FIS 14 079

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

MARGARET WOOD HASSAN
Governor

May 21, 2014

The Honorable Mary Jane Wallner, Chairperson
Fiscal Committee of the General Court
State House
Concord, NH 03301

Dear Chairperson Wallner and Members of the Fiscal Committee:

Through March of this year, the state was running approximately $25 million ahead of its conservative revenue plan. As I am sure you are aware, general and education fund unrestricted revenues, driven principally by shortfalls in revenues from business taxes and the interest and dividend tax, came in nearly $22 million below plan in April, reducing our current revenue surplus to just $3.9 million.

We built a conservative budget, estimating that in fiscal year 2014 business taxes would increase just $9.3 million, or 1.7 percent, over revenue collected in fiscal year 2013, and that interest and dividends taxes would grow by $3.1 million, or 3.3 percent over revenue received in fiscal year 2013.

While other revenue sources linked to the economy, including the real estate transfer tax and the meals and rentals tax, continue to perform above plan, the interest and dividends tax and business taxes dropped in April below collections during the same month of last year. The Department of Revenue Administration continues to analyze the reasons for these sudden drops in revenue. But the decreases appear to be related, at least in part, to a number of changes in the state tax code in recent years, as well as to businesses beginning to apply various tax credits and carry forwards accrued during the recession. As you know, we debated postponing some of those tax law changes during the last budget process, and worked to consider the fiscal impact.

As New Hampshire's employment and economic picture continue to improve, the Department of Revenue Administration will need further data and further analysis to determine whether this is a short-term drop or a long-term trend. But given the limited information, we should act prudently, responsibly, and expeditiously to continue to ensure a balanced budget for the biennium.

Therefore, in addition to the existing back-of-the-budget reduction to personnel, I am presenting an Executive Order freezing hiring, out-of-state travel, equipment, and

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purchasing funded with general funds, except when agencies are granted a waiver. I would ask that the legislative and judicial branches take similar actions. As we further analyze revenues, I will be meeting with agencies to examine additional reductions, some of which may require legislative approval.

Last year, we came together, focused on our shared purpose and priorities, and enacted the most bipartisan budget in over a decade. We must continue our bipartisan progress and work together in a fiscally responsible manner in order to ensure that we protect taxpayer dollars and the state's budget. We will continue to keep you updated as matters develop. Thank you for your assistance.

With every good wish,

Maggie H

Margaret Wood Hassan
Governor

Enclosures: Executive Order 2014-2

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MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

BY HER EXCELLENCY
MARGARET WOOD HASSAN, GOVERNOR
EXECUTIVE ORDER 2014-02

An order directing a freeze of Executive Branch hiring, purchasing, equipment, and out-of-state travel to reduce state general fund expenditures

WHEREAS, RSA 9:16-b provides that "[n]ot withstanding any other provision of law, the governor may, with prior approval of the fiscal committee, order reductions in any or all expenditure classes within any or all departments, as defined in RSA 9:1, if [she] determines at any time during the fiscal year that: (a) projected State revenues will be insufficient to maintain a balanced budget and that the likelihood of a serious deficit exists;" and

WHEREAS, the Governor has determined that the projected state revenues for Fiscal Years 2014 and 2015 are potentially insufficient to fund the state expenditures as authorized by Chapter 143, N. H. Laws of 2013; and

WHEREAS, the Governor and the Legislature are committed to taking such steps as are required to achieve a balanced budget by the end of the biennium; and

WHEREAS, the Governor has met with the presiding officers of the House and Senate and has thus determined that it is in the public interest to meet with the legislative fiscal committee, which has, in turn, responded to the Governor's initiative by consenting to certain actions to reduce state general fund expenditures;

NOW, THEREFORE, I, MARGARET WOOD HASSAN, GOVERNOR of the State of New Hampshire, by virtue of the power and authority vested in me by RSA 9:16-b and part II, article 41 of the New Hampshire Constitution, do hereby order the following steps to apply to all departments as defined in RSA 9:1 in order to effect a reduction in expenditures:

a. All full-time classified and unclassified employee positions funded in whole or in part by the general fund which are vacant on the effective date of this Executive Order or which become vacant after its effective date shall remain vacant during the remainder of the biennium encompassing fiscal years 2014 and 2015, with the exception of direct care, custodial care, and law enforcement positions. The appropriation for each such position shall be lapsed forthwith to the Salary

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Adjustment Fund, RSA 99:4, and the Employee Benefit Adjustment Account, RSA 9:17-c, as applicable.

b. No purchases shall be submitted or processed that require form RQ10, pursuant to Purchase and Property rules and procedures promulgated by the department of administrative services, if the purchases are funded in whole or in part with general funds, with the exception of purchases for food, drugs, fuel, medical supplies, or items necessary under emergency conditions that are required for the continued operation of the department. The commissioner of the department of administrative services shall have the authority for determining whether there exists an emergency condition at any department that necessitates the purchase of items subject to this Executive Order. This order shall not apply to purchases encumbered by contract or purchase orders on or before the date of this Executive Order.

c. No general fund monies appropriated for equipment, for the remainder of the biennium encompassing fiscal years 2014 and 2015, shall be expended or encumbered, except those encumbered by contract or purchase orders on or before the effective date of this Executive Order.

d. No general fund monies appropriated for Class 80 out-of-state travel, for the remainder of the biennium encompassing fiscal years 2014 and 2015, shall be expended or encumbered, except those encumbered on or before the effective date of this Executive Order.

e. The hiring, purchasing, equipment and out-of-state travel freeze directed by this order shall remain in effect until June 30, 2015 or until terminated under the provisions of RSA 9:16-b; provided, however, that individual exceptions to any of the above provisions may be requested by any agency in writing to the Governor. Any exceptions granted by the Governor shall be transmitted to the Fiscal Committee.

Given under my hand and seal at the Executive Chambers in Concord, this Twenty Second day of May, in the year of Our Lord, two thousand and fourteen and of the independence of the United States of America, two hundred and thirty-eight.

GOVERNOR OF NEW HAMPSHIRE

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FIS 14-071
Replacement

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

NICHOLAS A. TOUMPAS
COMMISSIONER

May 22, 2014

The Honorable Mary Jane Wallner
Chairman
Fiscal Committee of the General Court
Legislative Office Building
104 North State Street
Concord, N.H. 03301

Dear Chairman Wallner and Members of the Committee:

Requested Action

Pursuant to the requirements of the New Hampshire Health Protection Act (SB 413), codified at RSA 126-A:5,XXIII-XXVI, the New Hampshire Department of Health and Human Services requests approval of four amendments to the New Hampshire State Medicaid Plan in order to implement the mandatory Health Insurance Premium and Voluntary Bridge to Marketplace programs under the New Hampshire Health Protection Program for the new adult group in New Hampshire. These state plan amendments are:

1. Alternative Benefit Plan Amendment
2. Cost Sharing Amendment
3. Payment Amendment
4. FMAP Drawdown Amendment

The Department is also submitting, as an information item, an update on the statue of the Section 1115 waiver.

