to 90 day look back

Kurk - on change on page 12 - I yellow if you want to discuss now or later

Byron - we covered but will come back but trying to finish look back discussion on Rosenwald amendment

Byron - cost of program conservative Vs Aggressive - 6 million vs 11 million

LBA - impact on DSH was the less clear of all variables assuming we are already hitting the CAP, if not there might be a significant impact

Rosenwald - we didn't know if we were hitting the CAP

LBA - FY18 - $241.9 million CAP on hospitals. The maximum amount paid to hospitals to compensate them for their uncompensated care costs

Byron - if we hit the CAP no more payment, if 6.1 and 11.3 could be payable or not payable depending on the CAP

Kurk - I am comfortable.with what we have now

Byron - if you are comfortably with what we have now I have to maintain the request to get an amendment with Commissioner to get amendment to state plan for corrections

Wallner - Rosenwald brought a good amendment I am comfortable with the 90 day look back

Rogers - I believe we should go with the Rosenwald amendment she has shown a clear cost saving and it is a wise move no one has shown a reason not to go in this direction

Byron - my proposal is we stay with what we have in the bill not having the 90 day look back I think there is a cost to the amendment that is somewhat ambiguous It is open to interpretation

Rosenwald - I would like to move the amendment 1293h,seconded by Wallner

Lang - are we hitting the DSH cap

LBA - that is unclear

Byron - recess for a caucus until 11:20am

Byron called the work session back into order at 11:28am and asked for vote on amendment #2018-1293h on Rosenwald amendment

Vote - yes(Wallner, Nordgren, Rosenwald, Rogers) - 4- NO (Byron, Kurk, Danielson, Bates, Renzullo, Lang) 6 - motion fails

Kurk - Page 12 - line 26 delete as a result of participation in the Granite workforce program Should be regardless of the reason that the source of income the commissioner has no problem with this

Byron - can I assume the committee has no problem with this - seeing no problem I would ask that the LBA remove that language - "as a result..."

Kurk - I have a question With the change on page 13 - I thought before one could enter the Granite Work force one had to be in expanded Medicaid. This seems to say one can enter without being in expanded Medicaid

Meyers - I agree if committee wants to change the language I have no problem

Kurk - yes no person shall participate in granite workforce unless he or sheets a participant in expanded Medicaid

Meyers - DHHS has no problem with that concept

Byron - any concerns on the part of the committee with that wording - hearing no objection we will consider that as a committee change - next I want to go over the age requirement and change from 13 to six that section is on page 5 line 29 -

Byron - I propose when we drop the age requirement from 13 to 6 there was a concern that possibly summer vacation or school recess would create a problem in fulfilling the work requirement and child care at the time - we incorporate an ability on Commissioner part on the waiver granted by Commissioner for good cause that participant not be able to fulfill their work requirement

Meyers - that is helpful I still have a concern that an exemption that is that young but if what the committee decides to have it in there then having a good cause exemption is helpful

Byron - is the ability on your part to generate rules helpful

Meyer - page 6 line 26 is already there for good cause exemptions

Byron - then we don't need a change to incorporate in there

Meyers - I don't think there is space in the bill to put in every good cause exemption

Kurk - that suggests you can put in any where you want to determine on your own

Meyers - There are many committees with rule making authority to establish that

Kurk - administratively to decide what good cause is

Meyers - that is not true there is guidance with CMC to determine what good cause is and there is guidance in the bill that is decided to be address I.E page 5 line 1 that determines at a minimum so the senate at least at this point has contemplated that these come directly fro the CMC guidance

Kurk - but you are suggesting that administratively the good cause language you suggested allows you to do that

Meyers - subject to rule making guidance legislatively

Kurk - but JALCR doesn't have authority

Sen Bradley - if you want to add this as a good cause exemption add to Page 5 under 13 and goes back to the exemptions a good cause exemption

Byron - on page 5 around line 34 put good cause there

Bradley - no line 13

Meyers - end on line 12 new subsection line 5

Byron - any objection to adding good cause exemption

Lang - relative to child care is that narrowly defined

Byron - relating to the work requirement

Rosenwald - the other day the DHHS said they would expect an increase of about 20% that would potentially qualify and that would cost about 20 million

Byron - if there would be an exemption why would there be a cost and a scholarship issued

Rosenwald - that depends if a scholarship were issued

Kurk - Rosenwald offered an amendment on the 18th where we talked about the exemption so you could put in the section where it talks about the age of the child or in the good cause section if you put in the statute it is a statutory exemption rather that a good cause one

Meyers - a good cause exemption with a child older than 6 that does not allow why not put on page 5

Kurk - that is one place but in the Rosenwald amendment section 4 providing the exemption only one parent or caretaker per household for a scholarship is not available when the child is not in school is a statutory exemption

Meyers - the difference is if it is a statutory exemption there is no discretion

Kurk - could we put the Rosenwald language in that same section as the good cause language

Meyers - Rosenwald working looks more like a good cause exemption then a statutory language that would imply that someone has to make decision if the scholarship is available

Rosenwald - good cause exemption is like I didn't make my hours last night because I had to work nights and my child care wasn't open a statutory exemption would be someone going to night school so for this entire period I don't have child care how do we true this up with the fact there is a 12 month child care eligibility now what is someone's child care gets changed do we want the DHHS to interact with these 1400 families that often

Meyers - the word may imply that there is discretion involved so the amendment drafter introduces the idea of discretion under fed law when you qualify you have to do so for 12 months of the scholarship

Wallner - if we are going to have a reason we have to include not just that the scholarship is available that there is also a provider available

Meyers - if what geographic range

Bates - hold off on a decision of where to put this until we have language of what this is going to say

Byron - we have to decide today

Rosenwald - does the DHHS have language about appropriate providers from the child care program

Meyers - I don't

Wallner - if in TANF there is a work exemption that talks about if appropriate child care is not available

Lang - sounds like if under statutory it is exhaustive but if good cause it is exhausted list

Byron - next topic determination and use of medical loss ration now contains a medical loss ration the question is whether it should be removed is there a reason senate did not put it in

Sen Bradley - it was never discussed

Meyers - page 3 lines 11 & 12 includes MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

Byron - that was in the last draft

Rosenwald - I don't think we should go forward with it if we heard from the DHHS and the MCOS it is problematic

Danielson - is it necessary to address

Meyers -we don't believe so. The other point being as it appears in the point now there is no incentive for the MCOS to mange they have no potential to manage for less they have no incentive

Kurk - that money should go back into the pot and without this it won't

Byron - Rosenwald. You are against going forward with that

Byron - in favor of retaining:
Retaining - 5 (Byron, Kurk, Bates, Renzullo, Lang)
Not Retaining - 5 (Wallner, Rosenwald, Nordgren, Rogers, Danielson)
Fails - so it stays in

Byron - Sever ability

Kurk - you told us CMS will retain changes from the house why is this necessary

Meyers - you are saying the legislature will do what it wants it will hold us the issue of the waiver

Kurk - I suggested we put in the 1696 language

Rosenwald - would we be replacing the 1696 for the current language in the bill

Meyers - essentially yes

Byron. The Sever ability clause as it exists today is on page 18 line 36

Rosenwald - last week commissioner suggested on line 30 add "or not approved by CMS..."

Meyers - could read if any provision of this act is held in laid or not approved by CMS does not effect other provisions of the act

Byron - so is everybody accepting or in approval of inclusion of language by the Commissioner of this language

Byron - recess at 12:7pm until 1pm

Chairman Byron called the work session back into order at 1:15pm and announced there was a copy of language for page 5 line 12 regarding custodial parent;

"The beneficiary is a custodial parent of a child aged 6-12 who is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance or other related factor."

Meyers - this would be another good cause exemption part of the rules that would go thru the entire rule making process

Nordgren - so down on line 29 that section would this replace that

Meyers - it doesn't have to replace you could have both the statutory for the months of July and August and the good cause for the other months of the year

Rosenwald - it seems to make more sense to eliminate the one and keep the good cause because they are in some conflict

Nordgren - it adds the confusion

Danielson - could you explain the difference between the two

Meyers - the statutory exemption refereed to months of July and August that means that you could decide during those months the exemption is expanded automatically provided they apply only once for those two months the good cause exemption is creating a mechanism for lack of funding or provided the custodial parent would be given a good cause exemption that could not expand 12 months

Danielson - so under July and August they would not be required to work and flexibility to other parents

Kurk - how often would a person have to demonstrate they could not access child care

Meyers - when you are determined eligible you have to be determined every 12 months but at maximum could only be 12 months if it would be weekly determinations it is an administrative impossibility probably monthly and that would be in rules

Kurk - could we put that in this section

Meyers - how many positions will I be getting to do this

Kurk - your thought at this time would be monthly

Meyers - I would think maybe monthly

Rosenwald - you said one parent per household it says one parent or caretaker even if there is more than one custodial what kind of employer is going to hire if not going to work in July or August - I think there is conflict - it seems to also address nights and weekends-

Wallner - if looking at folks on a monthly basis - if two months later you could say I have a Summer camp then you lose that exemption if I find child care you would take away the exemption - the whole thing about July and August doesn't make sense to me

Byron - strike July and August and insert 5

Meyers - if the committee wants to include it

Rosenwald - if this language were a substitute for lines 23 if that

Byron - line 31-33 substitute

Nordgren - is it a problem with substitute language says custodial parent but line 30 says parent or caretaker

Meyer - fix it hat way

Nordgren - better to be consistent

Byron - drop it in there

Kurk - can we put in language about frequency

Meyers - I have to submit a plan to the Gov and Council, President of the Senate and Speaker of the House by Jan 1

Kurk - 1st line after who, as determined on a monthly basis

Byron - any objections

Rosenwald - I am confused about that if put in on line 12 are we still having conflicting language below

Kurk - no

Byron -lines 23-33 comes out

Kurk - lines 31-33 come out

Rosenwald - that is problematic one is talking about custodial and one is talking about only one parent - I would change line 3 that shall apply to only one parent or care talker

Lang - my concern is that courts are issuing dual custody parents so both parents are exempt from work requirement

Rosenwald - DHHS is not going to make these decisions as to who has custody

Danielson - wouldn't all this come under the discretion of the Commissioner it makes it simpler

Meyers - it comes under the rule making of at least 4 Committees

Byron - paragraph 5 between 12 and 3 with custodial parent or caretaker as determined on a monthly basis cross out lines 31-33

Kurk - so what we are creating is one standard for custodial parent in the rules that must comply with the statute which says one parent

Nordgren -we should put in statute monthly

Meyers - it will be done at a cost it has got to be paid

Wallner - Rosenwald why not in favor

Rosenwald - this would mean that one parent of a 6 year old can't find child care and half the time when living with other custodial parent if they have to work 3-11 what happens to that child

Nordgren - the solution is to just have the age 13

Byron - next item is Commissioners concerned with the calendar schedule

LBA - distribution of document

Henry Lipman - Medicaid Director DHHS - page 9 section 5 discussion on Line 7 -15 suggestion if remainder amount is less should there be language how it could work. Remainder amount greater than estimated and alcohol tax and premium fund line 7 aligns date to August.

Byron - what is the intention of Committee to incorporate into the draft -

Kurk - listening to Mr. Lipman it is convincing but it is not absorbed I would say yes let's put it in but for Tuesday's amendment yes

Byron - so without objection we will incorporate this in - this cover the issues I have

Byron -The MCOS have asked to address the loss ratio

Chris Kennedy - NHHealthy Families - for Profit
Richard Siegal - Wellsense not for Profit
we understand the issue with the MLR and the language the concern we have is the language as prevented flips the premise of managed care a shared risk between the state and the MCO and that price on the per member per months to manage this population if the MCO do a good job they make money if not then they eat it and that is why there is a benefit to the state in part they assume the risk. If you inset a provision that the MLR (a target number determine how much of the spending goes out the door to providers used by the accurate to determine the number per month negotiated by the MOC) when you say any amount below is returned to the state you are taken away the MCO ability to manage effectively if you take away and say the money will return to the state that is a problem to the MCO .

Kennedy - I agree. I will add there is an effect that it will stymie the MCOs to innovate within the program we have worked to innovate with in substance use disorder targeted to address this crisis that type of innovative program drives cost savings to keep our members healthy that will be cost savings recognize in the enterprise. Our problem with this provision says anything over this hits the fundamental balance of the program as it was intended.

Siegel - we understand the committee wants to achieve more stability on the state side the cost of managed care while health care cost is going up between 3 - 8% I would add that saving

assumption is built in to the rate so I would turn to the commissioner to speak in more detail to speak to this but for us this type of premise is very problematic and ask for you to remove this

Kurk - where does this money go if assumed rate of 90% is dripped to 85%

Siegel - that is money that is reinvested into organization the NH operation we are not for profit it is one of mort efficient of the organizations most of what we are taking in is going out the door

Kennedy - it behooves us to improve the program as much as possible I spoke to our substance abuse program

Kurk - all of this would go back directly to improve programs or is there a administrative operations

Sigel - if the financial is that MCO manages poorly or unexpected situations they eat that if they succeed if the MCO is financially healthy that benefits the state as its financial partner

Byron recess at 2:02pm until 11am Tuesday April 23

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 20, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 2:16**

Time Adjourned: 4:11

(please circle if present)

Committee Members: **Byron, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers**

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

Chairman Byron called the work session to order at 2:16pm

Commissioner Myers - DHHS
Henry Lipman - Medicaid Director DHHS

Myers - draft we are looking at says Rep Byron April 18, 2018 with yellow markings

Start on page 1 line 21 this defines the remainder amount being any surplus amounts the more that we have looked at this issue the more we think it may not accomplish what you have intended that if the program is managed for more than the established the potential surplus funds would go back to the extent the reason is to achieve efficiency in the program

1- there are any other areas that go to efficiency - page 3 of the bill including ways to increase use of ER, incentives bottom of page 2, so forth

2 - current contract include a 1% withhold provision if MCO don't meet that will be increase in next contract by a sum to give Dept control

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Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 20, 2018**

ROOM: **210-211** **Time Work Session Called to Order:** 2:06pm

Time Adjourned: 4:11pm

(please circle if present)

Committee Members: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers

Bill Sponsors:

Sen. Bradley	Sen. Morse	Rep. S. Schmidt
Rep. Umberger	Rep. Danielson	Rep. Kotowski

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Cam Myers - DHHS
Henry Lipman Medicaid Dir. - DHHS
Lynn Wilder - DHHS
Kevin Roads - DHHS

recess until 10am
Monday April 24

SB 313 Work Session Finance Div III

Friday April 20,2018

Reforming NH's Medicaid and Premium Assistance Program establishing the granite workforce pilot program and relative to certain liquor funds

Present:Byron,Hen essay, Kurk, Danielson,Bates, Renzullo,Wallner,Nordgren, Rosenwald, Rogers

Absent:

Chairman Byron called the work session to order at 2:16pm

Commissioner Myers - DHHS
Henry Lipman - Medicaid Director DHHS

Myers - draft we are looking at says Rep Byron April 18, 2018 with yellow markings

Start on page 1 line 21 this defines the remainder amount being any surplus amounts the more that we have looked at this issue the more we think it may not accomplish what you have intended that if the program is managed for more than the established the potential surplus funds would go back to the extent the reason is to achieve efficiency in the program

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Byron -recess at 4:08 until Monday April 23 at 10AM

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION II WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 19, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 3:17**

Time Adjourned: 4:25

(please circle if present)

Committee Members: **Umberger, Weyler, Allen, Kurk, Theberge, Eaton, M. Smith and Buco**

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
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TESTIMONY

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Henry Lipman - Medicaid Director - DHHS -
Lynn Wilder Div Family Asst - DHHS
Karin Rounds - CFO DHHS -

Byron - what happened to TAND spending dropping age to 6 for work requirements"

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Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

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TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Henry Lipman - Medicaid Dir - DHHS
Lyn Wilder - DHHS
Kavin Rounds DHHS
Jeff Myers DHHS

SB 313 Work Session

April 19, 2018

Finance Div III

Reforming NH's Medicaid and Premium Assistance Program establishing the granite workforce pilot program, and relative to certain liquor funds.

Present: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald, Rogers

Absent:

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DATE: **April 18, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 10:11**

Time Adjourned: 1202

(please circle if present)

Committee Members: **Umberger, Weyler, Allen, Kurk, Theberge, Eaton, M. Smith and Buco**

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TESTIMONY

Chairman Byron called the work session to order at 10:11am Announced this is not an amendment from himself this is with comment from DHHA

Henry Lipman - Medicaid Director DHHS
Amendment 1532h
Page 1(c)
Line 21

Page 1
Line 30 rep Kurk raised was in clear the pop was identified. What newly eligible adult are - the demonstration shall be for medical...and their spoke and dependents

Byron - we want to address that there will be not cross of bills

Lipman - page 2 line 3 - correctional facility county and state language reflects thru a state plan amendment and clarify by including incarcerated inmate to the extent provided under federal law

Kurk - contingency language

Lipman - when someone spends an overnight and not classified as an in-patient

Lipman - page 3 starting on line 21 and 25 = bringing for awe the minimum medical loss concept recovery made would be used to reduce the reminder amount

Rosenwald - would this be a conflict of interest for anybody in delivering care

Lipman - under the ACA the idea is to spend enough on medical care if you sped below you need to return it in this case return it to the state if you set a level too high we are trying to balance the incentives here

Rosenwald - isn't there an incentive for the state to lean on the MCOS to underspend how do we protect the enrollees that the right level is set

Lipman - federally it is set at 85% if you look it is in consultation with the actuarial So it is at the right level so there is not an incentive to set at a low level

Kurk - as I understand this the state itself doesn't benefit from any money that goes into the pot the remainder amount means the Insurance pays less or more so the state doesn't benefit if we didn't have this any result of underspending result to the benefit of the MCS the extra goes to their bottom lines

Lipman - wi

Lipman - page 5 line 8, 9 13 & 14 discussion about the level of rule making review Comm trying to balancing the rules getting done

Byron - lines 8,9, 13 & 14 proposal to use Joint aHealth care reform health care comm
Go back to line 5

Lipman - Commissioner trying to be more precise to community engagement and to refusing comply is existing law

Kurk - unless they receive approval but don't need approval of either I of the other two committees but has to go thru JLCAR could you explain the political or policy to include fiscal and HHS committee

Lipman - would like to come back with that

Byron - my understanding from prior bills where we had legislative committees approve change before there was a conflict issues can you describe

LBA - requiring leg committee to approve is a separation of powers problem JLCAR is a separate issue

Lipman - page 5 line 31 - sometimes is not temporary and require an annual certification

Rosenwald - Joint Health care reform legislation over are committee has only authors to review rules

Danielson - not sure but there is legislation now affecting that Committee and what it can do legislatively

Kurk - I think I misread this language 8-10 is not approval of rules but ability of Commissioner to initiate rule-making- only requires admission of rule making and the process would be he goes to ask hat he wants to initiate rules

Byron - your point is it just initiates there is no approval

Lipman - page 6 line 7 takes the age to under 6 the Commissioner's concern is leaving a child alone at night if someone has to work at night

Rosenwald - I have some language on this it is not an amendment but is language that could be an amendmentI

Byron - Mr Ripple is you could distribute

Rosenwald - my intention is to come to some consensus to deal with the fact that children are not at school all summer long and at night and weekend

Kurk - could you share with us what childcare funding is available for people who are subject to the

work requirement what kind of money and availability

Lyn Wilder - DHHS - acting Bureau Chief Family Assistance - the child care scholarship program - child care development funds for low income families come into state fed Prog 18. Million and TANF dollars up to 30% we transferred 10million = 40, million available for individuals for working, going to school looking for work - if below 138% of poverty - up to 220% of poverty level - th e lower the income the higher amount families can get

Kurk - how many people are covered by this and how many would be eligible for expanded Medicaid are we coving the same number or just in different bucket

Wilder - low income population with work requirement eligible thru age 13 can be increasing this service

Kurk. - Why

Wilder - with med - ex and work requirement

Kurk - so how do we put a cost to Rosenwald amendment

Wilder - would have to get back to you

Hennessey - looking at TANF spend on child care fund we doubled in last biennium do you know currently what our spend looks like

Wilder - I could work with our financial people

Hennessey - what has been charged against this account

Wilder - we would have to bring our fiscal folks here to answer these questions

Byron - we are getting to the point where next week doesn't exist I have A next week I have to take a vote by Tuesday

Wallner - I don't think that Rosenwald amendment will requires more spending her version says that tif eligible and the state has the scholarship there is no difference in the use of the scholarship those families would have been eligible in the original bill this doesn't increase the number of families eligible know

Rosenwald - it would save money to the extent if someone couldn't find a child care provided they wouldn't work

Wallner - I think we need to find the potential number of children is with this work requirement is would need child care is someone has given us that I have not seen it and we also don't know in the breakdown what the pot of money is we have for child care

Wallner - if you go to the dashboard you can see the number of children receiving child care scholarship monthly

Hennessey - I agree with Wallner the Byron amendment they do have access to child care but the Rosenwald doesn't incessant childcare spending it may decrease because it exempts them if they can't get childcare

Byron - Rosenwald you handed out proposal can you clarify

Rosenwald - implicit is I think is a shared assumption and believe that yon get children are not safe left

him alone at 24 hours a week but when they each age 6 they go to school but not all activity can take place drug in school hors - our goal is to encourage parents to get a job or pursue education that will get them out of poverty none of use would leave children at hoe alone my goal is to strike a middle ground - if we have a lot of families whose parents are divorced but child lives with both parents but both. Are required to meet an exemption but if there are two parents in the house and one has a Disability and cannot care for the child we need to exempt that family and it should not be six and twelve but rather seven and twelve

