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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 18-0008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

September 28, 2018

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers,

Enclosed is an approved copy of New Hampshire's (NH) State Plan Amendment (SPA) No 18-0008 entitled, "*New Hampshire Granite Advantage Cost Sharing,*" which transmitted language to amend the NH Title XIX State Plan cost sharing for the new adult group to align with cost sharing for other Medicaid eligibility categories.

Transmittal # 18-0008 -- New Hampshire Granite Advantage Cost Sharing
--Effective January 1, 2019

If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Henry Lipman, State Medicaid Director
Diane Peterson, Medicaid Business and Policy

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **New Hampshire**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NH-18-0008

Proposed Effective Date

01/01/2019 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 447.52; 42 CFR 447.56; 1915(b)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2019	$ 0.00
Second Year	2020	$ 0.00

Subject of Amendment

NH Granite Advantage Cost Sharing

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  Comments, if any, will follow

Signature of State Agency Official

Submitted By:	**Diane Peterson**
Last Revision Date:	**Aug 2, 2018**
Submit Date:	**Aug 2, 2018**

Date Received: 08/02/2018

Plan Approved - One Copy Attached

Date Approved: 09/28/2018

Effective Date of Approved Material: 01/01/2019

Signature of Regional Official

/s/

Typed Name: Richard McGreal

Division of Medicaid & Children's Health Operations
Boston Regional Office

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 18-0008 Approved: 09/28/2018 Effective: 01/01/2019	**STATE**: New Hampshire Cost Sharing, Granite Advantage
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: G2c - Cost Share Targeting, Page 1 G3 - Cost Sharing Limitations, Pages 1-5	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable):** G2c-Cost Share Targeting, Pages 1-2, TN 18-0003 G3-Cost Sharing Limitations, Pages 1-5, TN 16-0002

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

OMB Control Number: 0938-1148

Transmittal Number: NH - 18 - 0008

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

OMB Control Number: 0938-1148

Transmittal Number: NH - 18 - 0008

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.	No
The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.	Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - ☐ Other procedure

  Additional description of procedures used is provided below (optional):

  The state will rely on the following question in the single streamlined application: "Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian Health Program, or through a referral from one of these programs?" Any individual who answers "yes" will be exempt from cost-sharing.

- ■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

Members that have cost sharing are flagged with an indicator which includes the date span to which the cost sharing applies. It is possible for a member to have multiple cost sharing spans with different dates due to tracking of cost sharing, which occurs quarterly. This indicator and date spans are sent from the New HEIGHTS eligibility system to the MMIS. The MMIS stores this information and sends it to out managed care organizations and to our PBM for use in claims payment. Through EVS (electronic verification), providers are able to identify if the member has a cost sharing responsibility.

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

◉ 5%

○ 4%

○ 3%

○ 2%

○ 1%

○ Other: ____ %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

◉ Quarterly

○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☒ Managed care organization(s) track each family's incurred cost sharing, as follows:

For members enrolled in an MCO subject to copayment, cost sharing is limited to prescriptions. As claims are submitted for prescriptions filled within the family's current quarterly cap period, the MCO's PBM applies the incurred cost sharing for those prescriptions to the family's aggregate limit. The MCOs transmit weekly data files with the quarterly copayment information by member through fiscal agent's Electronic Data Interchange Gateway, a secure file transfer protocol (SFTP) server. The New Heights application produces a weekly report identifying household members and mailing addresses which is also sent via SFTP. Copayment and member data from all sources are uploaded into an Access database, which consolidates copayments by member and by household. Members and households that exceed the quarterly out of pocket limit are identified through Access queries.

☐ Other process:

■ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The eligibility and enrollment system, New Heights, will remove the signifier of copay from the member files when the family's aggregate limit has been reached. This information is sent to MMIS and then to the FFS PBM and to the MCOs to suppress copayment for the remainder of the quarter. Providers will continue to check MMIS for eligibility and will see that there is no copay for that member during the remainder of the quarter. Since copay tracking is being performed by the MCO's PBM to incurred cost sharing for prescriptions to the family's aggregate limit, if the MCO PBM identifies a member reaching the quarterly cap limit, the PBM will suppress copay, and DHHS will notify the member that the copay quarterly cap has been reached. DHHS' Access Database receives reports from the MCOs and the FFS PBM and will notify New Heights to suppress copay when the member has reached the aggregate limit. DHHS' Access Database also sends a notification to members who reach the family's aggregate limit.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. No

■ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The beneficiary may bring receipts to the Medicaid agency to demonstrate that they paid cost-sharing in excess of the aggregate limit for the quarter. The Medicaid agency will review the receipts and reimburse beneficiaries for any amount above the aggregate limit.

■ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

At any time, enrollees may notify the Medicaid agency of a change in income or other circumstances that might change their aggregate cost-sharing limit. Once a beneficiary notifies the Medicaid agency of such change, the Medicaid agency will review the updated information and change aggregate limits, if necessary.	
The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).	No

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