Background and Description of SPAs

The NH Department of Health and Human Services (DHHS) is submitting four Medicaid state plan amendments required for the implementation of the New Hampshire Health Protection Program to the Fiscal Committee for review and approval at the May 22, 2014, meeting.

Specifically, we are submitting the state plan amendments for (i) the Alternative Benefit Plan (ABP), which describes in detail the benefits to be made available to the new adult group under the New Hampshire Health Protection Program (NHHPP); (ii) the cost sharing requirements for the mandatory HIPP and Voluntary Bridge to Marketplace Programs; and (iii) the payment of the 100% FMAP for the new adult group through December 31, 2016, consistent with the requirements of the NHHPP. As part of the ABP SPA, we are submitting changes to the Medicaid state plan "payment pages" in order to authorize federal payment of the new Substance Use Disorder Benefit for the new adult group, which is a new benefit that is being authorized for federal payment for the first time.

For the Committee's information, we have summarized below the contents and purpose of the state plan amendments.

1. Alternative Benefit Plan SPA

The Alternative Benefit Plan is the plan established by the State for the medical benefits provided to the new adult group. Under federal law, the ABP must cover the 10 essential health benefits, early periodic screening diagnostic and treatment services for 19 and 20 year olds; and non-emergency medical transportation. In recognition of the requirements of the New Hampshire Health Protection Program to eventually transition most of the new adult group to Qualified Health Plans on the New Hampshire Marketplace, the Department is aligning its ABP with existing QHPs on the Marketplace.

The ABP SPA is made up of 11 separate sections, as follows:

ABP 1: This section identifies (i) the population for which the ABP is being established – the new adult group; (ii) that enrollment is mandatory, and (iii) that the new adult population will be State wide.

ABP 2a: This section documents how the ABP will be applied to the new adult group. It establishes that New Hampshire's ABP will not offer all of the benefits provided by the standard state Medicaid benefit. (As pointed out above, we are aligning the ABP with the Essential Health Benefits in the "Benchmark" plan for New Hampshire, which is the Mathew Thornton Blue Health Plan). This section also contains a series of boxes that contain a "check." These are federal requirements with which we must comply.

ABP2c: This section is very similar to ABP 2a. ABP2c documents assurances that will be provided to those newly eligible persons that are exempt from mandatory enrollment such as children, currently eligible parents, blind or disables persons, pregnant women and foster children.

The boxes checked in ABP2c are federal requirements. The boxes that contain an "x" indicate how the State will comply with certain requirements. For example, on page 1 of 3 of ABP2c, we have indicated that we will identify exempt individuals by reviewing eligibility criteria and through self-identification.

Page 1 of ABP 2c also contains a narrative that explains how New Hampshire will identify and provide benefits to those individuals who are "medically frail."

Federal law requires that individuals who have a physical, mental or emotional health condition that causes limitations in daily activities, such as bathing, dressing, daily chores or who live in a medical facility or nursing home must be offered the choice of receiving the State's current Medicaid benefit, as opposed to the ABP. These persons are considered 'medically frail," and, as such, must be given the opportunity to access services not included in the ABP, such as long term care services, provided that they also satisfy the medical necessity requirements for those services.

ABP3: This section documents the coverage that will be offered to the newly eligible population: the essential health benefits as established under the Mathew Thornton Blue Plan, plus the essential health benefits that are not included in that plan, namely, non-emergency medical transportation, Early Periodic Screening, Diagnosis and Treatment Services (EPSDT) for 19 and 20 year olds, and access to federally qualified health centers, rural health centers and family planning providers.

ABP4: This section references the cost-sharing plan that is being submitted for the new adult population. There is a separate SPA for cost-sharing that is being submitted to the Fiscal Committee. The contents of the cost-sharing proposal are described below in that section of the letter.

ABP5: The purpose of this section is to describe the benchmark plan that is used to establish the ABP in New Hampshire. The benchmark plan is the Mathew Thornton Blue plan, and also includes oral and vision benefits as established under a federal benefits plan called the FEDVIP plan.

This section also lists the benefits to be provided, along with information regarding prior authorization, service limits and scope of coverage limits, if any.

ABP7: The purpose of this section is to obtain state assurances for the provision of EPSDT services to 19 and 20 year olds in the new adult group.

ABP8: The purpose of this section is to establish that managed care will be used to deliver services to the new adult group.

ABP9: This section documents that New Hampshire will be providing the ABP to those newly eligible persons with access to cost effective employer sponsored insurance. To the extent that the employer insurance does not provide an essential health benefit included in the ABP, such benefit will be provided to the newly eligible person through a wrap of benefits. This same provision is made for any newly eligible that accesses coverage though a voluntary premium assistance program, if determined to be cost effective.

ABP10: This section reflects several general assurances regarding the ABP as required by federal law, such as compliance with existing law, non-discrimination provisions and the federal Medicaid statute.

ABP11: This section documents that for any benefit provided under the ABP that is not provided through managed care, the state will use a state plan approved payment methodology.

Please note there is no ABP2b or ABP6. Those sections do not apply to the ABP being submitted by the state.

2. Payment SPA

Included with the Alternative Benefit SPA are changes to the payment provisions of New Hampshire's State Medicaid plan that will authorize the payment by Medicaid of certain services required under federal law for the new adult group that the state does not now provide to the current population. These new services are the substance use disorder benefit and chiropractic services, which are included under the Essential Health Benefits. These Medicaid state plan "payment pages" must be amended to include these two categories of benefits so that services rendered for the new adult group will be paid by the federal government. These services will be paid with 100% federal funds through December 31, 2016.

Because the payment pages are changes to the New Hampshire State Medicaid plan, they are considered a state plan amendment that must be approved by the Fiscal Committee in accordance with the New Hampshire Health Protection Act.

3. Cost-Sharing SPA

The Cost Sharing SPA describes the charges and co-payments that will be applied to the new adult group consistent with the New Hampshire Health Protection Act. The language of SB 413 provides that:

> "To the greatest extent practicable the waiver or state plan amendments shall incorporate measures to promote continuity of health insurance coverage and personal responsibility, including but not limited to: co-pays, deductibles, disincentives for inappropriate emergency room use, and mandatory wellness programs. "

SB 413, 2014 Laws Ch. 3:2 XXIV(b).