Wallner - the way the bill came to us excepting families to children under 13 probably would have added children eligible but by reducing the age of the exemption we were adding children to the number we would have to add to the scholarship

Rosenwald - children that are families eligible thru age 12 this age was carefully considered by the senate

Danielson - at what point do we stop doing options we have parents then parents sedated and the. Parents not marrieds - to what end do we go is there a step parent involved

Rosenwald - I'm only looking at it from the safety of he minor child

Danielson - I used to teach marketing and I use to look at how it evolved and the question is would you agree - would you expect between 6 and 4 years olds the parent is working part-time I think that is how we look at this age group

Rosenwald - my background is in marketing also and I didn't understand the question

Danielson - one group under. And another is under 14 the parent is working part-time at this point - don't those groups make sense as we look at this argument

Rosenwald - we do know at least half of this group is working but many are extremely low income we can think about if someone at 13 is left alone for a long period of time you can get married at 13 and you can certainly get pregnant I don't know if you want to get supervised

Byron - recess until 11:10

Byron called the work session back Into order at 11: 15am

Lipman - page 7 line 9 this is the comment with respect with the waiver shall be consistent with all the terms of this chapter

AByron - will cause multiple issues with CMS - he was concerned that people will make mischief with this then he felt the program would have to shut down here he says it will cause multiple issues with CMS

Lipman - the acid test isn't allowed under federal terms that would be a problem

Byron - the legislature needs to lay out what it's expectation re with the work requirement and it is incumbent for the DHHS to lay out weather CMS allows that or not but it is our expectation that DHHS will seek them if we can't get them then we will go from there but are you saying the DHHS will not submit

Lipman - we will provide them with the legislation and in terms of having been in the role and having gone they the waiver process as many times if it doesn't mirror in terms of the legislation in terms that CMS can't grant if we know that they can't grant it we will submit but that shouldn't end the program

Byron - if the legislature is saying this is what we want it is incumbent for DHHS to ask for it

Rosenwald - trying to understand the timing in terms of waivers we have received in the past we would have to notify 6 months in advance if this went into effect in June and CMS then looked at it and said in the fall we would give you a waiver in said you have to change this what happens Jan 1

Lipman - then have to upend on something CMS wouldn't' approve

Byron - so DHHS saying to legislate you can ask for whatever you want but if CMS isn't going to approve we are not going to ask for this

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Byron - LBA can you tie this any thoughts - Sn Bradley

Bradley - five years it is consistent with the program

Byron - recess at 12:02pm until 2pm April 19 or 2 hours after close of House session

Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: April 18, 2018

ROOM: 210-211 Time Work Session Called to Order: 10:11AM

Time Adjourned: 12:00pm

(please circle if present)

Committee Members: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers

Bill Sponsors:

Sen. Bradley	Sen. Morse	Rep. S. Schmidt
Rep. Umberger	Rep. Danielson	Rep. Kotowski

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

*Henry Lipman - Medicaid Dir - DHHS

Recess until April 19, 2018 at 2pm or 2 hours after Close of House Session

SB 313 Work Session Finance Div III

April 18, 2018

Reforming NH's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Present: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald, Rogers

Absent:

Chairman Byron called the work session to order at 10:11am Announced this is not an amendment from himself this is with comment from DHHA

Henry Lipman - Medicaid Director DHHS
Amendment 1532h
Page 1(c)
Line 21

Page 1
Line 30 rep Kurk raised was in clear the pop was identified. What newly eligible adult are - the demonstration shall be for medical...and their spoke and dependents

Byron - we want to address that there will be not cross of bills

Lipman - page 2 line 3 - correctional facility county and state language reflects thru a state plan amendment and clarify by including incarcerated inmate to the extent provided under federal law

Kurk - contingency language

Lipman - when someone spends an overnight and not classified as an in-patient

Lipman - page 3 starting on line 21 and 25 = bringing for awe the minimum medical loss concept recovery made would be used to reduce the reminder amount

Rosenwald - would this be a conflict of interest for anybody in delivering care

Lipman - under the ACA the idea is to spend enough on medical care if you sped below you need to return it in this case return it to the state if you set a level too high we are trying to balance the incentives here

Rosenwald - isn't there an incentive for the state to lean on the MCOS to underspend how do we protect the enrollees that the right level is set

Lipman - federally it is set at 85% if you look it is in consultation with the actuarial So it is at the right level so there is not an incentive to set at a low level

Kurk - as I understand this the state itself doesn't benefit from any money that goes into the pot the remainder amount means the Insurance pays less or more so the state doesn't benefit if we

didn't have this any result of underspending result to the benefit of the MCS the extra goes to their bottom lines

Lipman - wi

Lipman - page 5 line 8, 9 13 & 14 discussion about the level of rule making review Comm trying to balancing the rules getting done

Byron - lines 8,9, 13 & 14 proposal to use Joint aHealth care reform healthcare comm
Go back to line 5

Lipman - Commissioner trying to be more precise to community engagement and to refusing comply is existing law

Kurk - unless they receive approval but don't need approval of either I of the other two committees but has to go thru JLCAR could you explain the political or policy to include fiscal and HHS committee

Lipman - would like to come back with that

Byron - my understanding from prior bills where we had legislative committees approve change before there was a conflict issues can you describe

LBA - requiring leg committee to approve is a separation of powers problem JLCAR is a separate issue

Lipman - page 5 line 31 - sometimes is not temporary and require an annual certification

Rosenwald - Joint Healthcare reform legislation over are committee has only authors to review rules

Danielson - not sure but there is legislation now affecting that Committee and what it can do legislatively

Kurk - I think I misread this language 8-10 is not approval of rules but ability of Commissioner to initiate rule-making- only requires admission of rule making and the process would be he goes to ask hat he wants to initiate rules

Byron - your point is it just initiates there is no approval

Lipman - page 6 line 7 takes the age to under 6 the Commissioner's concern is leaving a child alone at night if someone has to work at night

Rosenwald - I have some language on this it is not an amendment but is language that could be an amendmentl

Byron - Mr Ripple is you could distribute

Rosenwald - my intention is to come to some consensus to deal with the fact that children are not at school all summer long and at night and weekend

Kurk - could you share with us what childcare funding is available for people who are subject to the work requirement what kind of money and availability

Lyn Wilder - DHHS - acting Bureau Chief Family Assistance - the child care scholarship program - child care development funds for low income families come into state fed Prog 18. Million and TANF dollars up to 30% we transferred 10million = 40, million available for individuals for working, going to school looking for work - if below 138% of poverty - up to 220% of poverty level - th e lower the income the higher amount families can get

Kurk - how many people are covered by this and how many would be eligible for expanded Medicaid are we coving the same number or just in different bucket

Wilder - low income population with work requirement eligible thru age 13 can be increasing this service

Kurk. - Why

Wilder - with med - ex and work requirement

Kurk - so how do we put a cost to Rosenwald amendment

Wilder - would have to get back to you

Hennessey - looking at TANF spend on child care fund we doubled in last biennium do you know currently what our spend looks like

Wilder - I could work with our financial people

Hennessey - what has been charged against this account

Wilder - we would have to bring our fiscal folks here to answer these questions

Byron - we are getting to the point where next week doesn't exist I have A next week I have to take a vote by Tuesday

Wallner - I don't think that Rosenwald amendment will requires more spending her version says that tif eligible and the state has the scholarship there is no difference in the use of the scholarship those families would have been eligible in the original bill this doesn't increase the number of families eligible know

Rosenwald - it would save money to the extent if someone couldn't find a child care provided they wouldn't work

Wallner - I think we need to find the potential number of children is with this work requirement is would need child care is someone has given us that I have not seen it and we also don't know in the breakdown what the pot of money is we have for child care

Wallner - if you go to the dashboard you can see the number of children receiving child care scholarship monthly

Hennessey - I agree with Wallner the Byron amendment they do have access to child care but the Rosenwald doesn't incessant childcare spending it may decrease because it exempts them if they can't get childcare

Byron - Rosenwald you handed out proposal can you clarify

Rosenwald - implicit is I think is a shared assumption and believe that yon get children are not safe left him alone at 24 hours a week but when they each age 6 they go to school but not all activity can take place drug in school hors - our goal is to encourage parents to get a job or pursue education that will get them out of poverty none of use would leave children at hoe alone my goal is to strike a middle ground - if we have a lot of families whose parents are divorced but child lives with both parents but both. Are required to meet an exemption but if there are two parents in the house and one has a Disability and cannot care for the child we need to exempt that family and it should not be six and twelve but rather seven and twelve

Wallner - the way the bill came to us excepting families to children under 13 prolly would ot have added children eligible but by reducing the age of the exemption we were adding children to the number we would have to add to the scholarship

Rosenwald - children that are families eligible thru age 12 this age was carefully considered by the senate

Danielson - at what point do we stop doing options we have parents then parents sedated and the. Parents not marrieds - to what end do we go is there a step parent involved

Rosenwald - I'm only looking at it from the safety of he minor child

Danielson - I used to teach marketing and I use to look at how it evolved and the question is would you agree - would you expect between 6 and 4 years olds the parent is working part-time I think that is how we look at this age group

Rosenwald - my background is in marketing also and I didn't understand the question

Danielson - one group under. And another is under 14 the parent is working part-time at this point - don't those groups make sense as we look at this argument

Rosenwald - we do know at least half of this group is working but many are extremely low income we can think about if someone at 13 is left alone for a long period of time you can get married at 13 and you can certainly get pregnant I don't know if you want to get supervised

Byron - recess until 11:10

Byron called the work session back Into order at 11: 15am

Lipman - page 7 line 9 this is the comment with respect with the waiver shall be consistent with all the terms of this chapter

AByron - will cause multiple issues with CMS - he was concerned that people will make mischief with this then he felt the program would have to shut down here he says it will cause multiple issues with CMS

Lipman - the acid test isn't allowed under federal terms that would be a problem

Byron - the legislature needs to lay out what it's expectation re with the work requirment and it is incumbent for the DHHS to lay out weahter CMS allows that or not but it is our expectation that DHHS will seek them if we can't get them then we will go from there but are you saying the DHHS will not submit

Lipman - we will provide them with the legislation and in terms of having been in the role and having gone they the waiver process as many times if it doesn't mirror in terms of the legislation in terms that CMS can't grant if we know that they can't grant it we will submit but that shouldn't end the program

Byron - if the legislature is saying this is what we want it is incumbent for DHHS to ask for it

Rosenwald - trying to understand the timing in terms of waivers we have received in the past we would have to notify 6 months in advance if this went into effect in June and CMS then looked at it and said in the fall we would give you a waiver in said you have to change this what happens Jan 1

Lipman - then have to upend on something CMS wouldn't' approve

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Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 16, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 1:33**

Time Adjourned: 3:25

(please circle if present)

Committee Members: **Nordgren, Rosenwald, Wallner, Renzullo, Bates, Danielson, Kurk, Hennessey and Byron**

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

Mr. Ripple Amendment #2018-1532h

Henry Lipman
Lynn Wilder
Senator Bradley
Commissioner Meyers

Respectfully Submitted,

Rep Marjorie K. Smith
Clerk, Division II

4/16/18 File

Rep. Byron, Hills. 20
April 16, 2018
2018-1532h
01/03

Amendment to SB 313-FN

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, minus the following:

(a) The amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) All federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs related to the program;

(c) Any surplus funds generated as a result of the managed care organizations managing the cost of their services below the medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter; and

(d) Taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver

of the requirement to provide 90-day retroactive coverage and a waiver allowing state and county correctional facilities to conduct presumptive eligibility determinations for inmates. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all pre-existing authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. The commissioner shall also include in the

MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance. Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

(3) The commissioner shall establish for the managed care program beginning on July 1, 2019 and thereafter a medical loss ratio that is actuarially sound and that encourages cost efficiency in the delivery of care to the entire Medicaid population. Any surplus funds generated from the MCOs managing the cost of their services below the established medical loss ratio for the beneficiaries of the program shall be transferred to the fund and shall be included in the calculation of the remainder amount.

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g).

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment including by nonprofit organizations.

(2) Subsidized private sector employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph refuses to

engage in work or community engagement activities required in accordance with this subparagraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. Rules proposed under this subparagraph shall be submitted to the oversight committee on health and human services, established in RSA 126-A:13, the joint health care reform oversight committee, established in RSA 420-N:3, and the fiscal committee of the general court, each of which may review the rules prior to adoption and make recommendations to the commissioner regarding the rules. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.

(c) This subparagraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i).

(d) This subparagraph shall not apply to:

(1) A person who is temporarily unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A parent or caretaker of a dependent child under 6 years of age or a child with

developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker.

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Rules proposed under this paragraph shall be submitted to the oversight committee on health and human services, the joint health care reform oversight committee, and the fiscal committee of the general court, each of which may review the rules prior to adoption and make recommendations to the commissioner regarding the rules. The rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

(7) Annual certification of medical frailty pursuant to 42 C.F.R. section 440.315(f), including proof and duration of such condition on a form supplied by the department.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any

waiver approved by CMS. The waiver shall be consistent with all the terms of this chapter. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management. The MCOs shall work collaboratively with the department and any outside contractor in encouraging and monitoring work and community engagement activities.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity

to cure and for re-activation following noncompliance. Rules proposed under this paragraph shall be submitted to the oversight committee on health and human services, the joint health care reform oversight committee, and the fiscal committee of the general court, each of which may review the rules prior to adoption and make recommendations to the commissioner regarding the rules.

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, and to pay for the administrative costs for the program. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to MCOs. No state general funds shall be deposited into the fund. Deposits into the fund shall be limited exclusively to the following:

(a) Revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) Federal Medicaid reimbursement for program costs and administrative costs attributable to the program;

(c) Surplus funds generated as a result of MCOs managing the cost of their services below the medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter;

(d) Taxes attributable to premiums written for medical and other medical related services for the newly-eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b); and

(e) Gifts, grants, and donations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30,

2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before January 15, 2020, the commissioner shall calculate the actual remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before January 15 of each subsequent year, the commissioner shall calculate the actual remainder amount for the prior fiscal year. If the actual remainder amount is lower than the prior calculated estimated remainder amount for any fiscal year, the difference shall be retained in the fund and the next estimated remainder amount calculated by the commissioner shall be reduced by the amount of the difference.

VI. The commissioner, in accordance with the most current available information, shall be responsible for determining, every 3 months commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next 6-month period. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS. Upon making a determination that a projected shortfall exists, the commissioner shall:

(a) Within 48 hours of making the determination, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the fiscal committee of the general court of the program's pending termination; and

(b) Within 5 business days of making the determination, notify program participants of the program's pending termination.

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated

report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF) program to end the dependence of needy parents and low income childless adults ages 18 through 24 on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be provided to eligible participants through Granite Workforce. The total cost of the pilot program shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) Parents aged 18 through 64 with a child under age 18 in the household; or

(c) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(d) Childless adults between 18 and less than 25 years of age.

III. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

IV. Participants in the Granite Workforce program who are not already enrolled in the New Hampshire granite advantage health care program established in RSA 126-AA, shall enroll in the New Hampshire granite advantage health care program within 10 days of receiving employment

through participation in the Granite Workforce program. The individual shall be responsible for furnishing proof of enrollment to the department of employment security.

V. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program, adopted under RSA 541-A as chapter He-W 600, shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. After 3 months of the employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's salary for the prior month, not to exceed $2,000.

II. After 9 months of the continued employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's salary for the prior month, not to exceed $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications (RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence. Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire;

(b) Referring individuals to the department of business and economic affairs to utilize

available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures. Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Termination of Granite Workforce Program.

I. The commissioner of the department of health and human services shall be responsible for determining, every 3 months commencing no later than December 31, 2018, whether available TANF reserve funds total at least $40,000,000. If at any time the commissioner determines that available TANF reserve funds have fallen below $40,000,000, the commissioners of the departments of health and human services and employment security shall, within 20 business days of such determination, terminate the Granite Workforce program. The commissioners shall notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of the legislative fiscal committee, and Granite Workforce participants of the program's pending termination.

II. If at any time the New Hampshire granite advantage health care program, established under RSA 126-AA, terminates, the commissioners of the departments of health and human services and employment security shall terminate the Granite Workforce program. The date of the Granite Workforce program's termination shall align with that of the New Hampshire granite advantage health care program.

10 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] ***126-AA*** shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3.*** The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration***

of the New Hampshire granite advantage health care program, established in RSA 126-AA.

11 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5 e, I(b), less the amount made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5 b~~] *the lesser of the remainder amount, as defined in RSA 126-AA:1, V, or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV and taxes attributable to premiums written for medical and other medical-related services for the newly eligible Medicaid population, as defined in RSA 126-AA:1, V. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.*

12 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016,13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under [~~RSA 126-A:5, XXIV-XXV between July 1, 2014 – December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] *RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby* repealed 180 days after the event under this [~~subparagraph~~] *paragraph* occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services *and consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program.* The commissioner shall [~~immediately issue notice to program participants of the program's pending repeal~~]*:*

(a) Within 48 hours after the event under this paragraph has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the legislative fiscal committee of the program's pending termination; and

(b) Within 5 business days after the event in this paragraph has occurred, notify program participants of the program's pending termination.

13 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.4~~] *Five* percent of the previous fiscal year gross profits derived by the commission

from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

14 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding alcohol education and abuse prevention and treatment programs. *The commissioner of the department of health and human services may accept gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund.* The state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys *received from all other sources other than the liquor commission pursuant to RSA 176:16, III* shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3; *provided, however, that funds received from any source other than the liquor commission, pursuant to RSA 176:16, III, shall not be used to support the New Hampshire granite advantage health care program and shall not be deposited into the fund established in RSA 126-AA:3.*

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse

and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

15 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program established in RSA 126-AA.*

16 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] *126-AA*, and the federally qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

17 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program under RSA 126-AA* in which case all provisions of this chapter shall apply.

18 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and

human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the ~~[marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII]~~ ***New Hampshire granite advantage health care program under RSA 126-AA.*** If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

19 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

20 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

21 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the date of certification by the commissioner of the department of health and human services to the director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

22 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d (y)(1) to eliminate the state's share of funding for the New Hampshire granite advantage health care program, or if the federal government allows the use of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

23 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health

protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

24 Effective Date.

I. Paragraph II of section 23 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 23 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 20 of this act.

V. Section 3-9 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 11, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 2:05**

Time Adjourned: 2:41

(please circle if present)

Committee Members: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Chairman Byron opened the session at 2:05 pm

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Myers -we have not been allowed to verify if they are working we can't ask certain questions with respect to if they are working and what their income is - just the modified adjusted income
It is not zero it is less than one percent

Kurk - that is one percent of 138% poverty - do we have any demographic information about these people

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Recess at 2:41pm until Monday April 16 at 1pm

Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: (New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

DATE: April 11, 2018

ROOM: 210-211 Time Work Session Called to Order: 2:05pm

Time Adjourned: 2:41pm

(please circle if present)

Committee Members: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers

Bill Sponsors:

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TESTIMONY

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Jeff Mayes - CCM. DHHS

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SB 313 Work SessionFinance Div III

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Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 10, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 1:00**

Time Adjourned: 2:39

(please circle if present)

Committee Members: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers

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TESTIMONY

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Lyn Wilder - DHHS - Div of Family Assistance TANF Program - How it intersect with Medicaid bill look at section on Granite work force using TANF funds in order to fund this piece they have flexibility in how used for work programs ability to use for parents in legislation provides work program to provide them to enter work program and fill work requirements of program

Jeff Myers - DHHS - connection btw Medicaid and Granite Workforce discussed by expansion commission and focused on is reflected in the bill is a pilot program for 6 month program with idea we look at in the next budget it currently 3 million appropriated for this program for the population under 138% of the federal poverty level tie to the population subject tow the work requirement want to see how we can eliminate barriers like transportation there are funds for employer subsidy there is an expectation that some money will be used for some training like certificate training - the money will not be used for child care scholarships because there is already an established program that we are already using TANF funds to support. This 3 million pool would fund other types of barrier reductions. This language was approved by the House initially proposed by Gov Hassan and we took that as a based and tweaked only slightly. I fully expect there will be a conversation in the next budget with the Gov and the legislature.

Byron - page 11 lies 8-12 lays out who is eligible applicant of the program a parent 18-64 with a child under 18 in the HH and non-custodial so someone childless cannot participate why would you do it this way

Wilder - it connects back to the four goals of TANF and how we can spend our money - and it is to be spent on families it relates to how we can spend our money

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Byron - what if we changed to another percentage

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Byron - 138 is how it is scoped for the Medicaid where there is need in other areas as well would the other TANF areas that will capture those people

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Byron - to be eligible you have to been 138 level
Child under 18 and wondering do we add an or

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Wallner - estimate of how many will participate in the workforce program

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Meets about another 12000 eligible non-custodial

Myers - 3 million do we think we can help with that the answer Over the 6 month period is probably in the low hundreds
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Byron - subsidies for employers - Page 10 line 11

Richard Lavers- Dep Com Dept Employment Security - thru conversations with employers in state they don't like on boarding they like retaining you we are trying to address one of the two risk an employers has with this type of employee one is lack of skills we will get you that training the other risk is the lack of experience that is why a subsidized employment program will work now. The timing is perfect because these folks right now because of how our labor force is and these folks will not be competing within that industry with other folks to get themselves in the door theoretically they won;t have to compete with those experienced folks right now.

Byron - in the first slice of money you are giving 2,000 so day 1 the employer gets 2,000 if you are looking the employee is going to stay shouldn't you move that reward out about three months most I've worked for have had a 6 months' probation any period

Lavers - I am not disagreeing with that by offering that first payment when you come in and touching that expensive equipment we are addressing that high level of risk

Byron - day one there is no risk to the company you are probably in employee orientation

Lavers - we are trying to address the risk and incentivize the risk from day 1

Byron - should we choose a % of the salary so why did you choose 2000?

