ARC

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

FIS 26 171

Lori A. Weaver
Commissioner

Morissa S. Henn
Deputy Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 1-800-852-3345 Ext. 9200
Fax: 603-271-4912 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

August 27, 2026

The Honorable Ken Weyler, Chairman
Fiscal Committee of the General Court
State House
Concord, NH 03301

INFORMATIONAL ITEM

Granite Advantage Health Care Trust Fund, SFY 2026 Activities and Operations

Background Information

In accordance with RSA 126-AA:3, III., the Department of Health and Human Services (DHHS) hereby submits the following to report on the activities and operation of the Granite Advantage Trust fund, as required annually within 90 days of the close of each State Fiscal Year (SFY).

Chapter 79, Section 407, Laws of 2023, authorized the Granite Advantage Health Care Program (GAHCP) through December 31, 2030.

Activities and Operations

New Hampshire Granite Advantage Health Care Trust Fund provides coverage for the eligible Medicaid population as provided for under RSA 126-AA:2 covering adults from age 19 up to and including age 64 and who are not enrolled in or eligible for another eligibility group of Medicaid or who have Medicare.

Profile of the Granite Advantage Population

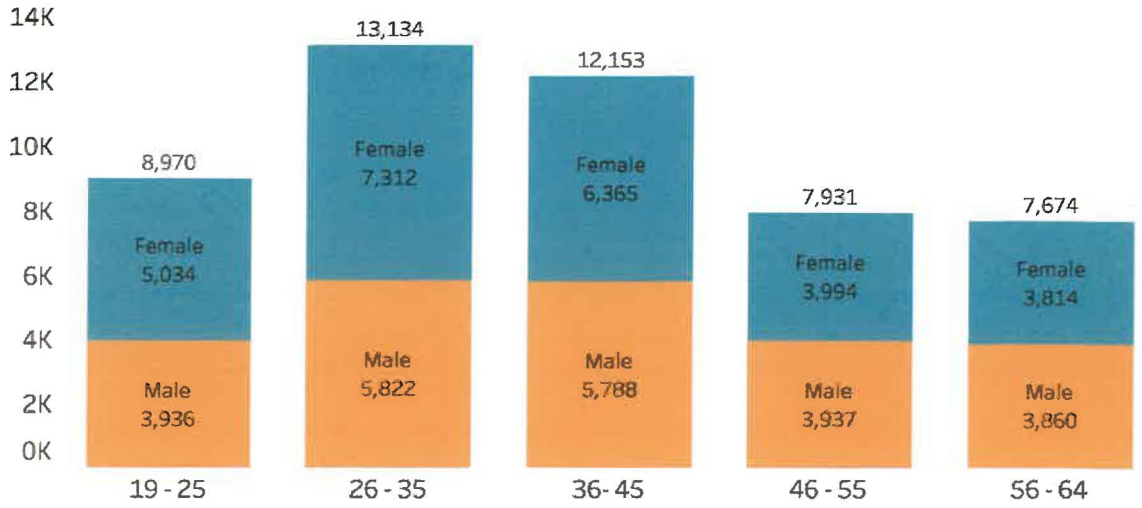
Across SFY 2026 there were 86,044 unique individuals who were enrolled in Granite Advantage at some point during the year, compared to SFY 2025 where there were 86,685 unique individuals. At the end of SFY 2026 there were 49,928 members in the program; at the end of SFY 2025 there were 59,772 members in the program.[1]

People aged 26 to 35 represent the largest age group the program serves, with 26% of the total population. Younger age groups (under age 45) have a higher share of female members and older age groups have roughly the same number of females and males on the program.

---

[1] *Note: the numbers reported in this letter are slightly higher than those reported on a more real-time basis by the Department due to inclusion of additional members who gained enrollment retroactively.*