In summary, the Department is proposing the following cost-sharing provisions:

1. The new adult group with incomes above 100% of the FPL will be subject to a prescription drug co-pay of $1 for generic prescription drugs and $4 for brand prescription drugs.
2. Those in the Ticket to Work Program (MEAD) above 100% of the FPL would remain subject to the current prescription drug co-pays of $1 for generic prescription drugs and $2 for brand prescription drugs.
3. The new adults with incomes under 100% of the FPL and the existing Medicaid beneficiaries who are under 100% of the FPL would not be subject to any co-pays.

Like the ABP SPA, the Cost Sharing SPA is comprised of several sections, as follows:

G1: This section documents that the state will comply with federal law in applying cost sharing to persons who are Medicaid beneficiaries. The boxes that contain a "check" are federal requirements, as are the boxes that are shaded in black. The boxes shaded in black appear automatically on the form (which is electronic) once the check is made at the beginning of a section. The boxes that contain an "x" reflect how the state will comply with a particular requirement.

G2a: This section affirms that the state does not charge cost sharing to those persons who are considered to be "categorically needy" of Medicaid coverage such as children, pregnant women, newborns, persons receiving SSI, the blind and disabled and those who are dual eligible. This SPA would not be approvable if we indicated that we apply cost sharing to the categorically needy.

G2b: This section affirms that the state does not charge cost sharing to those who are considered "medically needy," who are the population that are not eligible because of income, but would be eligible for Medicaid if they spent their excess income on medical bills, i.e. the "spend down population."

G2c: This section describes the cost sharing being applied to the new adult group in the New Hampshire Health Protection Program that is outlined above.

G3: This section documents how the state will comply with a variety of federal requirements for the imposition of cost sharing.

4. FMAP SPA

New Hampshire is also submitting an FMAP claiming SPA that will allow the state to claim the 100% federal funds for the new adult group for the period through December 31, 2016. The FMAP SPA identifies the population and the methodology used by the State to claim the federal funds to pay for all medical services for the new adult group.

5. Section 1115 Waiver Application

The Department is also submitting, for information, an update on the status of the Section 1115 waiver. As I informed you and the members of the Committee yesterday, the Department received a number of written comments at the very end of the public comment period, and the Department requires additional time in which to evaluate these comments in the context of the waiver.

We look forward to this afternoon's meeting.

Respectfully Submitted,

Nicholas A. Toumpas
Commissioner

Jeffrey A. Meyers
Director, Intergovernmental Affairs

Enclosures

cc: Members, Fiscal Committee

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: New Hampshire New Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Describe:

The State gives beneficiaries the option of receiving all official communications through an online portal, rather than a paper notice. Individuals who elect this option receive an email notifying them that a new notice has been uploaded to the portal. When the individuals log on to the portal, they see a PDF of a notice. The text of the notice is identical to the hard copy notice sent to other individuals.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan and informing them of the differences in the benefits.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan and informing them of the differences in the benefits.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Additionally, a Medicaid member can self-identify at any time as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

The state will review to ensure the person is newly eligible under Section 1902(a)(10)(A)(i)(VIII) and is not in any of the following categories: children; currently eligible parents; blind or disabled; pregnant women; or foster children.

☒ Self-identification

Describe:

During the application process, if a member answers "yes" to the following question: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?" it will trigger a "Medical Frailty Notice" along with the Medicaid eligibility determination notice informing them they have a right to choose between the Alternative Benefit Plan (ABP) and the ABP that is the Medicaid State Plan.

Every enrollee will receive a copy of their Rights and Responsibilities including information about medical frailty and how to get more information regarding their coverage options. A copy of this document is also provided to every member at the time of their annual redetermination or in the event they have an eligibility category change.

Additionally, a Medicaid member can self-identify at any time during their eligibility period as having a chronic substance use disorder, serious and complex medical condition, or physical, behavioral, intellectual, or developmental disorder and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information. Member Services staff will have a script for providing choice counseling to people who identify themselves as medically frail.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Alternative Benefit Plan

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☐ Review of claims data
- ☒ Self-identification
- ☒ Review at the time of eligibility redetermination
- ☐ Provider identification
- ☒ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ◉ Ad hoc basis
- ○ Other

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals who self-identify as medically frail at the time of application will return the notice included with their eligibility determination in order to notify the State that they would like to be disenrolled from the ABP and enrolled in the ABP that is the Medicaid State Plan. Instructions for completing this process are included in their eligibility determination notice.

Individuals seeking exemption from the Alternative Benefit Plan at any time during their period of eligibility will notify the Medicaid agency who will initiate the change process. The appropriate contact information for the agency is included in their eligibility determination notice. Once the applicant makes the request, the same notice delivered as part of the medically frail individuals' eligibility notice will be sent to the member. Individuals that would like to be enrolled in the ABP that is the Medicaid State Plan must complete the form and return it to the Medicaid agency to complete the process. All requests to disenroll from the ABP must be submitted in writing to the Medicaid agency.

The notices provided to individuals who either respond affirmatively to the triggering question on the initial application or who later self-identify as exempt include a description of the differences between the ABP and the ABP that is the Medicaid State Plan. The notices also inform individuals that if they elect to receive the ABP, they may request to be moved to the ABP that is the Medicaid State

Plan at any time by contacting the Medicaid agency.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

PRA Disclosure Statement

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

V.20131219

Alternative Benefit Plan

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Attachment 3.1-L- [ ]

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

New Hampshire has created its Adult Group Alternative Benefit Package based on the Matthew Thornton Blue Health Plan, which is the base benchmark plan selected by the State to define Essential Health Benefits for products in the Marketplace. The State has added the additional benefits required for the Alternative Benefit Package, but not covered by the base benchmark plan, namely, non-emergency medical transportation and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Individuals will also have access to FQHC and RHC services, as well as open access to family planning providers.

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Alternative Benefit Plan

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Matthew Thornton Blue Health Plan

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The Matthew Thornton Blue Health Plan is the second largest plan by enrollment in the small group insurance market. The Matthew Thornton Blue Health Plan was selected by the State of New Hampshire to be the base benchmark plan to define essential health benefits for the individual and small group markets in New Hampshire.

PRA Disclosure Statement

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Alternative Benefit Plan

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Attachment 3.1-L- ☐

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☑ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

The State will submit State Plan Amendments eliminating cost-sharing for all individuals with incomes less than or equal to 100% FPL. The State will submit State Plan Amendments to impose targeted cost-sharing on individuals in the new adult group with incomes above 100% FPL. The cost-sharing described in that State Plan Amendment will apply to all individuals in the new adult group with incomes above 100% FPL, regardless of whether they are receiving the Alternative Benefit Plan or the Alternative Benefit Plan that is the Medicaid State Plan.

PRA Disclosure Statement

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Alternative Benefit Plan

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Attachment 3.1-L- [ ]

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

The base benchmark plan is the Matthew Thornton Blue Health Plan, supplemented with FEDVIP pediatric oral and vision benefits.