Myers - isn't the company taking some kind of risk by taking the person on with no skills on day one so this is an incentive.

Byron - counter arguments is that company is trying to put in.

Kurk - this program is connected to a bill that deals with the expansion explosion

Myers - limited to those 138% of poverty

Wilder - giver the 3 million

Nordgren - I'm excited that Kurk is now worried people are going to lose their health insurance - is their a model for this

Myers - there are states that have Medicaid expansion and some have just gotten work requirements Kentucky, Indiana and Arkansas that are using TANF funds for barrier reduction we are not the first state to do this

Kurk - have you looked into the idea of privatizing this?

Lavers - if the population was just in need of a referral that might work instead of a wraparound services that they need that are more intensive than that

Kurk - and how do you know this have you served an expansion population?

Lavers - that scenario might work for a segment of the population and we will know more as folks are coming in the door we will know more after we can implement the pilot

Kurk - if Myers lost his job and employer told he would get 200,000 dollars they will jump at it you guys are the experts and I am just here to deal with the legal and legislative issues

Hennessey's - do you have a question

Kurk - I guess I don't

Danielson - have we lost our focus with the questioning we are going thru aren't we supposed to be looking at the cost of health care what we are trying to do is reduce the cost of health care - when we look at employment I don't know if we can employ these people I am asking how can we get this conversation back on line with the cost of health care am I offline about the way our court of discussion has gone this afternoon

Lavers - we see this if this program is passed as a great short term answers to our workforce needs thru - out the state employers want to find workers now and by reaching out to a population of individuals now if would be a shorter M solution we hope it would help

Myers - the discussion is a fair discussion I am not critical of any discussion at all this is a program that has been approved by the House of Representatives the point of all this is to try to connect them

Hennessey - have you thought of using a Skye type feature to reduce the barrier

Lavers - we do have video conference within our offices state wide and not make them incur the travel

Hennessey any other questions for this group

Kurk - would you come up with language that deals with the transition problem to deal with those transitioning to those from this to TANF so folks don't lose their eligibility if the need employers doesn't have insurance - we can't set up that situation that doesn't mean I want to keep people on expanded Medicaid any longer than possible

Rosenwald - people that get a job and they lose eligibility for the Medicaid expansion doesn't page 2 line 8 address that

Myers- helping them apply yes

Kurk - maybe that would help if we understood what the cost would be to transition

Rosenwald - isn't there a smoother transition for people up to 200% that are eligible

Jennifer Patterson - NH Insurance Dept - yes it is true that a person whose income rose above the 138% that went to the exchange they would go to the plan with increased cost sharing up to 200% cost sharing

Kurk - how much does it cost

Patterson - calculated by the exchange and is held constant if your income held to 200% of poverty it would be help constant

Kurk - could you provide a chart, what is the state; Scott for a person who is on the exchange's transitioning off the expansion

Patterson - those are federal tax credits

Kurk - so there is no cost to the state so there is an economic advantage to the state

Patterson - yes

Byron - issue with the prisons one of the things on page one of the bill you shall apply for waivers the DOC commissioner talked about the 90 day look back when they come in there is a determination of eligibility there is a point beyond that that they are covered by the program we were told that requires a waiver be filed with CMS

Myers - we also Ned a state plan amendment - The DOC in NH would take presumptive eligibility applies to the very narrow provision of those eligible if they require treatment in 24 hours we will follow up with CMS we would seek to have DOC do presumptive eligibility so we can capture that reimbursement.

Byron - should we write an amendment stating that in the 21-29 page one of as a separate section

Myers - we only need a state plan amendment - we will go forward and do it regardless if in the Bill or not but can do it of you want

Byron - we also have functionality as county - does that cover our county governments or only state governments

Henry Lipman - Medicaid Director - also includes county government

Myers - we have memos of understanding now for Medicaid enrollment I am happy to put in the state plan amendment that counties the counties will have to work with us but I do not want to be their staff.

Byron - I want to make sure I get the wording correct

Myers - we can get you some language

Byron - Mr Ripple if you can show on your cheat sheet that we are going to amend for

Myers - presumptive eligibility for DOC and counties

Byron - do you want something commissioner regarding an MOU

Myers - no

Kurk - did we get an answer how they decided on 200,000

Byron - no designed from the perspective that it would be a meaningful amount for an employer

Hennessey - don't remember if Ripple or DHHS was going to prepare TANF balance

Ripple - asked in relation of this and another bill so I don't have the numbers going out
590 and 592

Myers - the question is the use of TANF and working out- remember it is not a static number it builds every month

Byron - I would like to continue the work session to April 11 at 1pm. Recessed at 2:39PM

Respectfully Submitted,

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HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

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DATE: **April 10, 2018**

ROOM: **210-211** **Time Work Session Called to Order:** 1:01pm

Time Adjourned: 2:39pm

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Lyn Wilder - DHHS - Div of Family Asst - TANF Program

SB 313 Finance Work Session Finance Div III

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Byron - in the first slice of money you are giving 2,000 so day 1 the employer gets 2,000 if you are looking the employee is going to stay shouldn't you move that reward out about three moths most I've worked for have had a 6 months probation ay period

Lavers - I am not disagreeing with that by offering that first payment when you come in and touching that expensive equipment we are addressing that high level of risk

Byron - day one there is no risk to the company you are probably in employee orientation

Lavers - we are trying to address the risk and incentivize the risk from day 1

Byron - should we choose a % of the salary so why did you choose 2000

Myers - isn't the company taking some kind of risk by taking the person on with no skills on day one so this is an incentive.

Byron - counter arguments is that company is trying to put in.

Kurk - this program is connected to a bill that deals with the expansion explosion

Myers - limited to those 138% of poverty

Wilder - giver the 3 million

Nordgren - I'm excited that Kurk is now worried people are going to lose their health insurance - is their a model for this

Myers - there are states that have Medicaid expansion and some have just gotten work requirements Kentucky, Indiana and Arkansas that are using TANF funds for barrier reduction we are not the first state to do this

Kurk - have you looked into the idea of privatizing this

Lavers - if the population was just in need of a referral that might work instead of a wrap around services that they need that are more intensive than that

Kurk - and how do you know this have you served an expansion population

Lavers - that scenario might work for a segment of the population and we will know more as folks are coming in the door we will know more after we can implementing the pilot

Kurk - if Myers lost his job and employer told he would get 200,000 dollars they will jump at it you guys are the experts and I am just here to deal with the legal and legislative issues

Hennessey's - do you have a question

Kurk - I guess I don't

Danielson - have we lost our focus with the questioning we are going thru aren't we supposed to be looking at the cost of health care what we are trying to do is reduce the cost of health care - when we look at employment I don't know if we can employ these people I am asking how can we get this conversation back on line with the cost of health care am I offline about the way our court of discussion has gone this afternoon

Lavers - we see this if this program is passed as a great short term answers to our workforce needs thru - out the state employers want to find workers now and by reaching out to a population of individuals now if would be a shorter M solution we hope it would help

Myers - the discussion is a fair discussion I am not critical of any discussion at all this is a program that has been approved by the House of Representatives the point of all this is to try to connect them

Hennessey - have you thought of using a Skye type feature to reduce the barrier

Lavers - we do have video conference within our offices state wide and not make them incur the travel

Hennessey any other questions for this group

Kurk - would you come up with language that deals with the transition problem to deal with those transitioning to those from this to TANF so folks don't lose their eligibility if the need employers doesn't have insurance - we can't set up that situation that doesn't mean I want to keep people on expanded Medicaid any longer than possible

Rosenwald - people that get a job and they lose eligibility for the Medicaid expansion doesn't page 2 line 8 address that

Myers- helping them apply yes

Kurk - maybe that would help if we understood what the cost would be to transition

Rosenwald - isn't there a smoother transition for people up to 200% that are eligible

Jennifer Patterson - NH Insurance Dept - yes it is true that a person whose income rose above the 138% that went to the exchange they would go to the plan with increased cost sharing up to 200% cost sharing

Kurk - how much does it cost

Patterson - calculated by the exchange and is held constant if your income held to 200% of poverty it would be help constant

Kurk - could you provide a chart, what is the state;Scott for a person who is on the exchange's transitioning off the expansion

Patterson - those are federal tax credits

Kurk - so there is no cost to the state so there is an economic advantage to the state

Patterson - yes

Byron - issue with the prisons one of the things on page one of the bill you shall apply for waivers the DOC commissioner talked about the 90 day look back when they come in there is a determination of eligibility there is a point beyond that that they are covered by the program we were told that requires a waiver be filed with CMS

Myers - we also Ned a state plan amendment - The DOC in NH would take presumptive eligibility applies to the very narrow provision of those eligible if they require treatment in 24 hours we will follow up with CMS we would seek to have DOC do presumptive eligibility so we can capture that reimbursement.

Byron - should we write an amendment stating that in the 21-29 page one of as a separate section

Myers - we only need a state plan amendment - we will go forward and do it regardless if in theBIll or not but can do it of you want

Byron - we also have a functionality as county - does that cover our county governments or only state governments

Henry Lipman - Medicaid Director - also includes county government

Myers - we have memos of understanding now for Medicaid enrollment I am happy to put in the state plan amendment that counties the counties will have to work with us but I do not want to be their staff.

Byron - I want to make sure I get the wording correct

Myers - we can get you some language

Byron - Mr Ripple if you can show on your cheat sheet that we are going to amend for

Myers - presumptive eligibility for DOC and counties

Byron - do you want something commissioner regarding an MOU

Myers - no

Kurk - did we get a answer how they decided on 200,ooo

Byron - no designed from the perspective that it would be a meaningful amount for an employer

Hennessey - don't remember if Ripple or DHHS was going to prepare TANF balance

Ripple - asked in relation of this and another bill so I don't have the numbers going out 590 and 592

Myers - the question is the use of TANF and working out- remember it is not a static number it builds every month

Byron - I would like to continue the work session to April 11 at 1pm. Recessed at 2:39PM

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 9, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 1:46**

Time Adjourned: 3:08

(please circle if present)

Committee Members: **Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren and Rogers**

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

Chairman Byron called the committee to order at 1:07pm and recessed until 1:45 pm

Chairman Byron reopened the committee at 1:46pm

Commissioner AHelen Hanks Dept of Corrections - fortunate partner in the Medicaid paid to the tune of 2 million in the past two years seek the waiver of the 90 day process when we get a Medicaid number send it back to the hospital and they bill directly. I defer to Henry Lipman to respond to deeper questions. MD sought a state plan amendment that was approved to was a pro-active approach when enter hospital begin process then with a state plan amendment this effects any county Facility

Byron - you asked we defer to Mr Lipman do you know if somebody comes in and they are presumptively signed up for medicaid is that reversed back to prison system

J+Hanks - if we don't use the retroactive it would be General funded

Byron - my understanding is anyone can be classified that anyone can be presumptively funded by Medicaid question is dealing with happens if going thru the eligibility they find they are not eligible what are the implications

DOC - same as today I'd not presumptively eligible the state would pay the claim and prisons have a special provision under the ACA so unlike public who has look back period that is not available for prisoners

Byron - so presumptive doesn't work for prisoners

DOC - that is where 2 million impact is coming for

Byron. What is difference but pubic and prison owner walking into Hospital

DOC under current state if you came to Hospital and presumptively eligible there is a look back period they could go back and bill prior visits as Medicaid not true if a resident of a prison owner and technically not just an overnight that could be an overnight must be an in patient

DOC - if health and Human Services seeks the state plan Amendment and get the same amount of money as our general fund

Byron - in a general year how much money do you have to allocate for your in mate population

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If they are a qualified immigrant a green card holder after 5 years they are qualified for the program.

Byron - how about someone who has entered the country illegally

Lipman - illegally does not qualify for the program

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Lipman - Prisoners only have in state coverage

Kurk - so we can eliminate the 90 day look back coverage and still have our Prisoners covered

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Kurk - what happens then -

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Kurk - if Sept 1 someone determines we only have som much left in the alcohol fund and we know the remainder amount is 13 and we know we will be 4 million short what happens

Lipman - I think there are a few places where this is addressed we are required to provide quarterly under the bill calculations we are required to do a periodic update and where we do that assessment on page 7 starting on line 31-32 on 34-35 and onto the top of page 8

Kurk - we will have to deal with the word immediately lines 10-12 to make that more explicit - if we are 2 million short and the Commissioner goes back and reduces the 2,6 million and reduces it to 2 million and there is no problem is that correct

Lipman- it wouldn't play out like that what I was trying to suggest is that a particular line item could under or over perform there could be a number of other factors where it could be ok or not ok you are dealing with a lot of moving pieces all the time. The alcohol fund amount is abased on a report a year ahead and the premium report comes in in March of the calendar year and has been predicted for a long time but we don't know every month what the insurance tax is going to be for an example.

Sen Bradley. The scenario Kurk talked about if you dropped the overall cost it is still at the 90/10 ratio

Kurk - there are a number of factors that guarantee this program will not end with a shortfall in the remainder amount

Bradley - the language says that if at any time the commissioner determines a shortfall exists he will start the wind down begins

Kurk - depending on who the commissioners is they will make a decision

Bradley's no matter who the commissioner is they would have to follow the law

Danielson - is anybody keeping tabs on how much everyone is going to get from the alcohol fund everybody seems to be typing into the alcohol fund

Byron - that is going to depend on how much sales occur if the state sells more liquor there will be more going into it

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Kurk - and that took into account the higher needs of the additional population

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Kurk - it is my understanding that these folks are going to be paid for per actuaries and MCOS will eat that extra costs and cover in futures years contracts

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Byron - is there going to be rule-making and where is it authorized

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Commission Myers - funds coming out of Alcohol funds out of 18 aCAPH takes time so in order to jum start takes out of 17 CAPHR percentage will be calculated out of that

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Kurk - let's assume that you do as you describe but the numbers are coming in very high since the two fixed knows the also hold money and the insurance premium don't change and the costs are coming in higher and we have a shortfall and we are not going to make the time line and you know two of the revenue sources are already known and the question is weather or not we are going to collect from the high risk pool to cover the difference I am trying to see if the program can ever be terminated

Myers - what if the alcohol revenue is cut in half

Kurk - it doesn't matter

Myers - could there ever be an issues because two of the amounts are fixed we don;t see it without unanticipated changes in the marketplace

Kurk - I will talk to you later

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Myers - I have had discussions with our actuary and the community this says the rates have to have access so at the end of the day they have to be actuarial S sound and they Need to be sufficient. Before the date in the rate refresh we would have to bring to G & C a rate-refresh

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Myers - we have to refresh our rates on a fiscal year basis the federal Gov allows rates to be put into effect for only a 12 month period I don't yet have more information about what that rate will look like

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Danielson - specific indoor my town how many on Medicaid on my town

Recess at 3;08 until Tuesday April 10 @ 1pm

Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

SB 313 Work Session

April 9, 2018

Reforming NH's Medicaid and Premium Assistance Program establishing the granite workforce pilot program, and relative to certain liquor funds.

Present: Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rogers

Absent: Rosenwald

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Recess at 3;08 until Tuesday April 10 @ 1pm

Work Session Minutes

HOUSE COMMITTEE ON Finance

DIVISION II WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: **April 6, 2018**

ROOM: **210-211** **Time Work Session Called to Order: 1:30**

Time Adjourned:

(please circle if present)

Committee Members: **Umberger, Weyler, Allen, Kurk, Theberge, Eaton, M. Smith and Buco**

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

*Kevin Ripple handed out updated version of SB313-FN as passed by the House on 4/5/18 as well as the "NH Health Protection Program Demographic Profile 12/1/18", HB 2-FN-A/SB313 side by side comparison of the Granite Workforce, and the HB 517 (2017) House passed SB313 side by side comparison of the work requirements.
Discussion of SB313
Mr. Ripple believes the remainder amount as defined on page 1, line 11 and on page 14, line 4 needs clarification.
Recessed until 1:30 pm 4/6/18 LOB 210
Resumed Work Session @ 1:36pm
Senator Bradley
Commissioner Meyers, DHHS
Kristy Merrill-Bradley's Chief of Staff
Sen Bradley walked the Committee through the bill.
Commissioner Meyers noted eliminating any of the work requirements may result in CMS not approving.
Henry Lippman-Medicaid Director, DHHS also spoke
Kevin Ripple will get Green card holder eligibility for Medicaid expansion.
Comm. Meyers noted that the State already used the maximum amount of TANF funds eligible for childcare and thus the new wording on pg. 11, lines 37-38 and pg. 12, lines 1-5.
Comm. Meyers will walk the Div. through numbers relocated to lines 4-10 on pg. 14 on Monday, April 9th.
Recessed work session until Monday, April 9th at 1:00pm in LOB 210.

Respectfully Submitted,

Rep Katherine D. Rogers
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SB 313

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Comm. Meyers noted that the State already used the maximum amount of TANF funds eligible for childcare and thus the new wording on pg. 11, lines 37-38 and pg. 12, lines 1-5.

Comm. Meyers will walk the Div. through numbers relocated to lines 4-10 on pg. 14 on Monday, April 9th.

Recessed work session until Monday, April 9th at 1:00pm in LOB 210.

Respectfully Submitted,

Rep Katherine D. Rogers
Clerk, Division III

SB 313-FN - AS AMENDED BY THE HOUSE

03/08/2018 0984s
03/08/2018 1022s
5Apr2018... 1282h

2018 SESSION

18-2956
01/03

SENATE BILL ***313-FN***

AN ACT reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

SPONSORS: Sen. Bradley, Dist 3; Sen. Morse, Dist 22; Rep. S. Schmidt, Carr. 6; Rep. Umberger, Carr. 2; Rep. Danielson, Hills. 7; Rep. Kotowski, Merr. 24

COMMITTEE: Finance

AMENDED ANALYSIS

This bill:

I. Establishes the New Hampshire granite advantage health care program which shall replace the current New Hampshire health protection program. Under this program, those individuals eligible to receive benefits under the Medicaid program and newly eligible adults shall choose coverage offered by one of the managed care organizations contracted as vendors under the Medicaid program.

II. Establishes the granite workforce pilot program.

III. Increases the amount of liquor revenues to be deposited into the alcohol abuse prevention and treatment fund and provides that moneys deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund for substance use disorder prevention, treatment, and recovery.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03/08/2018 0984s
03/08/2018 1022s
5Apr2018... 1282h

18-2956
01/03

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eighteen

AN ACT reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, less the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV, less all federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs attributable to the program, and taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver of the requirement to provide 90-day retroactive coverage. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a

cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all pre-existing authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. The commissioner shall also include in the MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance. Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g).

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month, or an average of 600 hours over 6 months, based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment, including self-employment, including by nonprofit organizations.

(2) Subsidized private sector employment, including self-employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph refuses to engage in work or community engagement activities required in accordance with this subparagraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as

determined by the commissioner pursuant to rulemaking under RSA 541-A.

(c) This subparagraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i). In this subparagraph, "childless" means an adult who does not live with a dependent child which includes a child under 19 years of age or under 20 years of age if the child is a full-time student in a secondary school or the equivalent.

(d) This subparagraph shall not apply to:

(1) A person who is temporarily unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A parent or caretaker of a dependent child under 13 years of age or a child with developmental disabilities who is residing with the parent or caretaker.

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R section 440.315(f), and as defined in the alternative benefit plan in the state plan.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Those rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall

address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers.

The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity to cure and for re-activation following noncompliance.

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, and to pay for the administrative costs for the program. The commissioner may accept any gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund. No state general fund appropriations shall be deposited into the fund. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to managed care organizations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30, 2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before September 30, the commissioner shall calculate the estimated final remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before September 30 of each subsequent year, the commissioner shall calculate the estimated final remainder amount for the prior fiscal year. If the actual remainder amount is greater than the prior calculated estimated remainder for any fiscal year, the difference shall be retained in the trust fund and shall be used in the calculation of future estimated remainder amounts.

VI. The commissioner of the department of health and human services, in accordance with the most current available information, shall be responsible for determining, every 6 months commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next 6-month period. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS.

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on

Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the

commissioner concerning recommended monitoring and evaluation requirements for work and community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Ten members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report together with its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022.

126-AA:5 Evaluation Report Required.

I. The program shall employ an outcome-based evaluation of its Medicaid program annually to:

(a) Provide accountability to patients and the overall program.

(b) Ensure that patients are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care.

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

II. The results of the evaluation conducted under this section shall be in the form of a report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF) program to end the dependence of needy parents and low income childless adults ages 18 through 24 on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon

workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be provided to eligible participants through Granite Workforce. The total cost of the pilot program shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) Parents aged 18 through 64 with a child under age 18 in the household;

(c) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(d) Childless adults between 18 and less than 25 years of age.

III. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

IV. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program, adopted under RSA 541-A as chapter He-W 600, shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. Upon placement of a participant into a paying job and receiving verification of employment and wages from the employer, the department of employment security shall pay the employer a subsidy of $2,000.

II. After at least 3 full months of the continued employment of the participant and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a second subsidy of $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications (RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence. Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community

provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire;

(b) Referring individuals to the department of business and economic affairs to utilize available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New

Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures. Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] *126-AA* shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3.*** The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration of the New Hampshire granite advantage health care program, established in RSA 126-AA.***

10 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5-c, I(b), less the amount~~

~~made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5 b~~] ***the lesser of the remainder amount or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV and taxes attributable to premiums written for medical and other medical-related services for the newly eligible Medicaid population, as defined in RSA 126-AA:1, V. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.***

11 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016,13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under [~~RSA 126-A:5, XXIV-XXV between July 1, 2014 - December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] ***RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby*** repealed 180 days after the event under this [~~subparagraph~~] ***paragraph*** occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services. The commissioner shall immediately issue notice to program participants of the program's pending repeal ***consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program.***

12 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.4~~] ***Five*** percent of the previous fiscal year gross profits derived by the commission from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

13 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding

alcohol education and abuse prevention and treatment programs. ***The commissioner of the department of health and human services may accept gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund.*** The state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys ***received from all other sources other than the liquor commission pursuant to RSA 176:16, III*** shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3.