GAHCP Members by Age and Sex as of 6/30/2026

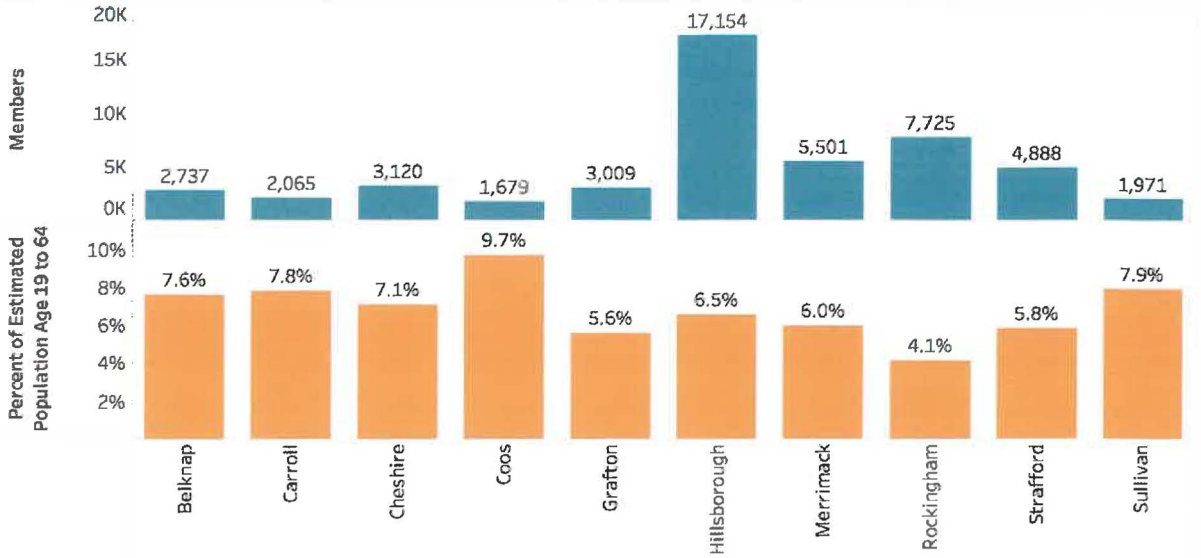


Note: Includes all available retroactive eligibility; Excludes records with missing data and people over age 64 in process of moving to another coverage group or ending their coverage. Source: MMIS as of 8/3/26.

The chart below shows the distribution of Granite Advantage membership by county. The county with the most members is Hillsborough County with 34% of membership.

However, adjusting for population, Coos County has the highest proportion of its age 19 to 64 population enrolled in Granite Advantage, 9.7%, as compared to 6.5% in Hillsborough County. Rockingham County has the lowest proportion of its population enrolled at 4.1%.

GAHCP Members and Percent of Population by County as of 6/30/2026



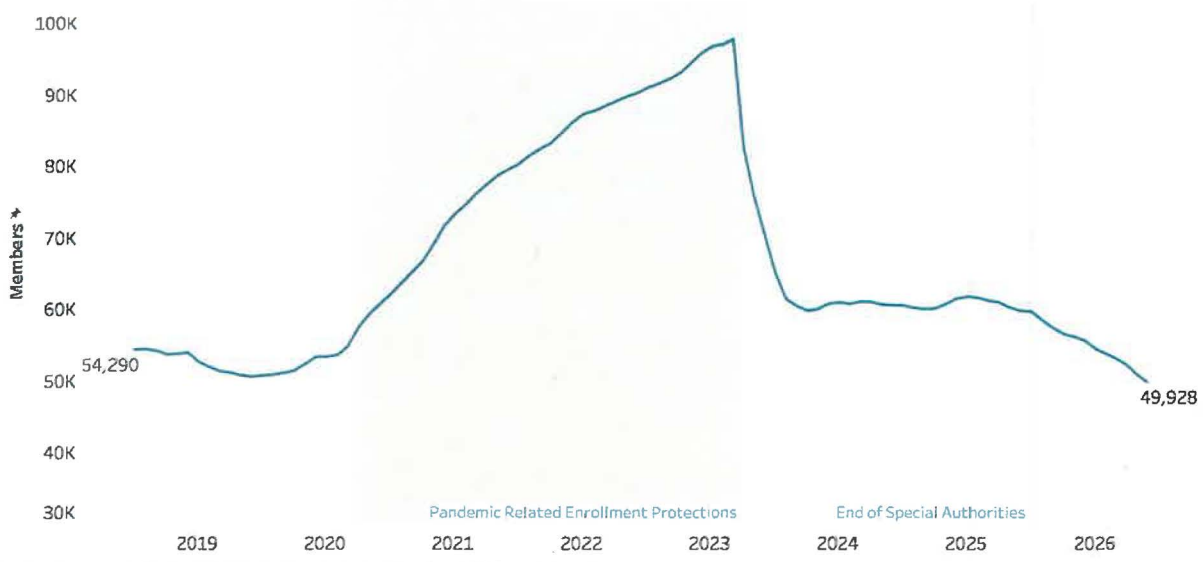
Note: Includes all available retroactive eligibility; Excludes records with missing data and people over age 64 in process of moving to another coverage group or ending their coverage. Source: MMIS as of 8/3/26, and 2025 US census estimates.