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

Secretary Approved

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services — Collapse All

Benefit Provided: Primary Care Visit to Treat an Injury of Illness
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Practitioner Office Visit (APRN, PA, etc.)
Source: Base Benchmark Small Group
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

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

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

Remove

Benefit Provided:

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

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

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

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

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

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

Benefit Provided:

Hospice Services

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None | Remove

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

Add

Alternative Benefit Plan

2. Essential Health Benefit: Emergency services — Collapse All

Benefit Provided: Urgent Care Centers or Facilities
Source: Base Benchmark Small Group — Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Hospital/Emergency Room Services
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Transportation/Ambulance
Source: Base Benchmark Small Group
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

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

Remove

Add

Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization — Collapse All

Benefit Provided: Inpatient Hospital Services
Source: Base Benchmark Small Group — Remove
Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Excludes coverage for reversal of voluntary sterilization; schlerotherapy for varicose veins and treatment of spider veins; sex change treatment; and corrective eye surgery.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization is required only for out-of-state inpatient hospitalization.

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group — Remove
Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization required for the following surgical services: bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty, and rhinoplasty.

Benefit Provided: Bariatric Surgery
Source: Base Benchmark Small Group
Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

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

Remove

Benefit Provided: Transplant

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Add

Alternative Benefit Plan

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

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Benefit Provided: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

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

Add

Alternative Benefit Plan

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

Collapse All

Benefit Provided: Mental/behavioral Health Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

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

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

Benefit Provided: Mental/behavioral health inpatient services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See below.

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

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

the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase of a substance abuse condition.
Benefits exclude IMDs.

Remove

Benefit Provided:
Substance Abuse Disorder Outpatient Services

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below.

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

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

Benefit Provided:
Substance Abuse Disorder Inpatient Services

Source:
Base Benchmark Small Group

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below.

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

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

the provider; and inpatient care for medical detoxification extending beyond the acute detoxification phase of a substance abuse condition. Benefit excludes IMDs.	Remove

Add

Alternative Benefit Plan

☒ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

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

Alternative Benefit Plan

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

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

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

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

Alternative Benefit Plan

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

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

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

Remove

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Cardiac Rehabilitation

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Habilitation Services

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Remove

Amount Limit:
20 visits for each therapy type

Duration Limit:
None

Scope Limit:
See below.

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

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

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

Benefit Provided:
Chiropractic Care

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
12 vistis per year

Duration Limit:
None

Scope Limit:
Includes spinal manipulation and manual medical intervention services

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

Benefit Provided:
Durable Medical Equipment

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

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

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

Remove

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services — Collapse All

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

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

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

Source: Base Benchmark Small Group — Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Add

Alternative Benefit Plan

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

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

Benefit Provided:

Preventive Care/Screening/Immunization

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add

Alternative Benefit Plan

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

Add

Alternative Benefit Plan

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

Other Base Benefit Provided:
Routine Eye Exam (Adult)

Source:
Base Benchmark

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
1 exam every 2 years

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit:
No prior authorization.

Add

Alternative Benefit Plan

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

Base Benchmark Benefit that was Substituted: Source:

Emergency Room Services | Base Benchmark | Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under New Hampshire Medicaid state plan as outpatient hospital care/emergency room services under EHB 2.

State plan benefit has no scope limit.

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

Add

Alternative Benefit Plan

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Alternative Benefit Plan

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

Other 1937 Benefit Provided:
Non-Emergency Medical Transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Other 1937 Benefit Provided:
Eyeglasses for individuals 21 and over

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

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

Duration Limit:
None

Scope Limit:
None

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

Other 1937 Benefit Provided:
Dental for individuals 21 and over

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

Coverage is limited to treatment of acute pain or infection

Remove

Other:

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

Add

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

PRA Disclosure Statement

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Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Benefits Assurances **ABP7**

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

All individuals in the new adult group who receive the Alternative Benefit Plan will be enrolled in Medicaid managed care plans. The ABP benefit package administered by the plans will include coverage for EPSDT services for 19 and 20 year olds. Dental benefits for 19 and 20 year olds are not included in the Medicaid managed care plan benefit package, and these benefits will be provided through the fee-for-service Medicaid program.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [ ] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The State will leverage its three existing Medicaid managed care plans to administer the ABP. The State will update the contracts with the plans to reflect the new ABP benefit package, and the State will establish capitation rates for the new adult group. The State will work closely with the plans to inform them about the benefits unique to the ABP. The State will require that plans contract with additional providers, as needed, to ensure adequate access to the full range of services offered in the ABP. The State will also require that the plans notify their participating providers of the unique features of the ABP.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

- [x] The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

- (•) Competitive procurement method (RFP, RFA).
- ( ) Other procurement/selection method.

Alternative Benefit Plan

Describe the method used by the state/territory to procure or select the MCOs: .

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+	Skilled Nursing Facility	Benefit will be provided through fee-for-service Medicaid.	X
+	Inpatient Hospital Swing Bed, SNF	Benefit will be provided through fee-for-service Medicaid.	X

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

☒ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☒ Individuals in a retroactive period of Medicaid eligibility.

☐ Other:

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process will be auto-assigned to an MCO. Auto-assignment processes will provide for verification of paid claims data within the past 6 months on fee-for-service (if applicable), to determine a regular site of primary or specialty care (if no primary care encounters are identified) and assign the enrollee to an MCO which has a contract with the provider that the enrollee's past claims history demonstrates an existing relationship. If this process fails to identify a provider relationship, the state will determine if a household member has selected a plan already, and enroll the non-assigned member into the same plan as their household member. For beneficiaries for whom it is not possible to determine any prior patient/provider relationship or family member plan selection, the state will randomly assign members to ensure equitable enrollment among plans. All managed care enrolled individuals may disenroll from the plan they selected or were autoassigned to within 90 days of their plan enrollment, with or without cause. If after 90 days, they have not disenrolled, they will be locked into that plan for a period of 12 months. If the member disenrolls from a plan within the 90 day window and does not disenroll from managed care (if that option applies) they must select a new plan in which to enroll.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

The state will amend its contracts with existing MCOs to include the full scope of ABP benefits. The state will also develop a capitation rate for the new adult group. MCOs will have the authority to develop utilization management plans, including selecting which categories of benefits are subject to prior authorization. As a result, the authorization requirements may differ from those set forth in ABP5, and they may differ across MCOs. The State will review and approve the MCO's utilization management plans. As part of that review process, the State will ensure that the prior authorization requirements imposed do not violate mental health parity requirements.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

(•) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Some long-term care benefits are not included in the MCO's benefit package currently; instead, the State provides these services through a separate fee-for-service process. To the extent the benefits that are not currently covered by the MCO benefit packages are included in the ABP, the State will cover those benefits through the fee-for-service system.