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

14 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program established in RSA 126-AA.***

15 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] ***126-AA***, and the

federally qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

16 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program under RSA 126-AA*** in which case all provisions of this chapter shall apply.

17 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII~~] ***New Hampshire granite advantage health care program under RSA 126-AA***. If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

18 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

19 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

20 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the date of certification by the commissioner of the department of health and human services to the

director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

21 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d (y)(1) to eliminate the state's share of funding for the New Hampshire granite advantage health care program, or if the federal government allows the use of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

22 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

23 Effective Date.

I. Paragraph II of section 22 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 22 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 20 of this act.

V. Section 3-8 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

LBAO
18-2956
Revised 1/25/18

SB 313-FN- FISCAL NOTE
AS INTRODUCED

AN ACT reforming New Hampshire's Medicaid and Premium Assistance Program.

FISCAL IMPACT: [X] State [ ] County [X] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Appropriation	$0	$0	$0	$0
Revenue	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Expenditures	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase	Indeterminable Increase
Funding Source:	[ ] General [ ] Education [ ] Highway [X] Other - Insurance premium tax, voluntary contributions, insurer assessment, federal funding.			

LOCAL:

Revenue	$0	$0	$0	$0
Expenditures	Indeterminable Decrease	Indeterminable Decrease	Indeterminable Decrease	Indeterminable Decrease

METHODOLOGY:

This bill creates a new chapter, RSA 126-AA, establishing the New Hampshire Granite Advantage Health Care Program (Granite Advantage Program), which will become effective on December 31, 2018 and replace the New Hampshire Health Protection Program (NHHPP), scheduled by law to terminate on that date. The Granite Advantage Program will differ from the NHHPP in that, rather than making coverage available by purchasing health plans certified for sale on the federally facilitated marketplace, it will offer coverage via Medicaid managed care organizations (MCO). As with the NHHPP, the Granite Advantage Program will make coverage available to individuals with incomes up to 138% of the federal poverty level.

The existing NHHPP is funded via: (1) federal funds, which as of January 1, 2018 cover 94% of program costs, declining to 90% on January 1, 2020, (2) insurance premium tax revenue attributable to premiums purchased under the NHHPP, and (3) other non-general fund revenue sources. These other non-general fund revenue sources consist of an assessment on insurers under RSA 404-G, as well as voluntary contributions accepted under RSA 126-A:5, d. This bill retains funding source (1), since federal funds will remain available regardless of delivery type, as well as funding source (2), since MCO coverage will remain subject to the state's insurance premium tax. The bill modifies funding source (3) by removing the requirement that a

"remainder amount" (i.e., costs remaining after funding sources (1) and (2) have been exhausted) be calculated and split evenly between the insurance assessment and voluntary contributions. While the bill allows for the possibility of using gifts, grants, and donations to fund the Granite Advantage Program, it does not specify that they be used to fund any particular share of program costs. Likewise, the bill allows for an insurer assessment under RSA 404-G, but, as noted by the Insurance Department, does not specify what level of financial support the assessment is expected to provide. Given this, it is unclear how remaining program costs will be funded if federal revenue and State Insurance Premium Tax Revenues are not sufficient. The bill does, however, make clear that State General Funds shall not be used to support the program.

The Department of Health and Human Services states that, due to limited detail about the design and operation of the Granite Advantage Program, it is unable to provide a detailed analysis of the bill's fiscal impact. For informational purposes, the Department's contracted actuary prepared a report in October 2017 on the cost effectiveness of an MCO model versus that of the existing model, and concluded reimbursement rates to providers would, on average, be lower under an MCO model, resulting in lower overall program costs. Using assumed expenditures of $378 million for the non-medically frail population served by the NHHPP in FY 2018, the analysis projected that expenditures for the same period under an MCO model would be approximately $167 million. Since the State's share of program costs in FY 2018 is 6% of the total, the actuary projected that State expenditures under the MCO model would be approximately $10 million versus $22.7 million under the existing NHHPP. These numbers do not include the cost of the medically frail population, which is currently served by MCOs and would continue to be served by MCOs under this bill. The report did not address such factors as the impact on uncompensated care claims, disproportionate share payments to hospitals, Medicaid Enhancement Tax revenue, or Insurance Premium Tax Revenue.

The Insurance Department projects that, once federal funding drops to 90% in calendar year 2020, federal funds plus Insurance Premium Tax Revenue will collectively fund 92% of program costs. The Department based this projection on an estimated enrollment of 46,000 and an estimated per member per month cost of $350, as well as assumed Insurance Premium Tax revenues attributable to the program of $2.6 million in FY20, $2.7 million in FY21, and $2.8 million in each of FY22 and FY23. The Department estimates that if the insurer assessment under RSA 404-G is expected to fully fund the remaining State share of program costs (which, as noted above, is not specified by the bill itself), the assessment will need to raise approximately $15 million per year. The assessment needed to raise this amount will be approximately $2.75 per member per month on the base of approximately 475,000 covered lives.

The New Hampshire Municipal Association assumes the bill will reduce expenditures by an indeterminable amount due to a decrease in costs for local welfare assistance.

The Department of Corrections is unable to determine the bill's fiscal impact.

The New Hampshire Association of Counties assumes the bill will have no impact on county finances.

AGENCIES CONTACTED:

Departments of Health and Human Services, Administrative Services, Corrections, and Revenue Administration, Insurance Department, New Hampshire Municipal Association, and New Hampshire Association of Counties

HOUSE COMMITTEE ON Finance

DIVISION III WORK SESSION ON SB 313-FN

BILL TITLE: **(New Title) reforming New Hampshire's Medicaid and Premium Assistance Program, establishing the granite workforce pilot program, and relative to certain liquor funds.**

DATE: April 6, 2018

ROOM: 210-211 Time Work Session Called to Order:

Time Adjourned:

(please circle if present)

Committee Members: **Byron, Hennessey, Kurk, Danielson, Bates, Renzullo, Wallner, Nordgren, Rosenwald and Rogers**

Bill Sponsors:

Sen. Bradley	**Sen. Morse**	**Rep. S. Schmidt**
Rep. Umberger	**Rep. Danielson**	**Rep. Kotowski**

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

SB313 4/6/18

Kevin Ripple handed out updated version of SB313-FN as Passed by the House on 4/5/18 as well as the "NH Health Protection Program Demographic Profile, 2/1/18", HB 2-FN-A/SB313 side by side comparison of the Granite workforce, and the HB 517(2017)/House Passed SB313 side by side comparison of the work requirements

Discussion of SB313

Mr. Ripple believes the Remainder amendment as defined on page 1, line 11 and on page 14, line 4 needs clarification

Recessed until 1:30pM 4/6/18 @ LOB 210
Resumed work session @ 1:36pm

Senator Bradley
Commissioner Meyers, DHHS
Kristy Merrill - Bradley's Chief of Staff

Sen Bradley walked the committee through the bill.

Commissioner Meyers noted eliminating

SB313 Cont.

~~Add~~ any of the work requirements may result in CMS not approving.

Henry Lippman - Medicaid Director, DHHS also spoke

Kevin Ripple will get Greencard holder eligibility for Medicaid expansion.

Comm. Meyers noted that the State already uses the maximum amount of TANF funds eligible for childcare and thus the new wording on pg 11, lines 37-38 and pg 12, lines 1-5.

Comm. Meyers will walk the DFW through numbers related to lines 4-10 on page 14 on Monday, April 9th.

Recessed work session until Monday, April 9th @ 1pm in LOB 210.

Amendments

Rep. Byron, Hills. 20
April 24, 2018
2018-1706h
01/03

Amendment to SB 313-FN

Amend RSA 126-AA:2, III(d)(4) as inserted by section 1 of the bill by replacing it with the following:

(4) A custodial parent or caretaker of a dependent child under 6 years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker in the case of a 2-parent household.

Rep. Wallner, Merr. 10
Rep. Rosenwald, Hills. 30
Rep. Nordgren, Graf. 12
Rep. Rogers, Merr. 28
April 24, 2018
2018-1730h
01/03

Draft Amendment to SB 313-FN

Amend RSA 126-AA:4, II(a) as inserted by section 1 of the bill by replacing it with the following:

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(11) Study the effects of the medical loss ratio on MCO rates.

Rep. Byron
SB 313 Draft Amendment
April 18, 2018

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, minus the following:

(a) The amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) All federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs related to the program;

(c) Any surplus funds generated as a result of the managed care organizations managing the cost of their services below the minimum medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter; and

(d) Taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver of the requirement to provide 90-day retroactive coverage and a state plan amendment allowing state and county correctional facilities to conduct presumptive eligibility determinations for incarcerated inmates to the extent provided under federal law. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of

the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all pre-existing authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. The commissioner shall also include in the MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance.

Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

(3) The commissioner shall establish for the managed care program beginning on July 1, 2019 and thereafter a minimum medical loss ratio that is actuarially sound and that encourages cost efficiency in the delivery of care to the entire Medicaid population. Any surplus funds generated from the MCOs managing the cost of their services below the established minimum medical loss ratio for the beneficiaries of the program shall be transferred to the fund and shall be included in the calculation of the remainder amount.

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g).

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual

resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment including by nonprofit organizations.

(2) Subsidized private sector employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph fails to comply with the work or community engagement activities required in accordance with this paragraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. Following approval by the joint health care reform oversight committee pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make

recommendations to the commissioner regarding the rules. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.

(c) This paragraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i).

(d) This paragraph shall not apply to:

(1) A person who is temporarily unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A parent or caretaker of a dependent child under 6 years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker. During the months of July and August, this exemption shall be expanded to include parents or caretakers of dependent children between the ages of 6 and 12, inclusive, provided that the exemption shall only apply to one parent or caretaker.

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights

laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Following approval by the joint health care reform oversight committee pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules. The rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

(7) Annual certification of medical frailty pursuant to 42 C.F.R. section 440.315(f), including proof and duration of such condition on a form supplied by the department.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. The waiver request submitted by the commissioner shall be consistent with all the terms of this chapter. In the event that the final approved waiver is inconsistent with any of the terms of this chapter, the commissioner shall provide written notification to the governor, speaker of the house, and president of the senate, informing them of the differences between the terms of this chapter and the approved waiver. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management. The MCOs shall work collaboratively with the department and any outside contractor in encouraging and monitoring work and community engagement activities.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity to cure and for re-activation following noncompliance. Following approval by the joint health care reform oversight committee pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules.

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, pay for the administrative costs for the program, and reimburse the federal government for any overpayments of federal funds. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to MCOs. No state general funds shall be deposited into the fund. Deposits into the fund shall be limited exclusively to the following:

(a) Revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) Federal Medicaid reimbursement for program costs and administrative costs attributable to the program;

(c) Surplus funds generated as a result of MCOs managing the cost of their services below the medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter;

(d) Taxes attributable to premiums written for medical and other medical related services for the newly-eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b);

(e) Funds received from the assessment under RSA 404-G;

(f) Any recoveries, settlements, or other payments from or on behalf of individuals who have enrolled in the New Hampshire granite advantage health program and subsequently been determined ineligible; and

(g) Gifts, grants, and donations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30,

2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before January 15, 2020, the commissioner shall calculate the actual remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before January 15 of each subsequent year, the commissioner shall calculate the actual remainder amount for the prior fiscal year. If the actual remainder amount is lower than the prior calculated estimated remainder amount for any fiscal year and the revenue transferred from the alcohol abuse prevention and treatment fund and taxes attributable to premiums written for medical and other medical services for the newly-eligible Medicaid population is greater than the actual remainder amount for that period, the difference shall be retained in the fund and the next estimated remainder amount calculated by the commissioner shall be reduced by the amount of the difference.

VI. The commissioner, in accordance with the most current available information, shall be responsible for determining, quarterly commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next 6-month period. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS. Upon making a determination that a projected shortfall exists, the commissioner shall:

(a) Within 48 hours of making the determination, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the fiscal committee of the general court of the program's pending termination; and

(b) Within 5 business days of making the determination, notify program participants of the program's pending termination.

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the commissioner concerning recommended monitoring and evaluation requirements for work and community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Ten members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report together with its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022.

126-AA:5 Evaluation Report Required.

I. The program shall employ an outcome-based evaluation of its Medicaid program annually to:

(a) Provide accountability to patients and the overall program.

(b) Ensure that patients are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care.

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

II. The results of the evaluation conducted under this section shall be in the form of a report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF)

program to end the dependence of needy parents ages 16 through 64 and low income childless adults ages 18 through 24 on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be provided to eligible participants through Granite Workforce. The total cost of the pilot program shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) Parents aged 18 through 64 with a child under age 18 in the household; or

(c) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(d) Childless adults between 18 and less than 25 years of age.

III. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

IV. Participants in the Granite Workforce program who are not already enrolled in the New Hampshire granite advantage health care program shall enroll in the New Hampshire granite advantage health advantage program within 10 days of satisfying the work and community engagement requirement in RSA 126-AA:2, III (a) through (e). The individual shall be responsible for furnishing proof of enrollment to the department of employment security.

V. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program adopted under RSA 541-A shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. After 3 months of the employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's salary for the prior month, not to exceed $2,000.

II. After 9 months of the continued employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's salary for the prior month, not to exceed $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications (RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence. Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire;

(b) Referring individuals to the department of business and economic affairs to utilize available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures. Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire

granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Termination of Granite Workforce Program.

I. The commissioner of the department of health and human services shall be responsible for determining, every 3 months commencing no later than December 31, 2018, whether available TANF reserve funds total at least $40,000,000. If at any time the commissioner determines that available TANF reserve funds have fallen below $40,000,000, the commissioners of the departments of health and human services and employment security shall, within 20 business days of such determination, terminate the Granite Workforce program. The commissioners shall notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of the legislative fiscal committee, and Granite Workforce participants of the program's pending termination.

II. If at any time the New Hampshire granite advantage health care program, established under RSA 126-AA, terminates, the commissioners of the departments of health and human services and employment security shall terminate the Granite Workforce program. The date of the Granite Workforce program's termination shall align with that of the New Hampshire granite advantage health care program.

10 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] ***126-AA*** shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3.*** The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration of the New Hampshire granite advantage health care program, established in RSA 126-AA.***

11 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5-c, I(b), less the amount made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5-b~~] ***the lesser of the remainder amount, as defined in RSA 126-AA:1, V, or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV and taxes attributable to premiums written for medical and other medical-***

related services for the newly eligible Medicaid population, as defined in RSA 126-AA:1, V. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.

12 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016,13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under [~~RSA 126-A:5, XXIV-XXV between July 1, 2014 – December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] ***RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby*** repealed 180 days after the event under this [~~subparagraph~~] ***paragraph*** occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services ***and consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program.*** The commissioner shall [~~immediately issue notice to program participants of the program's pending repeal~~]***:***

(a) Within 48 hours after the event under this paragraph has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the legislative fiscal committee of the program's pending termination; and

(b) Within 5 business days after the event in this paragraph has occurred, notify program participants of the program's pending termination.

13 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.4~~] ***Five*** percent of the previous fiscal year gross profits derived by the commission from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

14 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding alcohol education and abuse prevention and treatment programs. ***The commissioner of the department of health and human services may accept gifts, grants, donations, or other***

funding from any source and shall deposit all such revenue received into the fund. The state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys *received from all other sources other than the liquor commission pursuant to RSA 176:16, III* shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3; *provided, however, that funds received from any source other than the liquor commission, pursuant to RSA 176:16, III, shall not be used to support the New Hampshire granite advantage health care program and shall not be deposited into the fund established in RSA 126-AA:3.*

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

15 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program established in RSA 126-AA.*

16 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] *126-AA*, and the federally

qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

17 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program under RSA 126-AA*** in which case all provisions of this chapter shall apply.

18 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII~~] ***New Hampshire granite advantage health care program under RSA 126-AA***. If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

19 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

20 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

21 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the date of certification by the commissioner of the department of health and human services to the director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

22 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d (y)(1) to eliminate the state's share of funding for the New Hampshire

granite advantage health care program, or if the federal government allows the use of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

23 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

24 Effective Date.

I. Paragraph II of section 23 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 23 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 20 of this act.

V. Section 3-9 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

Rep. Byron
SB 313 Draft Amendment
April 23, 2018
With Highlighted Changes vs April 18 Draft Amendment

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, minus the following:

(a) The amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) All federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs related to the program;

(c) Any surplus funds generated as a result of the managed care organizations managing the cost of their services below the minimum medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter; and

(d) Taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver of the requirement to provide 90-day retroactive coverage and a state plan amendment allowing state and county correctional facilities to conduct presumptive eligibility determinations for incarcerated inmates to the extent provided under federal law. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of

the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all pre-existing authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. The commissioner shall also include in the MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance.

Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

(3) The commissioner shall establish for the managed care program beginning on July 1, 2019 and thereafter a minimum medical loss ratio that is actuarially sound and that encourages cost efficiency in the delivery of care to the entire Medicaid population. Any surplus funds generated from the MCOs managing the cost of their services below the established minimum medical loss ratio for the beneficiaries of the program shall be transferred to the fund and shall be included in the calculation of the remainder amount.

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g).

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual

resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment including by nonprofit organizations.

(2) Subsidized private sector employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph fails to comply with the work or community engagement activities required in accordance with this paragraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. Following approval by the joint health care reform oversight committee pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make

recommendations to the commissioner regarding the rules. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.

(c) This paragraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i).

(d) This paragraph shall not apply to:

(1) A person who is unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A parent or caretaker of a dependent child under 6 years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker. During the months of July and August, this exemption shall be expanded to include parents or caretakers of dependent children between the ages of 6 and 12, inclusive, provided that the exemption shall only apply to one parent or caretaker.

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights

laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Following approval by the joint health care reform oversight committee pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules. The rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

(7) Annual certification of medical frailty pursuant to 42 C.F.R. section 440.315(f), including proof and duration of such condition on a form supplied by the department.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. The waiver request submitted by the commissioner shall be consistent with all the terms of this chapter. In the event that the final approved waiver is inconsistent with any of the terms of this chapter, the commissioner shall provide written notification to the governor, speaker of the house, and president of the senate, informing them of the differences between the terms of this chapter and the approved waiver. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management. The MCOs shall work collaboratively with the department and any outside contractor in encouraging and monitoring work and community engagement activities.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity to cure and for re-activation following noncompliance. Following approval by the joint health care reform oversight committee pursuant to RSA 161:11 to initiate rulemaking, any rules proposed under this subparagraph shall be submitted to the fiscal committee of the general court, which shall review the rules prior to submission to the joint legislative committee on administrative rules and make recommendations to the commissioner regarding the rules.

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, pay for the administrative costs for the program, and reimburse the federal government for any overpayments of federal funds. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to MCOs. No state general funds shall be deposited into the fund. Deposits into the fund shall be limited exclusively to the following:

(a) Revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) Federal Medicaid reimbursement for program costs and administrative costs attributable to the program;

(c) Surplus funds generated as a result of MCOs managing the cost of their services below the medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter;

(d) Taxes attributable to premiums written for medical and other medical related services for the newly-eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b);

(e) Funds received from the assessment under RSA 404-G;

(f) Funds recovered or returnable to the Granite Advantage Health Care Trust Fund that were originally spent on the cost of coverage of the Granite Advantage Health Care Program; and

(g) Gifts, grants, and donations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30, 2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder

amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before January 15, 2020, the commissioner shall calculate the actual remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before January 15 of each subsequent year, the commissioner shall calculate the actual remainder amount for the prior fiscal year. If the actual remainder amount is lower than the prior calculated estimated remainder amount for any fiscal year and the revenue transferred from the alcohol abuse prevention and treatment fund and taxes attributable to premiums written for medical and other medical services for the newly-eligible Medicaid population is greater than the actual remainder amount for that period, the difference shall be retained in the fund and the next estimated remainder amount calculated by the commissioner shall be reduced by the amount of the difference.

VI. The commissioner, in accordance with the most current available information, shall be responsible for determining, quarterly commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next 6-month period. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS. Upon making a determination that a projected shortfall exists, the commissioner shall:

(a) Within 48 hours of making the determination, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the fiscal committee of the general court of the program's pending termination; and

(b) Within 10 business days of making the determination, notify program participants of the program's pending termination.

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the commissioner concerning recommended monitoring and evaluation requirements for work and community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Ten members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report together with its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022.

126-AA:5 Evaluation Report Required.

I. The program shall employ an outcome-based evaluation of its Medicaid program annually to:

(a) Provide accountability to patients and the overall program.

(b) Ensure that patients are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care.

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

II. The results of the evaluation conducted under this section shall be in the form of a report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF)

program to end the dependence of needy parents ages 18 through 64 and low income childless adults ages 18 through 24 on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be provided to eligible participants through Granite Workforce. The total cost of the pilot program shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) Parents aged 18 through 64 with a child under age 18 in the household; or

(c) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(d) Childless adults between 18 and less than 25 years of age.

III. An eligible recipient, whose wages subsequently cause the household to exceed 138 percent of the federal poverty level as a result of participation in the Granite Workforce program, shall continue to receive Granite Workforce program services as needed, including the subsidy for employers under section 4 of this act, provided the recipient's wages do not cause the household to exceed 250 percent of the federal poverty level. After the second employer subsidy is paid on behalf of a Granite Workforce recipient, the recipient will no longer be eligible for Granite Workforce services as long as household income exceeds 138 percent of the federal poverty level.

