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<td><strong>18-0008</strong></td>
<td>New Hampshire Cost Sharing, Granite Advantage</td>
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<td>G2c - Cost Share Targeting, Page 1</td>
<td>G2c-Cost Share Targeting, Pages 1-2, TN 18-0003</td>
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<tr>
<td>G3 - Cost Sharing Limitations, Pages 1-5</td>
<td>G3-Cost Sharing Limitations, Pages 1-5, TN 16-0002</td>
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<tr>
<td><strong>18-0003</strong></td>
<td>New Hampshire Medicaid Premiums Cost Share SPAs</td>
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<td>Approved 05/26/2017 Effective 01/01/2017</td>
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<td>16-0002</td>
<td>New Hampshire Medicaid Premiums Cost Share SPAs</td>
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Approved 09/27/2016 Effective 01/01/2016

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<tr>
<td>G2a-2 - NEW</td>
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Approved 03/20/2015 Effective 11/01/2014

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<td>G2c Pages G2c-1 to G2c-2, TN 14-0006</td>
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Approved 07/01/2014 Effective 07/01/2014

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</table>
# Medicaid Premiums and Cost Sharing

**State Name:** New Hampshire  
**Transmittal Number:** NH - 14 - 0006  
**OMB Control Number:** 0938-1148  
**Expiration date:** 10/31/2014

<table>
<thead>
<tr>
<th>Cost Sharing Requirements</th>
<th>G1</th>
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<tr>
<td>1916</td>
<td></td>
</tr>
<tr>
<td>1916A</td>
<td></td>
</tr>
<tr>
<td>42 CFR 447.50 through 447.57 (excluding 447.55)</td>
<td></td>
</tr>
</tbody>
</table>

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

- 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.

**Cost Sharing for Drugs**

The state charges cost sharing for drugs.

- The state has established differential cost sharing for preferred and non-preferred drugs.
  - The state identifies which drugs are considered to be non-preferred.

<table>
<thead>
<tr>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>
Medicaid Premiums and Cost Sharing

☑ 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

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.20140114
The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals.

<table>
<thead>
<tr>
<th>Service or Item</th>
<th>Amount</th>
<th>Dollars or Percentage</th>
<th>Unit</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Services or Items with Cost Sharing Amounts that Vary by Income

Indicate the income ranges by which the cost sharing amount for this service or item varies.

<table>
<thead>
<tr>
<th>Incomes Greater than 100 percent FPL</th>
<th>Incomes Less than or Equal to 100 percent FPL</th>
<th>Amount</th>
<th>Dollars or Percentage</th>
<th>Unit</th>
<th>Explanation</th>
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</thead>
<tbody>
<tr>
<td>+</td>
<td>+</td>
<td>1.00</td>
<td>$</td>
<td>Prescription</td>
<td>Preferred Prescriptions fills</td>
</tr>
<tr>
<td>+</td>
<td>+</td>
<td>2.00</td>
<td>$</td>
<td>Prescription</td>
<td>Non-preferred prescription fills</td>
</tr>
</tbody>
</table>

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

If the state charges cost sharing for non-preferred drugs (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 (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
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.20140415
Medicaid Premiums and Cost Sharing

State Name: New Hampshire
Transmittal Number: NH - 14 - 0006

<table>
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<tr>
<th>Cost Sharing Amounts - Medically Needy Individuals</th>
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<tbody>
<tr>
<td>1916</td>
<td></td>
</tr>
<tr>
<td>1916A</td>
<td></td>
</tr>
<tr>
<td>42 CFR 447.52 through 54</td>
<td></td>
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</tbody>
</table>

The state charges cost sharing to all medically needy individuals.

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: NH - 18 - 0008

<table>
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<td>1916A</td>
<td></td>
</tr>
<tr>
<td>42 CFR 447.52 through 54</td>
<td></td>
</tr>
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</table>

The state targets cost sharing to a specific group or groups of individuals.

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

V.20160722
Medicaid Premiums and Cost Sharing

State Name: New Hampshire
Transmittal Number: NH - 18 - 0008

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<td>1916</td>
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</tr>
<tr>
<td>1916A</td>
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</table>

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.
- 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.

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.

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 specifically 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 Medicaid system flags recipients who are exempt
☐ The Eligibility and Enrollment System flags recipients who are exempt
☐ The Medicaid card indicates if beneficiary is exempt
☒ The Eligibility Verification System notifies providers when a beneficiary is exempt
☐ Other procedure

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

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

Payments to Providers

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

Payments to Managed Care Organizations

Yes

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

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

Aggregate Limits

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

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

☒ 5%
☐ 4%
☐ 3%
☐ 2%
☐ 1%
☐ Other: __ %

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

☒ Quarterly
Monthly

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

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

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

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

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

☐ Other process:

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

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

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

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

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

☐ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:
At any time, enrollees may notify the Medicaid agency of a change in income or other circumstances that might change their aggregate cost-sharing limit. Once a beneficiary notifies the Medicaid agency of such change, the Medicaid agency will review the updated information and change aggregate limits, if necessary.

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

PRA Disclosure Statement

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

V.20160722
State/Territory: New Hampshire

(Reserved)
OFFICIAL

56a

State/Territory: New Hampshire

(Reserved)
OFFICIAL

56c

State/Territory: New Hampshire

(Reserved)

TN No. 14-0006
Supersedes
TN No. 91-23

Approval Date 07/01/2014

Effective Date 07/01/14
OFFICIAL

56d

State/Territory: New Hampshire

(Reserved)

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TN No. 14-0006
Supersedes
TN No. 91-23

Approval Date 07/01/2014

Effective Date 07/01/14
OFFICIAL

56e

State/Territory: New Hampshire

(Reserved)

TN No. 14-0006
Supersedes
TN No. 91-23

Approval Date 07/01/2014
Effective Date 07/01/14
OFFICIAL

56f

State/Territory: New Hampshire

(Reserved)

TN No. 14-0006
Supersedes
TN No. 91-23

Approval Date 07/01/2014
Effective Date 07/01/14
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New Hampshire

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

<table>
<thead>
<tr>
<th>Service</th>
<th>Type of Charge</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deductible</td>
<td>Copayment</td>
</tr>
<tr>
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Attachment 4.18-A, Page 1 - to be removed from state plan, supersedes 04-002

TN No. 14-0006  
Supersedes 04-002  
Approval Date 07/01/2014  
Effective Date 07/01/2014  
HCFA ID: 0053C/0061E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire

Attachment 4.18-A, Page 3 - to be removed from state plan, supersedes 85-12
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New Hampshire

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

<table>
<thead>
<tr>
<th>Service</th>
<th>Type of Charge</th>
<th>Amount and Basis for Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deductible</td>
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<td>Coinsurance</td>
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</tr>
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Attachment 4.18-C, Page 1 - to be removed from state plan, supersedes 04-002

TN No. 14-0006
Supersedes 04-002

Approval Date 07/01/2014
Effective Date: 07/01/2014

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire

Attachment 4.18-C, Page 2 - to be removed from state plan, supersedes 85-12

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State: New Hampshire

Attachment 4.18-C, Page 3 - to be removed from state plan, supersedes 85-12

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