Additionally, individuals will receive the ABP through fee-for-service while they are awaiting enrollment in an MCO.

All benefits provided through the fee-for-service system will be subject to the authorization requirements set forth in ABP5.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Procurement Methodology (Text Box Above Not Working): The state will leverage the three existing MCOs that are serving the currently eligible Medicaid population. The state used a competitive bid RFP process to identify those contractors. The technical scoring of the RFP bids consisted of an interdepartmental team of 10 members who read each proposal and scored them based on 11 domains, including, but not limited to pharmacy, care coordination, disease management, quality, member services, administration, behavioral health. Each team member scored each plan and then the team came together for consensus building to assign a score (maximum of 1100) to each plan. The three highest scoring plans were selected.

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- [ ]

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. [Yes]

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

All newly eligible individuals with access to cost-effective employer-sponsored insurance will be required to receive coverage through the State's Health Insurance Premium Payment (HIPP) program. The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. [Yes]

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

Newly eligible individuals will be permitted to voluntarily enroll in cost-effective individual market coverage consistent with updated State Plan Amendments that the state will submit separately. For a Medicaid beneficiary who receives coverage in a health plan in the individual market through the state's approved Medicaid state plan that provides premium assistance under section 1905(a) and regulations codified at 42 CFR §435.1015, the state assures that the Medicaid beneficiary will receive a benefit package that includes a wrap of benefits around the individual market health plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐ OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20131219

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: ___ - ___ - ____

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. — Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☒ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☐ The state includes an indicator in the Eligibility and Enrollment System
- ☐ The state includes an indicator in the Eligibility Verification System
- ☒ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. — No

Cost Sharing for Drugs

The state charges cost sharing for drugs. — Yes

The state has established differential cost sharing for preferred and non-preferred drugs. — Yes

■ The state identifies which drugs are considered to be non-preferred.

☑ The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

V.20140114

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: ___ - __ - ____

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals	G2a
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) 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.20140113

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

OMB Control Number: 0938-1148

Transmittal Number: ___ - ___ - ____

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy 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.20140116

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: ___ - ___ - ____

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

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. Yes

Population Name (optional): New Hampshire New Adult Group

Eligibility Group(s) Included: Adult group

Incomes Greater than 100% FPL TO Incomes Less than or Equal to 133% FPL

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Preferred Drugs	1.00	$	Prescription	Average Medicaid payment is $63.29	X
+	Non-Preferred Drugs	4.00	$	Prescription	Average Medicaid payment is $249.58	X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. Yes

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. Yes

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Population Name (optional): Ticket to Work and Work Incentives Program

Medicaid Premiums and Cost Sharing

Eligibility Group(s) Included: Ticket to Work Group

Incomes Greater than 100% FPL TO Incomes Less than or Equal to 450% FPL

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Preferred Drugs	1.00	$	Prescription	Average Medicaid payment is $63.29	X
+	Non-preferred Drugs	2.00	$	Prescription	Average Medicaid payment is $249.58	X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. Yes

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. Yes

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Add Population

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.20140107

Medicaid Premiums and Cost Sharing

State Name: New Hampshire

Transmittal Number: ___ - ___ - ____

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

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):

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

Medicaid Premiums and Cost Sharing

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. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

For individuals in the new adult group with incomes greater than 100% of the FPL, cost-sharing is limited to $1 for preferred drugs and $4 for non-preferred drugs. For individuals in current eligibility groups with incomes greater than 100% of the FPL who are not otherwise exempt from cost-sharing, cost-sharing is limited to $1 for preferred drugs and $2 for non-preferred drugs. Given the low amount of cost-sharing, it is very unlikely that any beneficiary with an income of at least 100% FPL would exceed 5% of his or her income in a given quarter. The State submitted an analysis to CMS indicating that over 99.9% of beneficiaries would have cost-sharing of less than 5% of 100% of the FPL each year, and 99.7% of beneficiaries would have total annual cost-sharing of less than $300 per year.

Example of Number of Services Required Each Quarter to Reach Cap at 100% FPL
Preferred drugs (36 prescriptions) - $36
Non-preferred drugs (27 prescriptions) $108
Total for the quarter - $144
Aggregate limit = $145.88

Estimated Annual Total

Co-pay	Members
$1-99	91.80%
$100-199	6.80%
$200-299	1.13%
$300-399	0.20%
$400-582	0.05%
$583+	0.02%

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 beneficiaries may bring receipts to the Medicaid agency to demonstrate that they have 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, beneficiaries may notify the Medicaid agency of a change in their income or other circumstance 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 the aggregate limits, if necessary.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). **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.20140116

State Plan Under Title XIX of the Social Security Act

State: New Hampshire

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on _____. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	N/A	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	N/A	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	N/A	N/A
Children Age 19 or 20	Not Covered	N/A	N/A	N/A	N/A
Childless Adults	Not Covered	N/A	N/A	N/A	N/A

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ■ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☐ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☒ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☐ Attachment E – Transition Methodologies

Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan

NEW HAMPSHIRE

12/17/2013

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives**			no	new SIPP conversion	SIPP
	Dollar standards by family size					
	1	$591	$639			
	2	$675	$739			
	3	$683	$763			
	4	$691	$788			
	5	$698	$811			
	6	$779	$909			
	7	$842	$988			
	8	$934	$1,097			
2	**Noninstitutionalized Disabled Persons**			n/a	new SIPP conversion	SIPP
	Dollar standards					
	Single	$688	$701			
	Couple	$1,012	$1,032			
3	**Institutionalized Disabled Persons**	300%	300%	n/a	ABD conversion template	n/a
	SSI FBR%					
4	**Children Age 19-20**	n/a	n/a	n/a	n/a	n/a
5	**Childless Adults**	n/a	n/a	n/a	n/a	n/a
	FPL %					

n/a: Not applicable.

FINAL DRAFT (5/21/14)

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

1. Chiropractor Services – Payment for chiropractor services provided under New Hampshire's alternative benefit plan is made on a fee for service basis. Payment is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

2. Services for the Treatment of Substance Use Disorders – New Hampshire's Medicaid state plan specifies the reimbursement methodology in Attachment 4.19-A and Attachment 4.19-B for some services that are rendered for the treatment of substance use disorders. Please refer to the appropriate, existing Attachments for these services as follows:

   Attachment 4.19-A – Inpatient Hospital Reimbursement
   - Inpatient Hospital Acute Care Services for Substance Use Disorders
   - Inpatient Governmental Psychiatric Hospital

   Attachment 4.19-B – Payment for All Types of Care Other Than Inpatient Hospital, Skilled Nursing, or Intermediate Nursing Care Services
   - Outpatient Hospital Services
   - Physician Services
   - Services of Other Licensed Practitioners
   - Clinic Services
   - EPSDT
   - Prescribed Drugs
   - Extended Services to Pregnant Women

FINAL DRAFT (5/21/14)

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

The reimbursement methodology for other services in the alternative benefit plan, that are not already in the state plan for the current eligibles, for treatment of substance use disorders are as described below:

(a) Services of Other Licensed Practitioners – Payment for master licensed alcohol and drug counselors (MLADC's) is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(b) Outpatient Services Facilities – Payment for services provided by outpatient facilities are as described below.