IV. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

V. Granite Workforce participants who are not already enrolled in the New Hampshire granite advantage health care program shall enroll in said program, and shall be responsible for furnishing proof of enrollment to the department of employment security.

VI. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program adopted under RSA 541-A shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. After 3 months of the employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's wages for the prior month, not to exceed $2,000.

II. After 9 months of the continued employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's wages for the prior month, not to exceed $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications (RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence. Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire;

(b) Referring individuals to the department of business and economic affairs to utilize available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures. Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Termination of Granite Workforce Program.

I. The commissioner of the department of health and human services shall be responsible for determining, every 3 months commencing no later than December 31, 2018, whether available TANF reserve funds total at least $40,000,000. If at any time the commissioner determines that available TANF reserve funds have fallen below $40,000,000, the commissioners of the departments of health and human services and employment security shall, within 20 business days of such determination, terminate the Granite Workforce program. The commissioners shall notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of the legislative fiscal committee, and Granite Workforce participants of the program's pending termination.

II. If at any time the New Hampshire granite advantage health care program, established under RSA 126-AA, terminates, the commissioners of the departments of health and human services and employment security shall terminate the Granite Workforce program. The date of the Granite Workforce program's termination shall align with that of the New Hampshire granite advantage health care program.

10 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] ***126-AA*** shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3.*** The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration of the New Hampshire granite advantage health care program, established in RSA 126-AA.***

11 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5-e, I(b), less the amount made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5-b~~] ***the lesser of the remainder amount, as defined in RSA 126-AA:1, V, or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV and taxes attributable to premiums written for medical and other medical-related services for the newly eligible Medicaid population, as defined in RSA 126-AA:1, V. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.***

12 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016,13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under [~~RSA 126-A:5, XXIV-XXV between July 1, 2014—December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] ***RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby*** repealed 180 days after the event under this [~~subparagraph~~] ***paragraph*** occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services ***and consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program***. The commissioner shall [~~immediately issue notice to program participants of the program's pending repeal~~]***:***

(a) Within 48 hours after the event under this paragraph has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the legislative fiscal committee of the program's pending termination; and

(b) Within 10 business days after the event in this paragraph has occurred, notify program participants of the program's pending termination.

13 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.~~4] ***Five*** percent of the previous fiscal year gross profits derived by the commission from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an

amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

14 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding alcohol education and abuse prevention and treatment programs. *The commissioner of the department of health and human services may accept gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund.* The state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys *received from all other sources other than the liquor commission pursuant to RSA 176:16, III* shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3; *provided, however, that funds received from any source other than the liquor commission, pursuant to RSA 176:16, III, shall not be used to support the New Hampshire granite advantage health care program and shall not be deposited into the fund established in RSA 126-AA:3.*

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

15 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual

health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program established in RSA 126-AA***.

16 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] ***126-AA***, and the federally qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

17 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] ***New Hampshire granite advantage health care program under RSA 126-AA*** in which case all provisions of this chapter shall apply.

18 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII~~] ***New Hampshire granite advantage health care program under RSA 126-AA***. If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

19 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

20 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act

which can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

21 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the date of certification by the commissioner of the department of health and human services to the director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

22 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d (y)(1) to eliminate the state's share of funding for the New Hampshire granite advantage health care program, or if the federal government allows the use of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

23 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

24 Effective Date.

I. Paragraph II of section 23 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 23 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 20 of this act.

V. Section 3-9 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

file

Rep. Rosenwald, Hills. 30
March 30, 2018
2018-1293h
01/03

Amendment to SB 313-FN

Amend RSA 126-AA:2, I(a) as inserted by section 1 of the bill by replacing it with the following:

I.(a) The commissioner shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

SB 313 language requested by Rep. Kurk:

II-a. An eligible recipient, whose wages subsequently causes the household to exceed 138% of the federal poverty level as a result of participation in Granite Workforce but not more than 250% shall continue to receive Granite Workforce program services as needed, including the subsidy for employers. After the second subsidy is paid to an employer on behalf of a Granite Workforce recipient, the recipient will no longer be eligible for Granite Workforce services as long as the household income exceeds 138% of the federal poverty level.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1																		
2									Remainder Amount Illustrations									
3								RA Less Than Est & AF & PT as expected		RA Less Than Est & AF & PT over perform		RA Less Than Est & AF & PT under perform		RA Greater Than Est & AF & PT as expected		RA Greater Than Est & AF & PT over perform		RA Greater Than Est & AF & PT under perform
4		Est Remainder Amt						$ 15.50		$ 15.50		$ 15.50		$ 16.00		$ 16.00		$ 16.00
5		Actual AF and PT						$ 15.50		$ 16.00		$ 13.00		$ 16.00		$ 18.00		$ 14.00
6		HRP Contribution limited to Line 5						$ 15.50		$ 15.50		$ 14.00		$ 16.00		$ 16.00		$ 16.00
7																		
8																		
9		Actual Remainder Amt						$ 15.00		$ 15.00		$ 15.00		$ 17.00		$ 17.00		$ 17.00
10																		
11																		
12		HRP Credit						$ (0.50)		$ (1.50)		$ (1.00)		$ -		$ -		$ (2.00)
13																		
14																		
15								HRP > 50% of RA, therefore a credit to HRP of $0.5		HRP > 50% of RA, and AF & PT over, so HRP should have only contributed $14, $1.50 credit		HRP limited to AF & PT		HRP limited to AF & PT		Actual AF & PT provided > than 50%, so HRP does not need added $		HRP limited to AF & PT, return $2 to HRP

V. On or before August ~~January~~ 15, 2020, the commissioner shall calculate the ~~estimated~~ projected final remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before August ~~January~~ 15 of each subsequent year, the commissioner shall calculate the ~~estimated~~ projected final remainder amount for the prior fiscal year. ~~If t~~ The projected final actual remainder ~~amount is lower than the prior calculated estimated remainder amount~~ for any fiscal year from the High Risk Pool is limited to the lower of ~~, and~~ (i)the revenue transferred from the alcohol abuse and prevention fund and taxes attributable to premiums written for medical and other medical services for the newly-eligible Medicaid population (ii) the dollar amount needed to satisfy the balance after federal reimbursement, and the revenue transferred from the alcohol abuse and prevention fund and taxes attributable to premiums written for medical and other medical services for the newly-eligible Medicaid population. ~~is greater than the actual remainder amount for that period, the~~ Any excess difference from the High Risk Pool for that period shall be retained in the fund and the next estimated remainder amount calculated by the commissioner shall be reduced by the amount of the difference.

Comment [LH1]: The original 9/30 date I understood was to help Insurers price their products for the High Risk Pool Contributions.

Comment [LH2]: Runout, settlement reconciliations, recoveries, rebates take more than six months to be reasonably considered final actuals.

Comment [LH3]: Examples: 1.Remainder Amount estimated at $15.5 m and HRP contributes $15.5 m, matching Liquor and Tax, and the final actual Remainder Amount is $15m, then $0.5 would be retained to offset a future HRP contribution. 2. The HRP contributes $16.0 based on the estimated $16.0 Remainder Amount. The projected actual Remainder Amount is greater than estimated $17, and the actual Liquor Fund and Premium Tax underperform and come in at $14. The HRP has a $2.0 credit.

Add after page 5, line 12:

(5) The beneficiary is a custodial parent of a child aged 6-12 who is unable to secure child care in order to participate in qualifying work and other community engagement either due to a lack of child care scholarship or the inability to obtain a child care provider due to capacity, distance, or other related factor.

Testimony

LBA **HB 2-FN-A / SB 313 SIDE BY SIDE COMPARISON**

04/06/18 **HB 517 (2017)** **HOUSE PASSED SB 313**

156:219 (Excerpt)	Section 1 (Excerpt)
(1) Newly eligible adults who are unemployed shall be eligible to receive benefits under RSA 126-A:5 XXIV-XXV, if the commissioner finds that the individual is engaging in at least 20 hours per week upon application of benefits, 25 hours per week after receiving 12 months of benefits over the lifetime of the applicant and 30 hours per week after receiving 24 months of benefits over the lifetime of the applicant of one or a combination of the following activities:	III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month, or an average of 600 hours over 6 months, based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:
(A) Unsubsidized employment.	(1) Unsubsidized employment, including self-employment, including by nonprofit organizations.
(B) Subsidized private sector employment.	(2) Subsidized private sector employment, including self-employment.
(C) Subsidized public sector employment.	(3) Subsidized public sector employment.
(D) Work experience, including work associated with the refurbishing of publicly assisted housing, if sufficient private sector employment is not available.	(4) On-the-job training.
(E) On-the-job training.	(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.
(F) Job search and job readiness assistance.	(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.
(G) Vocational educational training not to exceed 12 months with respect to any individual.	(7) Vocational educational training not to exceed 12 months with respect to any individual.
(H) Job skills training directly related to employment.	(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.
(I) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.	(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.
(J) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.	(10) Community service or public service.
(2) If an individual in a family receiving benefits under this subparagraph refuses to engage in work required in accordance with subparagraph (a), the assistance shall be terminated. The commissioner of the department of health and human services shall adopt rules under RSA 541-A, with approval of the governor and the fiscal committee of the general court, to determine good cause and other exceptions to termination.	(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.
(3) This subparagraph shall only apply to those considered, abled-bodied adults as defined in	

section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i). In this subparagraph, "childless" means an adult who does not live with a dependent child which includes a child under 18 years of age or under 20 years of age if the child is a full-time student in a secondary school or the equivalent.	(12) Participation in substance use disorder treatment.
(4) This subparagraph shall not apply to:	(b) If an individual in a family receiving benefits under this paragraph refuses to engage in work or community engagement activities required in accordance with this subparagraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:
(A) A person who is temporarily unable to participate in the requirements under subparagraph (a) due to illness or incapacity as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.	(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.
	(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.
	(3) The beneficiary has a family emergency or other life-changing event such as divorce.
(B) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.	(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.
(C) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.	(c) This subparagraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i). In this subparagraph, "childless" means an adult who does not live with a dependent child which includes a child under 19 years of age or under 20 years of age if the child is a full-time student in a secondary school or the equivalent.
(D) A parent or caretaker of a dependent child under 6 years of age.	(d) This subparagraph shall not apply to:
(5) Any waivers or amendments pursuant to this subparagraph shall be in place by April 30, 2018. Prior to submitting the waiver or state plan amendments to the CMS, the commissioner shall present the waiver or state plan amendments to the governor and the fiscal committee of the general court for approval. The program shall not be reauthorized until such waivers or state plan amendments have been approved by CMS. If the waiver or state plan is not approved, the commissioner shall immediately, no later than April 30, 2018, notify all program participants that the program has not been reauthorized beyond December 31, 2018.	(1) A person who is temporarily unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the

	department, the duration and limitations of the disability. (2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court. (3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required. (4) A parent or caretaker of a dependent child under 13 years of age or a child with developmental disabilities who is residing with the parent or caretaker. (5) Pregnant women. (6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness. (7) Beneficiaries who are identified as medically frail, under 42 C.F.R section 440.315(f), and as defined in the alternative benefit plan in the state plan. (8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives. (e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Those rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following: (1) Enrollment, suspension, and disenrollment procedures in the program.

	(2) Verification of compliance with community engagement activities. (3) Verification of exemptions from participation. (4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment. (5) Good cause exemptions. (6) Education and training of enrollees. IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner: (a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management. (b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules. (c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

NH Health Protection Program Unique Member Annual Enrollment, SFY15 - SFY18

Source: MMIS data as of 4/6/2018

SFY	Unique Members Enrolled
2015*	65,647
2016	82,110
2017	86,365
2018**	78,460

Notes:
*Includes 11 months of enrollment.
**Includes 9 months of enrollment.

NH Medicaid NHHPP Enrollment by Age, Federal Poverty Level Percent & Assistance Group Size, 4/1/2018

Source: MMIS data as of 4/6/2018

Age Group	Federal Poverty Level Percent Group	Assistance Group Size					Total	Percent by Total
		1	2	3	4	5+		
<25	0%	4,169	488	224	102	49	5,032	51.9%
	1-24%	188	23	29	14	9	263	2.7%
	25-49%	305	65	62	50	53	535	5.5%
	50-74%	379	151	135	96	78	839	8.7%
	75-99%	549	207	178	130	105	1,169	12.1%
	100-124%	561	233	195	134	96	1,219	12.6%
	125%+	329	113	67	83	49	641	6.6%
<25 Total		**6,480**	**1,280**	**890**	**609**	**439**	**9,698**	**100.0%**
<25 Percent by Total		**66.8%**	**13.2%**	**9.2%**	**6.3%**	**4.5%**	**100.0%**	
25-34	0%	7,291	643	395	198	150	8,677	53.8%
	1-24%	309	32	19	33	26	419	2.6%
	25-49%	328	65	68	65	83	609	3.8%
	50-74%	419	209	216	222	189	1,255	7.8%
	75-99%	638	355	376	298	281	1,948	12.1%
	100-124%	653	407	390	307	308	2,065	12.8%
	125%+	392	268	210	166	129	1,165	7.2%
25-34 Total		**10,030**	**1,979**	**1,674**	**1,289**	**1,166**	**16,138**	**100.0%**
25-34 Percent by Total		**62.2%**	**12.3%**	**10.4%**	**8.0%**	**7.2%**	**100.0%**	
35-44	0%	3,614	407	218	159	136	4,534	44.3%
	1-24%	145	29	20	38	38	270	2.6%
	25-49%	141	58	54	70	117	440	4.3%
	50-74%	176	174	208	249	242	1,049	10.2%
	75-99%	263	256	323	320	359	1,521	14.8%
	100-124%	306	246	299	376	368	1,595	15.6%
	125%+	159	174	162	153	187	835	8.2%
35-44 Total		**4,804**	**1,344**	**1,284**	**1,365**	**1,447**	**10,244**	**100.0%**
35-44 Percent by Total		**46.9%**	**13.1%**	**12.5%**	**13.3%**	**14.1%**	**100.0%**	
45-54	0%	3,681	422	97	87	38	4,325	48.0%
	1-24%	182	49	26	18	7	282	3.1%
	25-49%	189	74	36	36	40	375	4.2%
	50-74%	241	253	150	109	83	836	9.3%
	75-99%	398	341	190	185	129	1,243	13.8%
	100-124%	408	318	222	182	127	1,257	13.9%
	125%+	244	203	102	78	66	693	7.7%
45-54 Total		**5,343**	**1,660**	**823**	**695**	**490**	**9,011**	**100.0%**
45-54 Percent by Total		**59.3%**	**18.4%**	**9.1%**	**7.7%**	**5.4%**	**100.0%**	
55+	0%	2,881	383	57	7	5	3,333	40.8%
	1-24%	237	77	14	8	1	337	4.1%
	25-49%	316	93	26	9	7	451	5.5%
	50-74%	447	218	62	30	23	780	9.5%
	75-99%	805	335	81	37	29	1,287	15.7%
	100-124%	774	352	73	42	30	1,271	15.5%
	125%+	395	234	36	34	19	718	8.8%
55+ Total		**5,855**	**1,692**	**349**	**167**	**114**	**8,177**	**100.0%**
55+ Percent by Total		**71.6%**	**20.7%**	**4.3%**	**2.0%**	**1.4%**	**100.0%**	

Assistance Group Size is the size of the group of people (typically a family) that are counted for the purpose of determining Medicaid income eligibility

NH Medicaid NHHPP Enrollment by Federal Poverty Level Percent & Assistance Group Size, 4/1/2018

Source: MMIS data as of 4/6/2018

Federal Poverty Level Percent Group	Assistance Group Size					Total	Percent of Total
	1	2	3	4	5+		
0%	21,636	2,343	991	553	378	**25,901**	**48.6%**
1-24%	1,061	210	108	111	81	**1,571**	**2.9%**
25-49%	1,279	355	246	230	300	**2,410**	**4.5%**
50-74%	1,662	1,005	771	706	615	**4,759**	**8.9%**
75-99%	2,653	1,494	1,148	970	903	**7,168**	**13.5%**
100-124%	2,702	1,556	1,179	1,041	929	**7,407**	**13.9%**
125%+	1,519	992	577	514	450	**4,052**	**7.6%**
Total	**32,512**	**7,955**	**5,020**	**4,125**	**3,656**	**53,268**	**100.0%**
Percent of Total	**61.0%**	**14.9%**	**9.4%**	**7.7%**	**6.9%**	**100.0%**	

Assistance Group Size is the size of the group of people (typically a family) that are counted for the purpose of determining Medicaid income eligibility

Childhood exemption

(4) A parent or caretaker of a child through six years of age or a child with developmental disabilities who is residing with the parent or caretaker, provided that the exemption shall only apply to one parent or caretaker **per household. For children under seven years of age with a parent with a disability as defined under 126-AA:1, both parents may be eligible for exemption. For parents with children between the ages of six and 12, a parent may qualify for exemption to the extent that a childcare scholarship is not available or the parent is unable to find an appropriate provider willing to accept the scholarship for the hours that work and community engagement activities are scheduled when the child is not in school.**

Rep. Byron, Hills. 20
April 16, 2018
2018-1532h
01/03

Amendment to SB 313-FN

Amend the bill by replacing all after the enacting clause with the following:

1 New Chapter; New Hampshire Granite Advantage Health Care Program. Amend RSA by inserting after chapter 126-Z the following new chapter:

CHAPTER 126-AA

NEW HAMPSHIRE GRANITE ADVANTAGE HEALTH CARE PROGRAM

126-AA:1 Definitions. In this chapter:

I. "Commissioner" means the commissioner of the department of health and human services.

II. "Department" means the department of health and human services.

III. "Fund" means the New Hampshire granite advantage health care trust fund.

IV. "Program" means the New Hampshire granite advantage health care program.

V. "Remainder amount" means, for the 6-month period between January 1, 2019 and June 30, 2019 and for each single identified fiscal year thereafter for any authorized period of the granite advantage health care program, the cost of the program, including administrative costs attributable to the program, minus the following:

(a) The amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) All federal reimbursement for the program that period or fiscal year, including federal reimbursement for administrative costs related to the program;

(c) Any surplus funds generated as a result of the managed care organizations managing the cost of their services below the minimum medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter; and

Comment [LH1]: An amount MCOs obligated to return if they spend too little on services, e.g. 80 or 85% MLR

(d) Taxes attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b).

126-AA:2 New Hampshire Granite Advantage Health Care Program Established.

I.(a) The commissioner shall apply for any necessary waivers and state plan amendments to implement a 5-year demonstration program beginning on January 1, 2019 to create the New Hampshire granite advantage health care program which shall be funded exclusively from non-general fund sources, including federal funds. *The demonstration shall be for medical assistance for persons defined under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 16 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i) ("newly eligible adults")*

Comment [MJ2]: Adds language from SB 413 rfe eligibility

and their spouse and dependents. The commissioner shall include in an application for the necessary waivers submitted to the Centers for Medicare and Medicaid Services (CMS) a waiver of the requirement to provide 90-day retroactive coverage and a ~~waiver~~ *state plan amendment* allowing state and county correctional facilities to conduct presumptive eligibility determinations for ~~inmates~~ *incarcerated inmates to the extent provided under federal law*. To receive coverage under the program, those individuals in the new adult group who are eligible for benefits shall choose coverage offered by one of the managed care organizations (MCOs) awarded contracts as vendors under Medicaid managed care, pursuant to RSA 126-A:5, XIX(a). The program shall make coverage available in a cost-effective manner and shall provide cost transparency measures, and ensure that patients are utilizing the most appropriate level of care. Cost effectiveness shall be achieved by offering cash incentives and other forms of incentives to be offered to the insured by choosing preferred lower cost medical providers. Loss of incentives shall also be employed. MCOs shall employ reference-based pricing, cost transparency, and the use of incentives and loss of incentives to the Medicaid and newly eligible population. For the purposes of this subparagraph, "reference-based pricing" means setting a maximum amount payable for certain medical procedures.

Comment [MJ3]: Presumptive eligibility is via a SPA, not a waiver

(b) The department shall ensure through managed care contracts that MCOs incorporate measures to promote continuity of coverage, including, but not limited to, assisting over income participants in applying for coverage on the federal marketplace in New Hampshire and maintaining care and case management during the pendency of such application.

(c) The MCOs shall promote personal responsibility through the use of incentives, loss of incentives, and case management to the greatest extent practicable.

(d) Prior to submitting the waiver or state plan amendment to CMS, the commissioner shall present the waiver or state plan amendment to the governor and the fiscal committee of the general court for approval. The program shall not commence operation until such waivers or state plan amendments have been approved by CMS. All necessary waivers and state plan amendments shall be submitted by June 30, 2018. If all waivers necessary for the program are not approved by December 1, 2018, the commissioner shall immediately notify all program participants that the program will be terminated in accordance with the federally required Special Terms and Conditions No. 11-W-003298/1.

(e) In order to combat the opioid and heroin crisis facing New Hampshire, the department shall establish behavioral health rates sufficient to ensure access to, and provider capacity for all behavioral health services including, as appropriate, establishing specific substance use disorder services rate cells for inclusion into capitated rates for managed care.

(f) Any person transitioning from the premium assistance program to the program shall not lose coverage due solely to the transition, which shall be for a period of at least 90 days. All MCOs shall honor all pre-existing authorizations for care plans and treatments for all program participants for a period of not less than 90 days after enrollment.

(g)(1) The commissioner shall include in MCO contracts with the state clinically and actuarially sound incentives designed to improve care quality and utilization and to lower the total cost of care within the Medicaid managed care program. The commissioner shall also include in the MCO contract provisions an obligation for the MCO to include provider alignment incentives to leverage the combined efforts of the parties to achieve the purposes of the incentives. Preferential auto-assignment of newly eligible members, shared incentive pools, and differential capitation rates are among the options for incentives the commissioner may employ to achieve improved performance. Initial areas to improve care quality and utilization and to lower the total cost of care may include, but are not limited to:

(A) Appropriate use of emergency departments relative to low acuity non-emergent visits.

(B) Reduction in preventable admissions and 30-day hospital readmission for all causes.

(C) Timeliness of prenatal care and reductions in neonatal abstinence births.

(D) Timeliness of follow-up after a mental illness or substance use disorder admission.

(E) Reduction of polypharmacy resulting in drug interaction harm.

(2) The commissioner shall include in MCO contracts actuarial appropriate rebate provisions for failure to implement contractually agreed upon incentive measures.

(3) The commissioner shall establish for the managed care program beginning on July 1, 2019 and thereafter a minimum medical loss ratio that is actuarially sound and that encourages cost efficiency in the delivery of care to the entire Medicaid population. Any surplus funds generated from the MCOs managing the cost of their services below the established minimum medical loss ratio for the beneficiaries of the program shall be transferred to the fund and shall be included in the calculation of to reduce the remainder amount.

Comment [LH4]: Please note page 1 on line 21

Comment [LH5]: Please note page 1 on line 21

Comment [LH6]: Purpose of including

Deleted: the

(h) Savings generated as a result of individuals disenrolled from the program for failing to meet the work and community engagement requirement shall not be included in any calculation submitted to CMS to establish federal budget neutrality of any waiver issued for the program.

(i) Consistent with the state plan amendment submitted by the department and approved by CMS, all contracts between a Medicaid managed care organization and a federally qualified health care center, as defined in section 1905(1)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(1)(2)(B), providing services in geographic areas served by the plan, shall reimburse each such center for such services as provided in 42 U.S.C. section 18022(g).

II.(a) To receive benefits under this section and to the extent allowed by federal law, the individual shall:

(1) Provide all necessary information regarding financial eligibility, assets, residency, citizenship or immigration status, and insurance coverage to the department in accordance with rules, or interim rules, including those adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the program is subject to cancellation upon notice.

(b) If allowed by federal law, all resources which the individual and his or her family own shall be considered to determine eligibility under this paragraph, including cash, bank accounts, stocks, bonds, permanently unoccupied real estate, and trusts. The home in which the individual resides in, furniture, and one vehicle owned by the individual applying for benefits shall be excluded from the eligibility requirements for benefits under this paragraph. If, after counting or excluding the individual's household's resources, the total countable resources equal or fall below $25,000, he or she shall be considered asset eligible.

III.(a) Newly eligible adults who are unemployed shall be eligible to receive benefits under this paragraph if the commissioner finds that the individual is engaging in at least 100 hours per month based on an average of 25 hours per week in one or more work or other community engagement activities, as follows:

(1) Unsubsidized employment including by nonprofit organizations.

(2) Subsidized private sector employment.

(3) Subsidized public sector employment.

(4) On-the-job training.

(5) Job skills training related to employment, including credit hours earned from an accredited college or university in New Hampshire. Academic credit hours shall be credited against this requirement on an hourly basis.

(6) Job search and job readiness assistance, including, but not limited to, persons receiving unemployment benefits and other job training related services, such as job training workshops and time spent with employment counselors, offered by the department of employment security. Job search and job readiness assistance under this section shall be credited against this requirement on an hourly basis.

(7) Vocational educational training not to exceed 12 months with respect to any individual.

(8) Education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency.

(9) Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

(10) Community service or public service.

(11) Caregiver services for a nondependent relative or other person with a disabling medical or developmental condition.

(12) Participation in substance use disorder treatment.

(b) If an individual in a family receiving benefits under this paragraph ~~refuses~~ ***fails to comply with the*** ~~to engage in~~ work or community engagement activities required in accordance with this subparagraph, the assistance shall be terminated. The commissioner shall adopt rules under RSA 541-A to determine good cause and other exceptions to termination. ***Following approval by the joint health care reform oversight committee pursuant to RSA 161:11 to initiate rulemaking, any r***ules proposed under this subparagraph shall be submitted to the oversight committee on health and human services, established in RSA 126-A:13, ~~the joint health care reform oversight committee, established in RSA 420-N:3,~~ and the fiscal committee of the general court, each of which may review the rules prior to ~~adoption~~ ***submission to the joint legislative committee on rules*** and make recommendations to the commissioner regarding the rules. An individual may apply for good cause exemptions which shall include, at a minimum, the following verified circumstances:

Comment [MJ7]: Follows existing law

Comment [MJ8]: Must be submitted to JLCAR

(1) The beneficiary experiences the birth, or death, of a family member living with the beneficiary.

(2) The beneficiary experiences severe inclement weather, including a natural disaster, and therefore was unable to meet the requirement.

(3) The beneficiary has a family emergency or other life-changing event such as divorce.

(4) The beneficiary is a victim of domestic violence, dating violence, sexual assault, or stalking consistent with definitions and documentation required under the Violence Against Women Reauthorization Act of 2013 under 24 C.F.R. section 5.2005 and 24 C.F.R. section 5.2009, as determined by the commissioner pursuant to rulemaking under RSA 541-A.

(c) This subparagraph shall only apply to those considered, able-bodied adults as described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i).

(d) This subparagraph shall not apply to:

(1) A person who is ~~temporarily~~ unable to participate in the requirements under subparagraph (a) due to illness, incapacity, or treatment, including inpatient treatment, as certified by a licensed physician, an advanced practice registered nurse (APRN), a licensed behavioral health professional, a licensed physician assistant, a licensed drug and alcohol counselor (LADAC), or a board-certified psychologist. The physician, APRN, licensed behavioral health professional, licensed physician assistant, LADAC, or psychologist shall certify, on a form provided by the department, the duration and limitations of the disability.

Comment [MJ9]: If someone was suffering from cancer, that medical frailty may not be temporary. Duration is already provided for.

(2) A person participating in a state-certified drug court program, as certified by the administrative office of the superior court.

(3) A parent or caretaker as identified in RSA 167:82, II(g) where the required care is considered necessary by a licensed physician, APRN, board-certified psychologist, physician assistant, or licensed behavioral health professional who shall certify the duration that such care is required.

(4) A parent or caretaker of a dependent child under ~~6~~ *13* years of age or a child with developmental disabilities who is residing with the parent or caretaker; provided that the exemption shall only apply to one parent or caretaker.

Comment [MJ10]: Significant child welfare concern

(5) Pregnant women.

(6) A beneficiary who has a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the requirement for reasons related to that disability; or who has an immediate family member in the home with a disability under federal disability rights laws and who is unable to meet the requirement for reasons related to the disability of that family member, or the beneficiary or an immediate family member who is living in the home or the beneficiary experiences a hospitalization or serious illness.

(7) Beneficiaries who are identified as medically frail, under 42 C.F.R. section 440.315(f), and as defined in the alternative benefit plan and in the state plan and who are certified by a licensed physician or other medical professional to be unable to comply with the work and community engagement requirement as a result of their condition as medically frail. The department shall require proof of such limitation annually, including the duration of such disability, on a form approved by the department.

(8) Any beneficiary who is in compliance with the requirement of the Supplemental Nutritional Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) employment initiatives.

(e) The commissioner shall adopt rules under RSA 541-A pertaining to the community engagement requirement. Rules proposed under this paragraph shall be submitted to the oversight committee on health and human services, the joint health care reform oversight committee, and the fiscal committee of the general court, each of which may review the rules prior to adoption and make recommendations to the commissioner regarding the rules. The rules shall be consistent with the terms and conditions of any waiver issued by the Centers for Medicare and Medicaid Services for the program and shall address, at a minimum, the following:

(1) Enrollment, suspension, and disenrollment procedures in the program.

(2) Verification of compliance with community engagement activities.

(3) Verification of exemptions from participation.

(4) Opportunity to cure and re-activation following noncompliance, including not being barred from re-enrollment.

(5) Good cause exemptions.

(6) Education and training of enrollees.

(7) Annual certification of medical frailty pursuant to 42 C.F.R. section 440.315(f), including proof and duration of such condition on a form supplied by the department.

IV. The commissioner shall implement the work and community engagement requirement under paragraph III beginning January 1, 2019 in accordance with the terms and conditions of any waiver approved by CMS. ~~The waiver shall be consistent with all the terms of this chapter.~~ Verification of qualifying activities, exemptions, and enrollee status shall be accomplished in the following manner:

Comment [MJ11]: Will cause multiple issues with CMS and with implementation of the waiver

(a) MCOs under contract with the department shall share enrollee reported information regarding the work and community engagement requirement status obtained through standard contract activities including enrollment, outreach activities, and enrollee care management. The MCOs shall work collaboratively with the department and any outside contractor in encouraging and monitoring work and community engagement activities.

(b) For the period of January 1, 2019 through June 30, 2020 only, the department shall verify enrollee status to the greatest extent practicable through the verification of enrollee and MCO reported status and information, including information from the eligibility file. Enrollees shall be required to report information regarding their qualifying activities, exemptions, enrollee status, and changes in their status to the department in accordance with the department's rules.

(c) No later than January 1, 2019, the commissioner shall submit to the governor, president of the senate, and speaker of the house of representatives a plan for the implementation of a fully automated verification system that utilizes state and commercial data sources to assess compliance with all work and community engagement activities beginning on July 1, 2020. The plan shall provide an option to hire a third party vendor to manage the automated verification system.

V. A person shall not be eligible to enroll or participate in the program, unless such person verifies his or her United States citizenship by 2 forms of identification and proof of New Hampshire residency by either a New Hampshire driver's license or a nondriver's picture identification card issued pursuant to RSA 260:21.

VI. No person, organization, department, or agency shall submit the name of any person to the National Instant Criminal Background Check System (NICS) on the basis that the person has been adjudicated a "mental defective" or has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney.

VII. For any person determined to be eligible and who is enrolled in the program, the MCO shall support the individual to arrange a wellness visit with his or her primary care provider, either

previously identified or selected by the individual from a list of available primary care providers. The wellness visit shall include appropriate assessments of both physical and mental health, including screening for depression, mood, suicidality, and unhealthy substance use, for the purpose of developing a health wellness and care plan.

VIII. Any person receiving benefits from the program shall be responsible for providing information regarding his or her change in status or eligibility, including current contact information. The commissioner shall adopt rules, under RSA 541-A, pertaining to the opportunity to cure and for re-activation following noncompliance. ~~Rules proposed under this paragraph shall be submitted to the oversight committee on health and human services, the joint health care reform oversight committee, and the fiscal committee of the general court, each of which may review the rules prior to adoption and make recommendations to the commissioner regarding the rules.~~

Comment [MJ12]: This is duplicative of prior rules language. Not needed

126-AA:3 The New Hampshire Granite Advantage Health Care Trust Fund.

I. There is hereby established the New Hampshire granite advantage health care trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing. The fund shall be administered by the commissioner and shall be used solely to provide coverage for the newly eligible Medicaid population as provided for under RSA 126-AA:2, and to pay for the administrative costs for the program. All moneys in the fund shall be nonlapsing and shall be continually appropriated to the commissioner for the purposes of the fund. The fund shall be authorized to pay and/or reimburse the cost of medical services and cost-effective related services, including without limitation, capitation payments to MCOs. No state general funds shall be deposited into the fund. Deposits into the fund shall be limited exclusively to the following:

(a) Revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV;

(b) Federal Medicaid reimbursement for program costs and administrative costs attributable to the program;

(c) Surplus funds generated as a result of MCOs managing the cost of their services below the medical loss ratio established by the commissioner for the managed care program beginning on July 1, 2019 and thereafter;

(d) Taxes attributable to premiums written for medical and other medical related services for the newly-eligible Medicaid population as provided for under this chapter, consistent with RSA 400-A:32, III(b); and

(e) Gifts, grants, and donations.

II. The commissioner, as the administrator of the fund, shall have the sole authority to:

(a) Apply for federal funds to support the program.

(b) Notwithstanding any provision of law to the contrary, accept and expend federal funds as may be available for the program and the commissioner shall notify the bureau of

accounting services, by letter, with a copy to the fiscal committee of the general court and the legislative budget assistant.

(c) Make payments and reimbursements from the fund as outlined in this section.

III. The commissioner shall submit a report to the governor and the fiscal committee of the general court detailing the activities and operation of the trust fund annually within 90 days of the close of each state fiscal year.

IV. On or before August 15, 2018, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for the period of January 1, 2019 to June 30, 2019 and for state fiscal year 2020. The commissioner shall report the estimated annual remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate. Thereafter, on or before August 15 of each fiscal year, the commissioner, in consultation with the insurance commissioner, shall estimate the remainder amounts for both the current and next fiscal year. The commissioner shall report the estimated remainder amount to the insurance commissioner, the New Hampshire Health Plan, the governor, the speaker of the house of representatives, and the president of the senate.

V. On or before January 15, 2020, the commissioner shall calculate the estimated final remainder amount for the 6-month period between January 1, 2019 and June 30, 2019. On or before January 15 of each subsequent year, the commissioner shall calculate the estimated final remainder amount for the prior fiscal year. If the final actual remainder amount is lower than the prior calculated estimated remainder amount for any fiscal year, and the revenue transferred from the alcohol abuse and prevention fund and taxes attributable to premiums written for medical and other medical services for the newly-eligible Medicaid population is greater than the actual remainder amount for that period, the difference shall be retained in the fund and the next estimated remainder amount calculated by the commissioner shall be reduced by the amount of the difference.

VI. The commissioner, in accordance with the most current available information, shall be responsible for determining, ~~every 3 months~~ *quarterly* commencing no later than December 31, 2018, whether there is sufficient funding in the fund, to cover projected program costs for the nonfederal share for the next ~~6-month period~~ *quarter*. If at any time the commissioner determines that a projected shortfall exists, he or she shall terminate the program in accordance with the federally approved terms and conditions issued by CMS. Upon making a determination that a projected shortfall exists, the commissioner shall:

(a) Within 48 hours of making the determination, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the fiscal committee of the general court of the program's pending termination; and

(b) Within 5 business days of making the determination, *initiate notification of the Centers for Medicare and Medicaid Services and to all* program participants of the program's pending termination.

Comment [LH13]: The 9/30 date I understood was to help Insurers price their products for the High Risk Pool Contributions.

Comment [LH14]: Runout, settlement reconciliations, recoveries, rebates take more than six months to be truly final actuals.

Deleted: actual

Deleted: actual

Comment [LH15]: Example: Remainder Amount estimated at $15.5 m and HRP contributes $15.5 m, matching Liquor and Tax, and the final actual Remainder Amount is $15m, then $0.5 would be retained to offset a future HRP contribution.

Comment [MJ16]: Clarify and make consistent

Comment [MJ17]: Notification will take more than 5 business days

126-AA:4 Commission to Evaluate the Effectiveness and Future of the New Hampshire Granite Advantage Health Care Program.

I. There is hereby established a commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

(a) The members of the commission shall be as follows:

(1) Three members of the senate, appointed by the president of the senate, one of whom shall be a member of the minority party.

(2) Three members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party.

(3) The commissioner of the department of health and human services, or designee.

(4) The commissioner of the department of insurance, or designee.

(5) A representative of each managed care organization awarded contracts as vendors under the Medicaid managed care program, appointed by the governor.

(6) A representative of a hospital that operates in New Hampshire, appointed by the New Hampshire Hospital Association.

(7) A public member, who has health care expertise, appointed by the senate president.

(8) A public member, who currently receives coverage through the program, appointed by the speaker of the house of representatives.

(9) A public member representing the interests of taxpayers in New Hampshire, appointed by the president of the senate.

(10) A representative of the medical care advisory committee, department of health and human services, appointed by the commissioner of the department of health and human services.

(11) A licensed physician, appointed by the New Hampshire Medical Society.

(12) A licensed mental health professional, appointed by the National Alliance on Mental Illness New Hampshire.

(13) A licensed substance use disorder professional, appointed by the New Hampshire Alcohol and Drug Abuse Counselors Association.

(14) An advanced practice registered nurse (APRN), appointed by the New Hampshire Nurse Practitioner Association.

(15) The chairperson of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.

(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

II.(a) The commission shall evaluate the effectiveness and future of the program. Specifically the commission shall:

(1) Review the program's financial metrics.

(2) Review the program's product offerings.

(3) Review the program's impact on insurance premiums for individuals and small businesses.

(4) Make recommendations for future program modifications, including, but not limited to whether the program is the most cost-effective model for the long term versus a return to private market managed care.

(5) Evaluate non-general fund funding options for longer term continuation of the program, including options to accept funding from the federal government allowing a self-administered program.

(6) Review up-to-date information regarding changes in the level of uncompensated care through shared information from the department, the department of revenue administration, the insurance department, and provider organizations and the program's impact on insurance premium tax revenues and Medicaid enhancement tax revenue.

(7) Review the granite workforce pilot program.

(8) Evaluate reimbursement rates to determine if they are sufficient to ensure access to and provider capacity for all behavioral health services.

(9) Review the number of people who are found ineligible or who are dropped from the rolls of the program because of the work requirement.

(10) Review the program's provider reimbursement rates and overall financing structure to ensure it is able to provide a stable provider network and sustainable funding mechanism that serves patients, communities, and the state of New Hampshire.

(b) Any funding solutions recommended by the commission shall not include the use of new general funds.

(c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

(d) The commission shall make a recommendation on or by February 1, 2019 to the commissioner concerning recommended monitoring and evaluation requirements for work and community engagement requirements, including a draft of proposed metrics for quarterly and annual reporting, including suggested costs and benefits evaluations.

III. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Ten members of the commission shall constitute a quorum.

IV. The commission shall make an interim report on or before December 1, 2020 and a final report together with its findings and any recommendations for proposed legislation to the president

of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before December 1, 2022.

126-AA:5 Evaluation Report Required.

I. The program shall employ an outcome-based evaluation of its Medicaid program annually to:

(a) Provide accountability to patients and the overall program.

(b) Ensure that patients are making informed decisions in carrying out health care choices and utilizing the most appropriate level of care.

(c) Ensure that the use of incentives, the loss of incentives, cost transparency, and reference based pricing have been effective in lowering costs, while maintaining both quality and access and considering changes in health parameters.

II. The results of the evaluation conducted under this section shall be in the form of a report to be provided to CMS, the president of the senate, the speaker of the house of representatives, the governor, and the fiscal committee of the general court by December 31 of each year beginning in 2019.

2 Purpose Statement. The purpose of sections 3-9 of this act is to establish a pilot program by using allowable federal funds available from the Temporary Assistance to Needy Families (TANF) program to end the dependence of needy parents and low income childless adults ages 18 through 24 *and non-custodial parents of any age* on governmental programs by promoting job and work preparation and placing them into high labor need jobs based on the goals set forth in 45 C.F.R. section 260.20. The long-term goal of this program is to place low-income individuals into unsubsidized jobs in high labor need areas, transition them to self-sufficiency through providing career pathways with specific skills, and assist in eliminating barriers to work such as transportation and childcare. Taken together, these measures are designed to help low-income participants break the cycle of poverty and move them from living on the margin to the middle class and beyond.

Comment [MJ18]: This group is also eligible for TANF funding

3 Granite Workforce; Pilot Program Established.

I. The commissioner of the department of health and human services shall use allowable funds from the Temporary Assistance to Needy Families (TANF) program to provide subsidies to employers in high need areas, as determined by the department of employment security based upon workforce shortages, and to create a network of assistance to remove barriers to work for low-income families. The funds shall be used to establish a pilot program, referred to as Granite Workforce, a TANF nonassistance program, which shall accept enrollments by applicants for an initial period of 6 months. The program shall be jointly administered by the department of health and human services and the department of employment security. No cash assistance shall be provided to eligible participants through Granite Workforce. The total cost of the pilot program shall not exceed $3,000,000 in federal TANF funds for the biennium ending June 30, 2019.

II. To be eligible for Granite Workforce, applicants shall be:

(a) In a household with an income up to 138 percent of the federal poverty level; and

(b) *Enrolled in the Granite Advantage Health Care Program prior to receiving benefits in the Granite Workforce Program; and*

(c) Parents aged 18 through 64 with a child under age 18 in the household; or

(d) Noncustodial parents aged 18 through 64 with a child under the age of 18; or

(e) Childless adults between 18 and less than 25 years of age.

III. The department of employment security shall determine eligibility and entry into the program, using nationally recognized assessment tools for vocational and job readiness assessments. Vocational assessments shall include educational needs, vocational interest, personal values, and aptitude. The department shall use the assessment results to work with the participant to produce a long-term career plan for moving into the middle class and beyond.

IV. Participants in the Granite Workforce program ~~who are not already enrolled in the New Hampshire granite advantage health care program established in RSA 126-AA, shall enroll in the New Hampshire granite advantage health care program within 10 days of receiving employment through participation in the Granite Workforce program. The individual~~ shall be responsible for furnishing proof of enrollment to the department of employment security.

V. Except as otherwise provided in paragraph II regarding program eligibility, administrative rules governing the New Hampshire employment program, adopted under RSA 541-A ~~as chapter He-W 600,~~ shall apply to the Granite Workforce pilot program.

4 Granite Workforce; Subsidies for Employers.

I. After 3 months of the employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's salary for the prior month, not to exceed $2,000.

II. After 9 months of the continued employment of the participant in a paying job and receiving verification of the continued employment and wages from the employer, the department of employment security shall pay the employer a subsidy equal to 50 percent of the employee's salary for the prior month, not to exceed $2,000.

III. If an overpayment is made, the employer shall reimburse the department that amount upon being notified by the department.