(1) Intensive Outpatient Services: Payment for intensive outpatient services provided by outpatient facilities shall be made at a per diem rate as established by the department pursuant to NH RSA 161:4, VI. Intensive outpatient services are comprised of a combination of individual and group treatment services for three hours/day, three days/week. The service is similar to the current Medicaid behavioral health service of ½ day of behavioral health partial hospitalization (H0035) and was, therefore, priced at the same rate.

(2) Partial hospitalization: Payment for partial hospitalization provided in an outpatient services facility shall be made at a per diem rate as established by the department pursuant to NH RSA 161:4, VI. Partial hospitalization is comprised of a combination of a range of group and individual outpatient treatment services that are provided at least 20 hours/week. It was determined that this level and intensity of service was similar to the current medicaid covered full day of behavioral health partial hospitalization (S0201) and was, therefore, priced at the same rate.

FINAL DRAFT (5/21/14)

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(b) Outpatient Services Facilities (continued)

(3) Medically Monitored Outpatient Withdrawal Management: Payment for medically monitored outpatient withdrawal management provided in an outpatient services facility shall be made at a per visit rate as established by the department pursuant to NH RSA 161:4, VI. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's per visit rate or the provider's usual and customary charge. These services must be supervised by a physician and include such things as physician assessment for withdrawal, vitals, and physician management of any elevated levels. This service typically takes place over the course of 3-10 days. Due to the nature of the service, it was compared to a physician visit for ratesetting purposes. It was determined that it was best compared to an established patient office visit, which is defined as requiring 2 of 3 components (detailed history, detailed exam, medical decisions of moderate complexity). It was, therefore, priced equivalent to Medicaid's current rate for the office visit code of 99214.

(4) Individual, Family, or Group Counseling: Individual, family, or group counseling provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(5) Peer Recovery Support: Payment for peer recovery support provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

FINAL DRAFT (5/21/14)
ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(b) Outpatient Services Facilities (continued)

(6) Crisis Intervention: Payment for crisis intervention provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(7) Non-Peer Recovery Support: Payment for non-peer recovery support provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(8) Continuous Recovery Monitoring: Payment for continuous recovery monitoring provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

(9) Assessments: Payment for assessments provided in an outpatient services facility shall be made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. Rates were set as of July 1, 2014, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

FINAL DRAFT (5/21/14)

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(c) Residential Treatment and Rehabilitation Facilities – Payment for services provided in residential treatment and rehabilitation facilities of fewer than 17 beds is as described below.

(1) Rehabilitative Services: Payment for services in residential treatment and rehabilitation facilities shall be made at a per diem as established by the department pursuant to NH RSA 161:4, VI, and based on the appropriate level of intensity (low, medium, high, or specialty care such as extended services to pregnant women and children) in accordance with the American Society of Addiction Medicine (ASAM) Criteria. The per diem rates were established based on rates paid by medicaid or on a contract basis by various divisions for similar services and based on clinical determinations of similarities of service delivery, practitioner involvement, and intensity. Payment does not include room and board.

A clinical determination was made that the low level intensity service for adults should be priced at the current medicaid rate for therapeutic behavioral health services (H2020) which is a per diem rate of $120.00. By their nature, adolescent services are more involved than adult services at the low level of intensity. These adolescent services were priced at a per diem rate of $128.00.

The high level intensity services for adults was priced based on the current medicaid rate ($162.60) for high level intensity services. The comparable medium level intensity services for adolescents was priced at a per diem rate of $170.00. This rate was based on the current medicaid rate ($170.00) for a similar adolescent facility under the division for children, youth and families, and the fact that adolescent services are more involved than adult services and thus should be priced somewhat higher.

High intensity specialty care, which encompasses the extended services to pregnant women substance use programs, was priced using the current program's price of $162.60 as a basis. This medicaid rate was set about 20 years ago based on cost reporting and contract prices that were then reviewed and substantiated a year after the program was launched. Based on this information, and in comparison to the proposed adult high intensity rate of $162.60, a rate of $230 has been set for the high intensity specialty level of care for pregnant and postpartum women in substance use treatment programs. This rate takes into account that the $162.60 rate has not been increased in over 20 years with such proposed increase being equivalent to less than a 2% inflation factor over each of 18 years. It also takes into consideration the complexities of specialty care for this population such as ensuring access to obstetrical care and active participation in pre-natal care and parenting.

FINAL DRAFT (5/21/14)

ALTERNATIVE BENEFIT PLAN

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

ALTERNATIVE BENEFIT PLAN:

2. Services for Treatment of Substance Use Disorders (continued)

(c) Residential Treatment and Rehabilitation Facilities (continued)

Once the above rates were calculated, they were compared to the average per diem rate for a rehabilitation hospital stay to ensure that they were reasonable; rates were found to be substantially and acceptably less than the average per diem rate of $847.59.

(2) Medically monitored withdrawal management: Medically monitored withdrawal management provided in a residential treatment and rehabilitation facility includes medical service components such as monitoring of vital signs and managing medications for withdrawal from alcohol and other drug substances. This service is clinically equivalent to a high intensity level of specialty care and thus payment shall be made at the $230 per diem rate as described above for high intensity specialty care.