5 Referral for Barriers to Employment. The department of health and human services, in consultation with the department of employment security, shall issue a request for applications (RFAs) for community providers interested in offering case management services to participants with barriers to employment. Participants shall be identified by the department of employment security using an assessment process that screens for barriers to employment including, but not limited to, transportation, child care, substance use, mental health, and domestic violence.

Comment [MJ19]: Intended to address eligibility issue raised by Rep. Kurk

Comment [MJ20]: Rules may be amended and added as a separate section for this program.

Thereafter, the department of employment security shall refer to community providers those individuals deemed needing assistance with removing barriers to employment. When child care is identified as a barrier to employment, the department of employment security or the community provider shall refer the individual to available child care service programs, including, specifically the child care scholarship program administered by the department of health and human services. In addition to employer subsidies authorized under this section, TANF funds allocated to the Granite Workforce program shall be used to pay for other services that eliminate barriers to work in accordance with all TANF guidelines.

6 Network of Education and Training.

I. If after the assessment conducted by the department of employment security additional job training, education, or skills development is necessary prior to job placement, the department of employment security shall address those needs by:

(a) Referring individuals to training and apprenticeship opportunities offered by the community college system of New Hampshire:

(b) Referring individuals to the department of business and economic affairs to utilize available training funds and support services;

(c) Referring individuals to education and employment programs for youth available through the department of education; or

(d) Referring individuals to training available through other colleges and training programs.

II. All industry specific skills and training will be provided for jobs in high need areas, as determined by the department of employment security based upon workforce shortages.

7 Job Placement. Upon determining the participant is job ready, the department of employment security shall place individuals into jobs with employers in high need areas, as determined by the department of employment security based upon workforce shortages. This includes, but is not limited to, high labor need jobs in the fields of healthcare, advanced manufacturing, construction/building trades, information technology, and hospitality. Training and job placement shall focus on:

I. Supporting health care/safety issues: training/jobs to combat the opioid crisis, including nurses, nursing assistants, clinicians, social workers, and treatment providers at the licensed alcohol and drug addictions counselor and licensed mental health counselor levels. Additionally, jobs to address long-term care needs, home healthcare services, and expanding mental/behavioral health services.

II. Advanced manufacturing to meet employer needs: training/jobs that include computer-aided drafting and design, electronic and mechanical engineering, precision welding, computer numerical controlled precision machining, robotics, and automation.

III. Construction/building trades to address critical infrastructure needs: training/jobs for building roads, bridges, municipality infrastructure, and ensuring safe drinking water.

IV. Information technology: training/jobs to allow businesses to excel in an ever-increasing network dependent business environment.

V. Hospitality-training/jobs to address the workforce shortage and support New Hampshire's tourism industry, to include but not be limited to hotel workers, restaurant workers, campground workers, lift operators, state park workers, and amusement park workers.

8 Reporting Requirement; Measurement of Outcomes.

I. The department of health and human services shall prepare a report on the outcomes of the Granite Workforce program using appropriate standard common performance measures. Program partners, as a condition of participation, shall be required to provide the department with the relevant data. Metrics to be measured shall include, but are not limited to:

(a) Degree of participation.

(b) Progress with overcoming barriers.

(c) Entry into employment.

(d) Job retention.

(e) Earnings gain.

(f) Movement within established federal poverty level measurements, including the Supplemental Nutrition Assistance Program (SNAP) and the New Hampshire granite advantage health care program under RSA 126-AA.

(g) Health insurance coverage provider.

(h) Attainment of education or training, including credentials.

II. The report shall be issued to the speaker of the house of representatives, president of the senate, the governor, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established under RSA 126-AA:4, and the state library on or before December 1, 2019.

9 Termination of Granite Workforce Program.

I. The commissioner of the department of health and human services shall be responsible for determining, every 3 months commencing no later than December 31, 2018, whether available TANF reserve funds total at least $40,000,000. If at any time the commissioner determines that available TANF reserve funds have fallen below $40,000,000, the commissioners of the departments of health and human services and employment security shall, within 20 business days of such determination, terminate the Granite Workforce program. The commissioners shall notify the governor, the speaker of the house of representatives, the president of the senate, the chairperson of the legislative fiscal committee, and Granite Workforce participants of the program's pending termination.

II. If at any time the New Hampshire granite advantage health care program, established under RSA 126-AA, terminates, the commissioners of the departments of health and human services

and employment security shall terminate the Granite Workforce program. The date of the Granite Workforce program's termination shall align with that of the New Hampshire granite advantage health care program.

10 Insurance Premium Tax; New Hampshire Granite Advantage Health Care Program. Amend RSA 400-A:32, III to read as follows:

III.(a) Except as provided in subparagraph (b), the taxes imposed in paragraphs I and II of this section shall be promptly forwarded by the commissioner to the state treasurer for deposit to the general fund.

(b) Taxes imposed attributable to premiums written for medical and other medical related services for the newly eligible Medicaid population as provided for under RSA [~~126-A:5, XXIV-XXVI~~] *126-AA* shall be deposited into the New Hampshire [~~health protection trust fund, established in RSA 126-A:5-b~~] ***granite advantage health care trust fund established in RSA 126-AA:3.*** The commissioner shall notify the state treasurer of sums for deposit into the New Hampshire [~~health protection~~] ***granite advantage health care*** trust fund no later than 30 days after receipt of said taxes. ***The moneys in the trust fund may be used for the administration of the New Hampshire granite advantage health care program, established in RSA 126-AA.***

11 Plan of Operation for the High Risk Pool. Amend RSA 404-G:5-a, IV(d) to read as follows:

(d) [~~For the period of January 1, 2017 through December 31, 2018,~~] An amount not to exceed [~~50 percent of the remainder amount, as defined in RSA 126-A:5-c, I(b), less the amount made available to the program pursuant to RSA 404-G:11, VI. The association shall transfer all amounts collected pursuant to this subparagraph and the amount made available to the program pursuant to RSA 404-G:11, VI to the New Hampshire health protection trust fund, established pursuant to RSA 126-A:5-b~~] ***the lesser of the remainder amount, as defined in RSA 126-AA:1, V, or the amount of revenue transferred from the alcohol abuse prevention and treatment fund pursuant to RSA 176-A:1, IV and taxes attributable to premiums written for medical and other medical-related services for the newly eligible Medicaid population, as defined in RSA 126-AA:1, V. The association shall transfer all amounts collected pursuant to this subparagraph to the New Hampshire granite advantage health care trust fund established pursuant to RSA 126-AA:3.***

12 New Hampshire Granite Advantage Health Care Program; Federal Match. Amend 2014, 3:10, I as amended by 2016, 13:13 to read as follows:

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under [~~RSA 126-A:5, XXIV-XXV between July 1, 2014 – December 31, 2016 is less than 100 percent, less than 95 percent in 2017 and less than 94 percent in 2018, of the amount as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIV and XXV shall be~~] ***RSA 126-AA is less than 94 percent in 2018, less than 93 percent in 2019, and less than 90 percent in 2020 and any year thereafter in which the program is authorized, then the program is hereby*** repealed 180

days after the event under this [~~subparagraph~~] *paragraph* occurs upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services *and consistent with the terms and conditions of any waiver approved by the Centers for Medicare and Medicaid Services for the program.* The commissioner shall [~~immediately issue notice to program participants of the program's pending repeal~~]*:*

(a) Within 48 hours after the event under this paragraph has occurred, notify the governor, the speaker of the house of representatives, the president of the senate, and the chairperson of the legislative fiscal committee of the program's pending termination; and

(b) Within 5 business days after the event in this paragraph has occurred, initiate notification of CMS and program participants of the program's pending termination.

13 Liquor Commission; Funds. Amend RSA 176:16, III to read as follows:

III. [~~3.~~4] *Five* percent of the previous fiscal year gross profits derived by the commission from the sale of liquor shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1. For the purpose of this section, gross profit shall be defined as total operating revenue minus the cost of sales and services as presented in the state of New Hampshire comprehensive annual financial report, statement of revenues, expenses, and changes in net position for proprietary funds.

III-a. In order to facilitate the initial funding of the granite advantage health care trust fund, established under RSA 126-AA:3, for the period of January 1 to June 30, 2019, an amount no less than 1/2 of the 5 percent of such gross profits based on the state comprehensive annual financial report for the state fiscal year 2017 shall be deposited into the alcohol abuse prevention and treatment fund no later than November 30, 2018.

III-b. No amount greater than 5% of the previous fiscal year gross profits derived by the commission from the sale of liquor as determined under this section shall be deposited into the alcohol abuse prevention and treatment fund established by RSA 176-A:1 for the purpose of supporting the payment of the non-federal share of the Granite Advantage Health Care Program.

Comment [MJ21]: Addresses cap of liquor fund use for non-federal share

14 Alcohol Abuse Prevention and Treatment Fund. Amend RSA 176-A:1, II and III to read as follows:

II. The fund shall be nonlapsing and continually appropriated for the purposes of funding alcohol education and abuse prevention and treatment programs. *The commissioner of the department of health and human services may accept gifts, grants, donations, or other funding from any source and shall deposit all such revenue received into the fund.* The

state treasurer shall invest the moneys deposited in the fund as provided by law. Interest earned on moneys deposited in the fund shall be deposited into the fund.

III. Moneys *received from all other sources other than the liquor commission pursuant to RSA 176:16, III* shall be disbursed from the fund upon the authorization of the governor's commission on alcohol and drug abuse prevention, treatment, and recovery established pursuant to RSA 12-J:1. Funds disbursed shall be used for alcohol and other drug abuse prevention, treatment, and recovery services, and other purposes related to the duties of the commission under RSA 12-J:3. ~~*provided, however, that funds received from any source other than the liquor commission, pursuant to RSA 176:16, III, shall not be used to support the New Hampshire granite advantage health care program and shall not be deposited into the fund established in RSA 126-AA:3.*~~

IV. Moneys received from the liquor commission pursuant to RSA 176:16, III and deposited into the fund shall be transferred to the New Hampshire granite advantage health care trust fund, established under RSA 126-AA:3, for use in ensuring the delivery of substance use disorder prevention, treatment, and recovery and other behavioral health services for persons enrolled in the New Hampshire granite advantage health care program; provided, however, that any program or service approved by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery that would have been funded from moneys transferred from the fund shall be paid for with federal or other funds available from within the department of health and human services. For this purpose and no later than December 1, 2018, the sum of $5,100,000 from the alcohol abuse and prevention treatment fund shall be transferred to the granite advantage health care trust fund for use in the period of January 1 to June 30, 2019. Beginning July 1, 2019 the funds deposited into the fund shall be transferred to the granite advantage health care trust fund established under RSA 126-AA:3 annually no later than June 1 for use during the forthcoming fiscal year based upon the most recently issued comprehensive annual financial report of the state.

15 Individual Health Insurance Market; Purpose. Amend RSA 404-G:1, II to read as follows:

II. Create a nonprofit, voluntary organization to facilitate the availability of affordable individual nongroup health insurance by establishing an assessment mechanism and an individual health insurance market mandatory risk sharing plan as a mechanism to distribute the risks associated within the individual nongroup market and to support the [~~marketplace premium assistance program established in RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program established in RSA 126-AA.*

16 Individual Health Insurance Market; Definitions. Amend RSA 404-G:2, X-a to read as follows:

X-a. "Plan of operation" means the plan of operation of the risk sharing mechanism, the high risk pool, support for the program established in RSA [~~126-A:5, XXV~~] *126-AA*, and the federally qualified high risk pool, including articles, bylaws and operating rules, procedures and policies adopted by the association.

17 Managed Care Law; Right to External Review. Amend RSA 420-J:5-a, II(a) to read as follows:

(a) Health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs but through a contracted health carrier, except where those services are provided through private insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV~~] *New Hampshire granite advantage health care program under RSA 126-AA* in which case all provisions of this chapter shall apply.

18 Insurance Department; Administration Fund. Amend RSA 400-A:39, VI(a) to read as follows:

(a) Based on the annual statement filed in such year by each insurer under RSA 400-A:31, RSA 420-A:20, RSA 420-B:9, RSA 420-F:9, or other financial statement filed under RSA 415-E:11, the commissioner shall ascertain each insurer's amount of gross direct premiums written, including policy, membership and other fees, service charges, policy dividends applied in payment for insurance, and all other considerations for insurance originating from policies covering property, subjects, or risks located, resident or to be performed in New Hampshire after deducting return premiums and dividends actually returned or credited to policyholders. The premium for Medicaid managed care coverage provided by a health carrier contracting with the department of health and human services under RSA 126-A:5, XIX shall not be included in an insurer's assessable premium, except where that coverage is provided through the purchase of insurance coverage pursuant to the [~~marketplace premium assistance program under RSA 126-A:5, XXV, or through the health insurance premium payment program under RSA 126-A:5, XXIII~~] *New Hampshire granite advantage health care program under RSA 126-AA.* If any such insurer does not otherwise timely provide the commissioner with the information necessary for such ascertainment, it shall do so on or before May 1 of each year.

19 New Subparagraph; Application of Receipts; New Hampshire Advantage Health Care Program. Amend RSA 6:12, I(b) by inserting after subparagraph (339) the following new subparagraph:

(340) Moneys deposited in the New Hampshire granite advantage health care trust fund under RSA 126-AA:3.

20 Severability. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provisions or applications, and to this end the provisions of this act are severable.

21 Contingency. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect on the date of certification by the commissioner of the department of health and human services to the director of legislative services and the secretary of state that 42 U.S.C. section 1396a(e)(14)(c) has been repealed or amended to permit the application of an asset test.

22 Funding; New Hampshire Granite Advantage Health Care Program. If the federal government amends 42 U.S.C. section 1396d (y)(1) to eliminate the state's share of funding for the New Hampshire granite advantage health care program, or if the federal government allows the use of savings within the Medicaid program to apply to the state's share of funding the program, or if any other state is permitted to receive funds from the federal government to allow a solely federally funded program, the commissioner of health and human services shall send a letter of notification regarding this change to the governor, the president of the senate, the speaker of the house of representatives, the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program established in RSA 126-AA, and the chairperson of the appropriate standing committee of the house and senate. The commissioner shall apply for the necessary waivers to similarly fund the New Hampshire granite advantage health care program.

23 Repeals. The following are repealed:

I. RSA 404-G:2, X-c, relative to the marketplace premium assistance program.

II. RSA 126-AA:4, relative to the commission to evaluate the effectiveness and future of the New Hampshire granite advantage health care program.

III. RSA 126-AA, relative to the New Hampshire granite advantage health care program.

IV. RSA 126-A:5-c, relative to funding the state share of the New Hampshire health protection program.

V. RSA 126-A:5-d, relative to voluntary contribution.

VI. RSA 126-A:5, XXX, relative to the New Hampshire health protection program.

VII. RSA 6:12, I(b)(340), relative to the moneys deposited in the New Hampshire granite advantage health care trust fund.

24 Effective Date.

I. Paragraph II of section 23 of this act shall take effect December 1, 2022.

II. Paragraphs III and VII of section 23 of this act shall take effect December 31, 2023.

III. Section 1 of this act shall take effect upon its passage.

IV. RSA 126-AA:2, II(b) as inserted by section 1 of this act shall take effect as provided in section 20 of this act.

V. Section 3-9 of this act shall take effect January 1, 2019.

VI. The remainder of this act shall take effect December 31, 2018.

TANF Authority for Granite Workforce in SB 313

The TANF program is a block grant program, which allows the state flexibility in program development, but within the bounds of meeting the 4 statutory purposes in the Social Security Act at 42 USC 601 and in regulations at 45 CFR 260.20, those being:

(a) Provide assistance to needy families so that their children may be cared for in their own homes or in the homes of relatives
(b) End the dependence of needy parents on government benefits by promoting job preparation, work and marriage;
(c) Prevent and reduce out of wedlock pregnancies and establish numerical goals for preventing and reducing the incidence of these pregnancies; and
(d) Encourage the formation and maintenance of two-parent families

42 USC 604 titled Use of Grants indicates a state to which a grant is made can use the grant in any manner reasonably calculated to accomplish the purposes establish by the law, and in any manner that was authorized under prior law.

In the state plan we must define eligible families for each program. Federal regulations do require that there is a child or youth involved in the case, and that the family be 'needy', and states can define the term 'needy'. Eligibility criteria is not the same for every service and the plan describes the services available to eligibility groups or refers to the family assistance policy manual for further reference. The plan is then submitted for review and approval by the Federal Administration of Children and Families (ACF).

Our most recent state plan is approved for 2017-2020. We also have the ability to submit an amendment any time a policy change is made so if other programs are authorized they will be added. We can do this after the fact, as long as it is within the quarter in which the change is made.

45 CFR sections for the TANF State Plan:

§201.2 General. - The State plan is a comprehensive statement submitted by the State agency describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, the regulations in subtitle A and this chapter of this title, and other applicable official issuances of the Department. The State plan contains all information necessary for the Administration to determine whether the plan can be approved, as a basis for Federal financial participation in the State program.

§ 201.3 Approval of State plans and amendments.
The State plan consists of written documents furnished by the State to cover each of its programs under the Act: Old-age assistance (title I); aid and services to needy families with children (part A of title IV); aid to the blind (title X); aid to the permanently and totally disabled (title XIV); or aid to the aged, blind or disabled (title XVI). The State may submit the common material on more than one program as an integrated plan. However, it must identify the provisions pertinent to each title since a separate plan must be approved for each public assistance title. A plan submitted under title XVI encompasses, under a single

plan, the programs otherwise covered by three separate plans under titles I, X, and XIV. After approval of the original plan by the Administration, all relevant changes, required by new statutes, rules, regulations, interpretations, and court decisions, are required to be submitted currently so that the Administration may determine whether the plan continues to meet Federal requirements and policies.

(a) *Submittal.* State plans and revisions of the plans are submitted first to the State governor or his designee for review in accordance with § 204.1 of this chapter, and then to the regional office. The States are encouraged to obtain consultation of the regional staff when a plan is in process of preparation or revision.

(b) *Review.* Staff in the regional offices are responsible for review of State plans and amendments. They also initiate discussion with the State agency on clarification of significant aspects of the plan which come to their attention in the course of this review. State plan material on which the regional staff has questions concerning the application of Federal policy is referred with recommendations as required to the central office for technical assistance. Comments and suggestions, including those of consultants in specified areas, may be prepared by the central office for use by the regional staff in negotiations with the State agency.

(c) *Action.* The Regional Administrator, exercised delegated authority to take affirmative action on State plans and amendments thereto on the basis of policy statements or precedents previously approved by the Administrator. The Administrator retains authority for determining that proposed plan material is not approvable, or that a previously approved plan no longer meets the requirements for approval, except that a final determination of disapproval may not be made without prior consultation and discussion by the Administrator with the Secretary. The Regional Administrator, or the Administrator formally notifies the State agency of the actions taken on State plans or revisions.

(d) *Basis for approval.* Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet, the requirements for approval are based on relevant Federal statutes and regulations. Guidelines are furnished to assist in the interpretation of the regulations.

(e) *Prompt approval of State plans.* Pursuant to section 1116 of the Act, the determination as to whether a State plan submitted for approval conforms to the requirements for approval under the Act and regulations issued pursuant thereto shall be made promptly and not later than the 90th day following the date on which the plan submittal is received in the regional office, unless the Regional Administrator, has secured from the State agency a written agreement to extend that period.

(f) *Prompt approval of plan amendments.* Any amendment of an approved State plan may, at the option of the State, be considered as a submission of a new State plan. If the State requests that such amendment be so considered the determination as to its conformity with the requirements for approval shall be made promptly and not later than the 90th day following the date on which such a request is received in the regional office with respect to an amendment that has been received in such office, unless the Regional Administrator, has secured from the State agency a written agreement to extend that period. In absence of request by a State that an amendment of an approved State plan shall be considered as a submission of a new State plan, the procedures under § 201.6 (a) and (b) shall be applicable.

(g) *Effective date.* The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted, and with respect to expenditures for assistance under such plan, may not be earlier than the first day on which the plan is in operation on a statewide basis. The same applies with respect to plan amendments that provide additional assistance or services to persons eligible under the approved plan or that make new groups eligible for assistance or services provided under the approved plan. For other plan amendments the effective date shall be as specified in other sections of this chapter.

From Administration for Children & Families (ACF) guidance for States - https://www.acf.hhs.gov/sites/default/files/ofa/categories_and_definitions_for_tanf_and_moe_funds.pdf :

TANF Non-Assistance: Expenditures that fulfill at least one of the four purposes of TANF (1 - provide assistance for needy families; 2 - promote job preparation, work, and marriage; 3 - prevent and reduce out-of-wedlock pregnancies; and 4 - encourage the formation and maintenance of two-parent families) but do not meet the definition of assistance at 45 CFR 260.31(a).

- Work Related Activities/Expenses: Expenditures include the following three subcategories:
  - Work Subsidies: Payments to employers or third parties to help cover the costs of employee wages, benefits, supervision, or training. Does not include expenditures related to payments to or on behalf of participants in community service and work experience activities that are within the definition of assistance.

  - Education and Training: Expenditures on educational activities that are consistent with the recognized work activities countable toward TANF participation rates or as a supplement to such activities, including secondary education (including alternative programs); adult education, GED, and ESL classes; education directly related to employment; education provided as vocational educational training; and postsecondary education. Does not include costs of early childhood education or after-school or summer enrichment programs for children in elementary or junior high school.

  - Other Work Activities/Expenses: Expenditures on work activities or work expenses that have not been reported as education or work subsidies (including staff costs related to providing work experience and community service activities, on-the-job training, job search and job readiness, job skills training, and training provided as vocational educational training), related services (such as employment counseling, coaching, job development, information and referral, and outreach to business and nonprofit community groups), and other work-related expenses such as costs for work clothes and equipment. Includes such costs when provided as part of a diversion program or as transitional services to individuals who ceased to receive assistance due to employment.

SB 313 Granite Workforce Subsidized Employment Provision

Below includes the Federal Poverty Guideline amounts for eligibility for Granite Workforce broken out by a household (HH) size of three and includes an indication of an employer subsidy at each FPG amount.

At 138% of FPG:

- HH size of 3 (could be two parents with one child or one parent with two children) the income limit for eligibility would be:
  - $28,676.40 annually,
  - $2,389.70 monthly or
  - $13.79 hourly at 40 hours a week or a month in wages.
- Employer subsidy for one month of wages at 50% reimbursement would be $1,194.85.

At 200% of FPG:

- HH size of 3:
  - $41,560.00 annually,
  - $3,463.33 monthly or
  - $19.98 hourly at 40 hours a week or a month in wages.
- Employer subsidy for one month of wages at 50% reimbursement would be $1,731.67.

At 250% of FPG:

- HH size of 3:
  - $51,950.00 annually,
  - $4,329.17 monthly or
  - $24.98 hourly at 40 hours a week or a month in wages.
- Employer subsidy for one month of wages at 50% reimbursement would be $2,164.58.

NH Health Protection Program (NHHPP) Enrollment by City or Town, 4/1/2018

Source: MMIS data as of 4/2/2018

City / Town	Member Count	City / Town	Member Count	City / Town	Member Count
ACWORTH	31	CONCORD	2,357	HALE'S LOCATION	-
ALBANY	47	CONWAY	651	HAMPSTEAD	152
ALEXANDRIA	84	CORNISH	49	HAMPTON	514
ALLENSTOWN	240	CROYDON	29	HAMPTON FALLS	42
ALSTEAD	94	DALTON	63	HANCOCK	45
ALTON	200	DANBURY	57	HANOVER	83
AMHERST	185	DANVILLE	113	HARRISVILLE	21
ANDOVER	83	DEERFIELD	112	HART'S LOCATION	-
ANTRIM	146	DEERING	97	HAVERHILL	254
ASHLAND	123	DERRY	1,248	HEBRON	28
ATKINSON	88	DORCHESTER	22	HENNIKER	110
AUBURN	97	DOVER	1,087	HILL	52
BARNSTEAD	178	DUBLIN	56	HILLSBOROUGH	302
BARRINGTON	254	DUMMER	21	HINSDALE	201
BARTLETT	101	DUNBARTON	50	HOLDERNESS	79
BATH	58	DURHAM	124	HOLLIS	101
BEDFORD	299	EAST KINGSTON	51	HOOKSETT	367
BELMONT	375	EASTON	9	HOPKINTON	133
BENNINGTON	67	EATON	16	HUDSON	683
BENTON	7	EFFINGHAM	133	JACKSON	24
BERLIN	689	ELLSWORTH	-	JAFFREY	230
BETHLEHEM	166	ENFIELD	133	JEFFERSON	37
BOSCAWEN	157	EPPING	223	KEENE	1,264
BOW	140	EPSOM	155	KENSINGTON	47
BRADFORD	79	ERROL	15	KINGSTON	178
BRENTWOOD	72	EXETER	430	LACONIA	1,417
BRIDGEWATER	37	FARMINGTON	374	LANCASTER	212
BRISTOL	177	FITZWILLIAM	109	LANDAFF	14
BROOKFIELD	22	FRANCESTOWN	39	LANGDON	11
BROOKLINE	107	FRANCONIA	45	LEBANON	429
CAMPTON	127	FRANKLIN	613	LEE	103
CANAAN	167	FREEDOM	66	LEMPSTER	56
CANDIA	93	FREMONT	92	LINCOLN	84
CANTERBURY	73	GILFORD	228	LISBON	119
CARROLL	38	GILMANTON	136	LITCHFIELD	167
CENTER HARBOR	49	GILSUM	33	LITTLETON	409
CHARLESTOWN	244	GOFFSTOWN	322	LONDONDERRY	542
CHATHAM	14	GORHAM	140	LOUDON	176
CHESTER	107	GOSHEN	38	LYMAN	23
CHESTERFIELD	98	GRAFTON	81	LYME	29
CHICHESTER	70	GRANTHAM	49	LYNDEBOROUGH	60
CLAREMONT	927	GREENFIELD	72	MADBURY	37
CLARKSVILLE	16	GREENLAND	90	MADISON	121
COLEBROOK	162	GREENVILLE	118	MANCHESTER	7,666
COLUMBIA	39	GROTON	16	MARLBOROUGH	89

NH Health Protection Program (NHHPP) Enrollment by City or Town, 4/1/2018

Source: MMIS data as of 4/2/2018

City / Town	Member Count	City / Town	Member Count	City / Town	Member Count
MARLOW	28	PLYMOUTH	232	WALPOLE	123
MASON	28	PORTSMOUTH	821	WARNER	102
MEREDITH	290	RANDOLPH	9	WARREN	62
MERRIMACK	509	RAYMOND	391	WASHINGTON	42
MIDDLETON	81	RICHMOND	52	WATERVILLE VALLEY	10
MILAN	51	RINDGE	173	WEARE	263
MILFORD	476	ROCHESTER	1,964	WEBSTER	70
MILLSFIELD	-	ROLLINSFORD	66	WENTWORTH	55
MILTON	188	ROXBURY	8	WENTWORTH'S LOCATION	-
MONROE	17	RUMNEY	86	WESTMORELAND	51
MONT VERNON	52	RYE	111	WHITEFIELD	152
MOULTONBOROUGH	150	SALEM	701	WILMOT	46
NASHUA	3,921	SALISBURY	44	WILTON	132
NELSON	27	SANBORNTON	103	WINCHESTER	267
NEW BOSTON	110	SANDOWN	141	WINDHAM	232
NEW CASTLE	-	SANDWICH	48	WINDSOR	8
NEW DURHAM	82	SEABROOK	513	WOLFEBORO	233
NEW HAMPTON	98	SHARON	11	WOODSTOCK	73
NEW IPSWICH	178	SHELBURNE	9	**Total**	**52,899**
NEW LONDON	45	SOMERSWORTH	561		
NEWBURY	62	SOUTH HAMPTON	23		
NEWFIELDS	29	SPRINGFIELD	24		
NEWINGTON	10	STARK	31		
NEWMARKET	284	STEWARTSTOWN	73		
NEWPORT	375	STODDARD	41		
NEWTON	120	STRAFFORD	124		
NORTH HAMPTON	84	STRATFORD	88		
NORTHFIELD	205	STRATHAM	113		
NORTHUMBERLAND	149	SUGAR HILL	14		
NORTHWOOD	145	SULLIVAN	41		
NOTTINGHAM	113	SUNAPEE	83		
ORANGE	9	SURRY	16		
ORFORD	27	SUTTON	49		
OSSIPEE	311	SWANZEY	317		
PELHAM	289	TAMWORTH	193		
PEMBROKE	213	TEMPLE	60		
PETERBOROUGH	204	THORNTON	126		
PIERMONT	33	TILTON	199		
PITTSBURG	46	TROY	122		
PITTSFIELD	248	TUFTONBORO	101		
PLAINFIELD	44	UNITY	29		
PLAISTOW	195	WAKEFIELD	229		

Note: Towns with fewer than 5 members have been suppressed (indicated by "-"), towns with no members, members with unknown town or out-of-state not shown.

	A	B	E	F	G	H	I	J
1	**SUMMARY OF FUNDING FOR TANF PROGRAM - FEDERAL FUNDS ONLY**							
2	**MOE SPEND OF GF REQUIRED AT $32M PER YEAR (this is in addition to the TANF spending totals below)**							
3			**TANF SFY 2014**	**TANF SFY 2015**	**TANF SFY 2016**	**TANF SFY 2017**	***TANF SFY 2018***	***TANF SFY 2019***
4		**List of activities funded**						
5			**ACTUAL**	**ACTUAL**	**ACTUAL**	**ACTUAL**	***Estimated***	***Estimated***
6								
7	Work Activities	Bureau of Welfare to Work Staff Costs, NHEP Contracts, Employment & Training Costs	**6,456,582**	**4,125,614**	**3,126,646**	**2,559,878**	*9,323,172*	*9,358,473*
8								
9	Basic Assistance	Cash Assistance to Clients	**8,946,698**	**5,277,779**	**3,904,145**	**5,746,205**	*10,239,805*	*10,239,805*
10								
13	DCYF/DJJS - Child and Family Services (5855) (Prior Law)	Svcs for Abuse/Neglect & CHINS authorized under AFDC	**3,623,249**	**4,380,391**	**6,002,654**	**8,081,641**	*6,500,000*	*6,500,000*
14								
15	Prevention of out of wedlock pregnancies (Family Planning/Home Visiting)	Contracts for Family Planning and Home Visiting Services	**576,643**	**593,226**	**639,626**	**841,420**	*900,000*	*900,000*
16								
17	Non-Recurrent Costs-Emergency Assistance	Emergency Assistance	**278,868**	**102,195**	**133,857**	**207,005**	*750,000*	*750,000*
18								
19	Transfer to CCDF for Child Care/SSBG Family Res Supp Contracts		**2,335,166**	**4,200,000**	**5,136,937**	**5,136,937**	*11,413,683*	*11,413,683*
20								
21	Support Services	Open Doors; Isiah 58; veterans				**895,817**	*264,000*	*264,000*
22								
23	Other (Field Elig and CPSW Staff Costs)	Costs of Eligibility Staff and Child Protective Social Workers	**2,948,829**	**1,325,948**	**1,003,879**	**1,237,380**	*1,500,000*	*1,500,000*
24								
25	Information Systems Operation & Support	New HEIGHTS and other system costs	**1,394,182**	**839,999**	**819,856**	**1,140,142**	*1,000,000*	*1,000,000*
26								
27	Administration	Costs of other staff that support TANF across the Dept; Translation and Interpretation contract costs. EBT contract costs. GTW $550k for evaluation review	**4,326,349**	**1,874,899**	**2,416,979**	**2,832,901**	*2,500,000*	*2,500,000*
28								
31	**Total**		**$ 30,886,566**	**$ 22,720,051**	**$ 23,184,579**	**$ 28,679,326**	*44,390,660*	*44,425,961*
32								
33								
34			***SFY14***	***SFY15***	***SFY16***	***SFY17***		
35								
36	TANF Balance		$ 21,687,290	$ 28,900,919	*$ 44,702,129*	*$ 60,116,738*	*$ 70,074,914*	*$ 64,205,515*
37	Federal Grant		$ 38,100,195	$ 38,521,261	*$ 38,599,188*	*$ 38,637,502*	*$ 38,521,261*	*$ 38,521,261*
38	Projected Expenditures		$ (30,886,566)	$ (22,720,051)	*$ (23,184,579)*	*$ (28,679,326)*	(44,390,660)	(44,425,961)
39	Ending Balance		$ 28,900,919	$ 44,702,129	*$ 60,116,738*	*$ 70,074,914*	$ 64,205,515	$ 58,300,815
40	**BALANCE ROUNDED TO MILLIONS**		**$ 28.9**	**$ 44.7**	**$ 60.1**	**$ 70.1**	**$ 64.2**	**$ 58.3**
41								
42	TANF 14, TANF 15 & TANF 16 are actual dollars expended							
43	TANF 18 & TANF 19 are as submitted in the agency phase of the budget							
44								
45								
46								

Under TANF, States have the flexibility and resources to develop programs that reach all needy families and promote success at work. Some important areas for States and communities to address include:

- Ensuring that families have sufficient food, medical coverage, quality affordable child care, and reliable transportation that enables them to work;
- Ensuring that custodial parents receive child support from noncustodial parents so they may pay their bills and adequately provide for their children;
- Focusing on education and training opportunities that improve wages and working conditions for low-income families;
- Crafting services for families with special needs or multiple employment barriers that appropriately and effectively address their needs; and
- Developing collaborative linkages among employers, local leaders and organizations, and faith-based and nonprofit community groups so as to combine their resources and talents to create jobs, support work and make low-income neighborhoods more viable.

As a general rule, States must use the available funds for eligible, needy families with a child and for one of the four purposes of the TANF program:

1. To provide assistance to needy families;
2. To end dependence of needy parents by promoting job preparation, work and marriage;
3. To prevent and reduce out-of-wedlock pregnancies; and
4. To encourage the formation and maintenance of two-parent families.

Currently NH provides the following services that are paid for as part of TANF from a combination of federal and general funds:

Basic Assistance

Cash Assistance

Work-Related Activities

Education and Training through the New Hampshire Employment Program (NHEP)

Work Supports and Supportive Services

Work Supports – Employment and Training Services (ETS) to resolve barriers to employment

Child Care

Transferred to Child Care and Development Fund for Child Care Scholarships

Program Management

Administrative Costs

Systems

Child Welfare Services

Authorized Under Prior Law: Child Welfare or Foster Care (Assistance and Nonassistance)

Other Areas

Nonrecurrent Short-Term Benefits

Transferred to Social Services Block Grant

Home Visiting Programs

Authorized Solely Under Prior Law (Assistance and Nonassistance): Juvenile Justice Payments

Authorized Solely Under Prior Law (Assistance and Nonassistance): Emergency Assistance

Related Link:

ACF's TANF Funding Guide

: https://archive.acf.hhs.gov/programs/ofa/resources/funding_guide.htm

April 9th Testimony

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET CONCORD NH 03301 3857
603-271-9200 FAX 603-271-4912 TDD ACCESS RELAY NH 1-800-735-2964

JEFFREY A. MEYERS
COMMISSIONER

January 11, 2018

His Excellency, Governor Christopher T. Sununu
State House, 107 North Main Street
Concord, NH 03301

RE: NH Health Protection Program, Remainder Amount Calculation

Dear Governor Sununu:

I am writing to report the "remainder amount" calculation for the New Hampshire Health Protection Program due on January 15, 2018, as required in Section 13:6 of HB 1696 (2016 Laws Ch.13) codified at RSA 126-A:5-c(IV), a projected Remainder Amount of $9,106,954.

The remainder amount includes anticipated high risk pool amounts and reflects that the estimated premium tax revenue will be deposited into the Trust Fund by April of 2018. Should that not occur, for any reason, then the remainder amount would require further recalculation.

	CY 2017 ACTUAL	CY 2018 Projection
Cost of Coverage for the Program	$451,820,753	$549,634,206
Health Insurer Provider Fee	$3,396,864	$950,000
Administrative Costs	$646,800	$2,170,640
Total Costs	**$455,864,417**	**$552,754,845**
Less:		
Federal Reimbursement: Program & Admin	$432,780,136	$516,898,077
Estimated Insurance Premium Tax Revenue	$0	$10,600,000
Total Reimbursement & Tax Contributions	$432,780,136	$527,498,077
Balance of non-federal remaining CY2017 year-end		$3,524,814
Remainder Amount	**$23,084,281**	**$21,731,954**
Remainder Amt	$23,084,281	$21,731,954
High Risk Pool	$13,139,474	$12,625,000
Remainder Amount	**$9,944,807**	**$9,106,954**

Please note, the Health Insurer Provider fee is payable under Section 9010 of the ACA and imposes an annual fee on Health Insurance Providers. The fee is allocated to qualifying health insurers based on their premium in the previous year. Each health insurer's fee is calculated as their market share multiplied by the annual fee. Market share is based on commercial, Medicare and Medicaid premium revenue after applying prescribed dollar thresholds. Not-for-profit insurers that receive more than 80% of their premium revenue from Medicare, Medicaid and SCHIP are exempt from the fee.

As provided in the statute, no state general funds are used to fund the 6% non-federal share of the program in calendar year 2018. The Department will revisit these calculations by August 15, 2018, as required under the statute.

Sincerely,

Jeffrey A. Meyers
Commissioner

cc: The Honorable Gene G. Chandler, Speaker of the House of Representatives
The Honorable Chuck Morse, Senate President
Roger A. Sevigny, Commissioner, New Hampshire Insurance Department
Michael Kane, Legislative Budget Assistant
J. Michael Degnan, New Hampshire Health Plan
Peter Ames, Foundation for Healthy Communities

Granite Advantage Health Program Funding Estimate

	GAHP 6 mos SFY 2019 1/1/19-6/30/19	GAHP 12 mos SFY 2020
Cost of Coverage for the Program	$169.0	$352.8
Administrative Costs	$1.5	$1.5
Total Costs	**$170.5**	**$354.3**
Less:		
Federal Reimbursement	$158.6	$324.2
State Share	$11.9	$30.1
Alcohol Fund	$5.1	$10.2
Insurance Premium Tax Revenue	$6.0	$4.9
Remainder Amount Needed	**$0.8**	**$15.0**
High Risk Pool Contribution	$0.8	$15.0
Net	**$0.0**	**$0.0**

Notes:

Reporting format reflects the SB 313 change in the definition of the Remainder Amount and moving to a State Fiscal year basis.

1 **Cost of Coverage:**

SFY19 is a six month period under MCM coinciding with the 1/1/9-6/30/19 start date of the Granite Advantage Health Program, and moving to a SFY basis.

2 **Federal Match Rates:**

93% federal match eff 1/1/19 GAHP Period 1/1/19-6/30/19
91.5% federal match 12 Mos SFY 2020 (93% for the first six months and 90% thereafter)

Apr 11 '19 Tax

90 day retroactive annual cost $000 FY 19

DHHS cost for claims (7%)	2,400	
Total claims	34,285	
Hospital claims at 30% (conservative)	10,285	
MET revenue at 5.4%	555	23%
Hospital claims at 60% (aggressive)	20,571	
MET revenue at 5.4%	1,110	46%

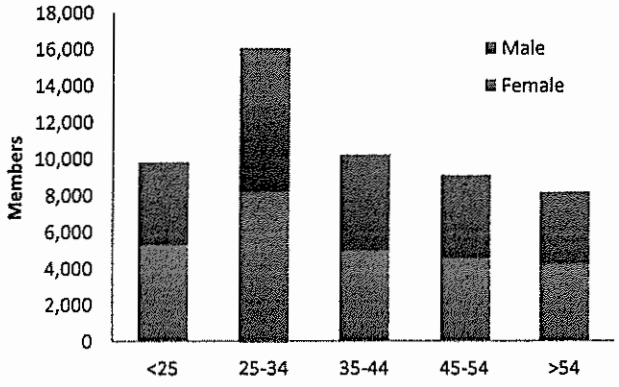
DSH to provider payments	TF	GF
Conservative case	12,285	6,142
Aggressive case	22,571	11,285

Rosenwald

NH Health Protection Program Demographic Profile, 2/1/18

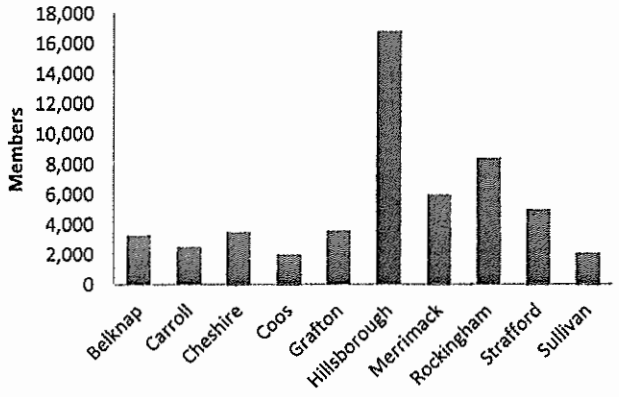
Data Source: 2/2/18 extract from MMIS

Enrollment by Age Group and Gender



Members	Gender			Age
Age Group	Female	Male	Total	Percent
<25	5,292	4,502	9,794	18%
25-34	8,224	7,875	16,099	30%
35-44	5,046	5,153	10,199	19%
45-54	4,595	4,494	9,089	17%
>54	4,286	3,890	8,176	15%
Total	**27,443**	**25,914**	**53,357**	
Gender Percent	51%	49%		

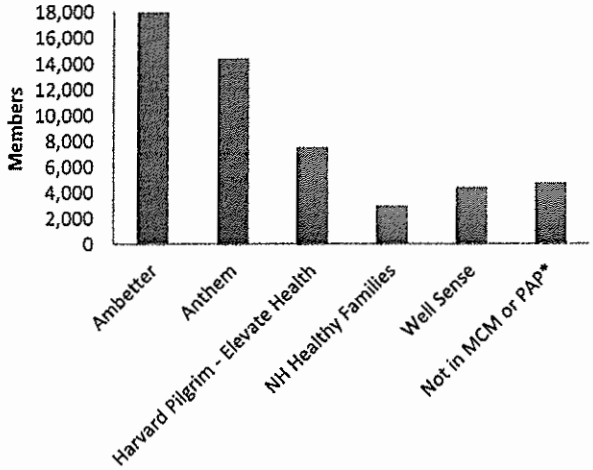
Enrollment by County



County	Members	Percent
Belknap	3,247	6%
Carroll	2,523	5%
Cheshire	3,527	7%
Coos	2,046	4%
Grafton	3,579	7%
Hillsborough	16,831	32%
Merrimack	6,028	11%
Rockingham	8,417	16%
Strafford	5,051	9%
Sullivan	2,094	4%
Total*	**53,343**	

*Excludes members with unknown county

Enrollment by Health Plan



Health Plan	Members	Percent
Ambetter	19,033	36%
Anthem	14,480	27%
Harvard Pilgrim - Elevate Health	7,540	14%
NH Healthy Families	3,033	6%
Well Sense	4,486	8%
Not in MCM or PAP*	4,785	9%
Total	**53,357**	

* Members not yet in a plan are in their initial plan selection window, waiting until the first of the month to join a plan, or are in the Health Insurance Premium Payment part of NHHPP. Members in Medicaid MCOs are either medically frail or are in their PAP plan selection window after having migrated from a standard Medicaid category to NHHPP.