New Hampshire Department of Health and Human Services

Fiscal Committee Presentation on NH's "Building Capacity for Transformation" Section 1115 Demonstration Waiver

May 22, 2014

Presentation Outline

- Summary of Public Hearings and Comment Period
  - List of Stakeholders
- Potential Costs Not Otherwise Matchable (CNOM) Funding Sources
- Designated State Health Program (DSHP) Descriptions
- Total Funds Expenditures / (Savings) for DSHP Initiatives
  - Community Reform Pool Pilot Program Expenditures
- Budget Neutrality

Summary of Public Hearings and Comment Period

- Public comments were collected from Monday, April 21, 2014 until Tuesday, May 20, 2014 at 5:00PM
- Public hearings were held on Thursday, May 8, 2014 and Tuesday, May 12, 2014
- In total, 35 public comments, questions, and/or testimonies were received:
    - 13 comments were received Tuesday afternoon (May 20th) and early Wednesday morning (May 21st), and are still under review and consideration by DHHS
- In addition to convening two public hearings and considering public comments, DHHS met in-person with representatives from the following organizations:
    - NH Association of Counties
    - NH Hospital Association
    - Behavioral Health Association (the governing body and trade association for CMHCs)
    - NH Dental Society
    - MCAC
    - SUD Stakeholder Representatives

List of Stakeholders

Representatives from the following organizations submitted testimonies and comments at the two Public Hearings:

- Seacoast Mental Health Center
- American Dental Association Board of Trustees Member, and Past President of Dental Hygienists' Association
- DHHS Division of Public Health Services
- Dental HealthWorks Board of Directors Member, and Creator of the InShape Program
- National Alliance on Mental Illness New Hampshire
- New Hampshire Dental Society
- Gateways Community Services
- New Hampshire Oral Health Coalition
- New Futures
- Genesis Behavioral Health
- NH Kids Count
- New Hampshire Legal Assistance
- NH Voices for Health
- Disability Rights Center

Representatives from the following organizations, along with one anonymous organization, submitted written comments via email to 1115waiver@dhhs.state.nh.us:

- NH Dental Hygienists' Association
- American Dental Association Board of Trustees Member, and Past President of Dental Hygienists' Association
- Dental HealthWorks Board of Directors Member, and Creator of the InShape Program
- New Hampshire Legal Assistance
- NH Alcohol & Drug Abuse Counselors Association, and NH Training Institute on Addictive Disorders
- Genesis Behavioral Health
- New Futures, Inc.

List of Stakeholders (Continued)

Representatives from the following organizations submitted comments Tuesday Afternoon (May 20th) and early Wednesday Morning (May 21st). These comments are still under review and consideration by DHHS:

- NH Oral Health Coalition
- Greater Derry Oral Health Collaborative Corporation
- NH Children's Behavioral Health Collaborative
- Community Partners, Behavioral Health & Developmental Services of Stratford County, Inc.
- Harbor Homes Inc. and the Partnership for Successful Living
- Bi-State Primary Care Association
- New Hampshire Public Health Association
- New Hampshire Medical Society and NH Society of Eye Physicians & Surgeons
- New Hampshire Kids Count
- Brain Injury Association of New Hampshire
- BMC HealthNet Plan / Well Sense Health Plan
- Planned Parenthood of Northern New England
- NH Voices for Health

Potential Costs Not Otherwise Matchable (CNOM) Funding Sources

State of New Hampshire Health Care Funding Summary of Potential CNOM Resources*	
Funding Sources	**Funding Amount**
State Funding Sources	
Department of Health and Human Services SFY 2015 Biennial Budget	
Glencliff Home General Funds	$7,544,949
New Hampshire Hospital General Funds	$24,650,441
Sununu Youth Services Center General Funds	$14,683,277
Department of Health and Human Services 10 Year Mental Health Plan/DOJ Settlement	$3,227,000
Department of Health and Human Services SFY 2015 Biennial Budget for Laconia DRF	$1,235,043
Department of Corrections SFY 2015 Biennial Budget for Medical and Dental Services	$10,760,687
State Funding Sources Total	**$62,101,397**
Municipality Funding Sources	
2013 Report of Appropriations Actually Voted (M-2 Form) reported to the Department of Revenue Administration	
Health Administration	$4,320,521
Health Agencies & Hosp. & Other	$7,367,123
Municipality Funding Sources Total	**$11,687,644**
County Funding Sources	
Correctional Medical/Health Spending	$6,093,757
County Funding Sources Total	**$6,093,757**
Grand Total	**$79,882,798**

Please note that this list of unmatched health care funding only reflects potential sources for Federal match and has not yet been reviewed and analyzed sufficiently to determine whether all the funds are potentially useable for matching purposes.

Designated State Health Program (DSHP) Descriptions

DHHS initially designed five DSHPs to receive funding from CMS through the "Building Capacity for Transformation" Section 1115 Demonstration Waiver:

1. **Community Reform Pool.** Establish a community reform pool focused on mental health and physical health delivery system issues that includes hospitals, health systems, and other community providers (e.g. CMHCs, FQHCs, and/or RHCs) and contains the five different components: Capacity-retention Payments; Capacity-expansion Payments; New Service Payments; Pilot Program Pool; and Incentive Pool.
2. **Enhance Community Based Mental Health Services.** Request DSHP funding to help implement the components of its 10 Year Mental Health Plan and its settlement with the United States Department of Justice, referred to as the *Community Mental Health Agreement (CMHA)*, for the State's non-Medicaid population.
3. **Substance Use Disorder (SUD) Workforce Development.** Establish a fund for training education and workforce development programs focused on SUD treatment in which providers would apply and DHHS would administer.
4. **InShape Program Expansion.** Establish a funding pool to continue and expand this program by awarding grant applications from hospitals, health systems, and/or community providers to implement an InShape Program that includes children with severe mental illness (SMI) and 1915(c) Developmentally Disabled waiver enrollees as participants and adds smoking cessation program as a component for participants who smoke.
5. **Oral Health Pilot Program.** Pilot an expanded Medicaid oral health program for pregnant women that establishes an oral health education program for all mothers, encourages participation by all mothers who smoke in an approved smoking cessation program, and establishes a dental benefit that provides coverage to all mothers during pregnancy until their child's fifth birthday.

Sixth Designated State Health Program

DHHS added a sixth DSHP focused on enhancing community-based services for children and youth:

- DHHS implemented of a "System of Care" also known as "F.A.S.T. Forward" for children and youth who have serious emotional disturbances and are at risk for multi-agency involvement:
  - A coordinated network of comprehensive individualized services
  - Supported by the children's strategic behavioral health plan for New Hampshire from the Children's Behavioral Health Collaborative
  - Infrastructure but not services is funded by a federal grant from the Substance Abuse and Mental Health Services Administration (SAMSHA)
  - Most but not all services under the "System of Care" service array are currently covered by Medicaid
- In order to ensure successful and sustainable implementation of "System of Care", DHHS proposes a new Medicaid benefit to cover "System of Care" required services that are not currently covered by Medicaid for 20 recipients per year:
  - Wraparound team meeting participation
  - Respite care
  - Flexible spending
  - Mobile crisis response
  - Wrap around facilitation and care coordination (once the SAMSHA grant expires in 2016)

Total Funds Expenditures / (Savings) for DSHP Initiatives

Total Funds Expenditures / (Savings) for DSHP Initiatives						
	DY1	DY2	DY3	DY4	DY5	Total
DSHP: Community Reform Pool						
Capacity Retention	$15,932,857	$13,194,318	$13,658,098	$14,138,180	$14,635,137	$71,558,591
Capacity Expansion	$3,762,363	$3,115,688	$3,225,205	$3,338,571	$3,455,921	$16,897,749
New Service	$1,240,565	$1,027,337	$1,063,448	$1,100,828	$1,139,522	$5,571,700
Pilot Program Pool ***(see next slide)**	$21,800,000	$12,000,000	$12,000,000	$12,000,000	$10,400,000	$68,200,000
Provider Incentive Pool	$0	$0	$5,867,469	$5,989,350	$6,115,516	$17,972,335
Subtotal	*$42,735,786*	*$29,337,343*	*$35,814,219*	*$36,566,929*	*$35,746,097*	*$180,200,374*
DSHP: Enhance Community Based Mental Health Services	$8,534,851	$11,022,950	$12,456,169	$13,021,057	$13,411,689	$58,446,716
DSHP: Invest in SUD Workforce Development	$2,000,000	$1,500,000	$500,000	$500,000	$500,000	$5,000,000
DSHP: InShape Program						
Expand program to children with SMI and individuals enrolled in DD waiver	$1,752,681	$2,502,344	$2,918,077	$3,349,439	$3,794,317	$14,316,858
Cover additional SMI Adults not currently enrolled in InShape	$87,872	$179,258	$271,794	$370,480	$473,004	$1,382,407
Add smoking cessation for all InShape enrollees	$36,447	$79,244	$116,610	$128,830	$141,492	$502,625
Subtotal	*$1,877,000*	*$2,760,846*	*$3,306,482*	*$3,848,749*	*$4,408,813*	*$16,201,890*
DSHP: Oral Health for Pregnant Women and Mothers						
Education	$43,481	$44,351	$45,238	$46,142	$47,065	$226,277
Dental Coverage (mothers age <21 at delivery)	$0	$41,224	$76,428	$106,581	$132,802	$357,036
Dental Coverage (mothers age 21 and over at delivery)	$995,531	$1,845,592	$2,576,864	$3,211,050	$3,766,184	$12,395,221
Subtotal	*$1,039,012*	*$1,931,166*	*$2,698,530*	*$3,363,774*	*$3,946,051*	*$12,978,534*
DSHP: System of Care / FAST Forward						
Cover new services	$212,197	$218,563	$225,120	$231,874	$238,830	$1,126,585
Transition services from grant to DSHP	$184,291	$189,819	$195,514	$201,379	$207,421	$978,424
Subtotal	*$396,488*	*$408,383*	*$420,634*	*$433,253*	*$446,251*	*$2,105,009*
Total Funds Expenditures for DSHP Initiatives	**$56,583,137**	**$46,960,689**	**$55,196,034**	**$57,733,762**	**$58,458,901**	**$274,932,523**
Total Funds Savings for DSHP Initiatives	**($26,305,150)**	**($39,617,259)**	**($53,857,896)**	**($65,050,393)**	**($71,628,722)**	**($256,459,420)**
Net Total Funds Expenditures / (Savings) for DSHP Initiatives	**$30,277,987**	**$7,343,430**	**$1,338,138**	**($7,316,631)**	**($13,169,821)**	**$18,473,103**

Community Reform Pool Pilot Program Expenditures

Pilot Program Initiatives within the Community Reform Pool	DY1*	DY2	DY3	DY4	DY5	Total
Alternative Delivery Models to increase access to services • Focus on mental health / physical health meeting the needs of the expansion populations	$4.8 M	$3 M	$3 M	$3 M	$2 M	**$15.8 M**
Telehealth Delivery Models to increase access to services and improve coordination of behavioral and physical health services	$1.8 M	$1 M	$1 M	$1 M	$1 M	**$5.8 M**
Care Models to Support MCM Step 1 Initiatives • Patient Center Medical Homes • Disease specific programs	$5.8 M	$4 M	$4 M	$4 M	$3 M	**$20.8 M**
Care Models to Support Integration of Behavioral Health, Physical Health, SUD and Long Term Care • Health Homes • Co-occurring Disorders / Comorbidity Specific Programs • Coordination of Behavioral health / Physical health / Long Term Services and Supports (LTSS) • In-Home technology	$3.8 M	$3 M	$3 M	$3 M	$3 M	**$15.8 M**
Quality Improvement projects related to mental health	$2.8 M	$2 M	$2 M	$2 M	$2 M	**$10.8 M**
Initiatives Supporting NH State Health Improvement Plan • Preference to mental health focused proposals • Preference to newly insured focused proposals	$2.8 M	$2 M	$2 M	$2 M	$2 M	**$10.8 M**
Subtotal for Pilot Program Pool	**$21.8 M***	**$15 M**	**$15 M**	**$15 M**	**$13 M**	**$79.8 M**
Quality Withholds for Provider Incentive Pool	$0	$3 M	$3 M	$3 M	$2.6 M	**$11.6 M**
Total for Pilot Program Pool	**$21.8 M**	**$12 M**	**$12 M**	**$12 M**	**$10.4 M**	**$68.2 M**

***Note:** *Quality Withholds for the Provider Incentive Pool start in Demonstration Year 2. In Demonstration Year 1, this amount will be paid out through the Pilot Program Pool.*

Budget Neutrality

- Total spending under the "Building Capacity for Transformation" Section 1115 Demonstration Waiver must be *equal to* or *less than* what the Federal government would have spent without the waiver
- DHHS's budget neutrality methodology includes the following three components:
    1. Managed care savings related to the implementation of the Medicaid Care Management (MCM) program
    2. Net expenditures related to the six Designated State Health Programs (DSHPs) included in the Building Capacity for Transformation Section 1115 Demonstration Waiver. In developing the net expenditures, DHHS considered estimated expenditures for the DSHPs as well as related savings in other Medicaid services that are expected to result from the DSHPs
    3. DHHS is requesting expenditures over the entire five year Demonstration Waiver period for Costs Not Otherwise Matchable (CNOM) related to programs that provide vital services that today are not reimbursed by Medicaid or any other Federal source
- Using this budget neutrality methodology, DHHS estimates a net savings of **$46.9M** over the entire five year Demonstration Waiver period

F13 14-071
Additional Information
#2

May 22, 2014

Chairman Mary Jane Wallner & members of the Legislative Fiscal Committee

Dear Chairman Wallner & members of the committee:

We are writing to affirm the commitment of the New Hampshire Dept of Health and Human Services to proceed with public notice of a Medicaid state plan amendment that will remove coverage for non-emergency services provided in hospital emergency departments for the new adult population under the New Hampshire Health Protection program.

The Department will submit the state plan amendment to the Fiscal Committee within the next 60 days. Along with the state plan amendment, the Department will submit all public comments received during the notice period.

Nicholas A. Toumpas

Commissioner, Dept. of Health & Human Services

Jeffrey A. Meyers

Director, Intergovernmental Affairs