Enrollment in Granite Advantage had averaged approximately 51,500 in 2019 prior to the COVID-19 pandemic, with some variation throughout each year. However, as shown in the chart on the following page, due to the COVID-19 pandemic, enrollment steadily increased since March 2020 to nearly 98,000 members as of the end of March 2023, a 90% increase over the 2019 average.

These increases were mostly due to protections put in place by the Federal Families First Coronavirus Response Act (FFCRA), which required states, as a condition of receiving an enhanced federal match for Medicaid (except for adult expansion) to suspend termination of eligibility for Medicaid except for members who die, move out of state, or request ending Medicaid coverage. The protections under the FFCRA law ended on March 31, 2023, via the Consolidated Appropriations Act of 2023 resulting in a steep decline in enrollment (known as the "Medicaid Unwind") to a level a few thousand people above pre-pandemic levels. During the post-unwind period, enrollment averaged 60,613 per month. On 6/30/2025 final pandemic-era authorities ended, resulting in further decline throughout SFY2026 to a low of 49,928 at the end of the fiscal year. Current enrollment is at its lowest point in over 10 years.

Updates to eligibility requirements, while reducing enrollment significantly have also impacted the composition of the individuals covered. The people who remain in the program on average have a much higher acuity as expressed in use rates and costs per person compared those who have left the program.

GAHCP Member Eligibility Trend, July 2018 to June 2026



Note: Includes all available retroactive eligibility; Point in time data for the end of each month. Source: NH MMIS as of 8/3/26

GAHCP members use a broad range of services. Below are two tables, the first showing unique service users and payments to providers at a high level and the second showing some key services provided to members (note: payments are duplicated between the two tables, and the same service users can be in multiple rows in each table). It is important in understanding the tables below that the unique service users across the whole year are included. Because members enter and exit the program throughout the year, these numbers can't be compared directly to the point in time membership shown above. As stated earlier, across SFY 2025 there were nearly 86,685 unique individuals who were enrolled in the GAHCP at some point during the year.

The first table shows, at a high level, that pharmacy and professional (e.g., primary care, psychotherapy) services account for the largest share of payments, followed by outpatient hospital services.

GAHCP Payments to Providers for Main Service Groups, FY 2026

Data Available Through 8/4/2026

	Unique Service Users	Payments
Inpatient Hospital	5,156	$97.1M
Outpatient Hospital	40,642	$103.4M
Professional	55,794	$191.0M
Pharmacy	49,150	$160.3M
Dental	10,780	$5.2M
Nursing Facility	36	$2.4M

Note: Data does not have complete claims information for the final months in the period. Data represents service payments to providers or fee-for-service equivalent payments in cases where the plan pays providers through sub-capitated arrangements. Does not include payments for non-emergency transportation or administrative costs. Source: MMIS as of 8/4/26.

In terms of specific types of services delivered to the population, a significant proportion of the GAHCP program population makes use of mental health and substance use disorder services.

GAHCP Payments to Providers for Selected Key Service Groups, FY 2026

Data Available Through 8/4/2026

	Unique Service Users	Payments
Preventive/Well Care Visits	16,046	$2.8M
Evaluation and Management Visits	46,807	$39.2M
Maternity Care	430	$3.3M
Mental Health Inpatient Hospital Treatment	859	$14.2M
Mental Health Medication Treatment	25,444	$14.5M
Mental Health Outpatient Services	14,049	$34.3M
SUD Residential or Inpatient Hospital Treatment	2,095	$18.9M
SUD Medication Assisted Treatment	7,099	$22.1M
SUD Outpatient Services	6,421	$38.9M
Emergency Department Visits	18,332	$31.4M

Note: Data now includes behavioral health crisis services (included in outpatient) which were previously not included, Data does not have complete claims information for the final months in the period. Data represents service payments to providers or fee-for-service equivalent payments in cases where the plan pays providers through sub-capitated arrangements. Data may be duplicated between categories. Source: EBI as of 8/4/2026.

Operational Cost of Granite Advantage Coverage SFY 2026

All moneys in the GAHCP Trust fund are non-lapsing and continually appropriated to the Commissioner for the purposes of the fund. As authorized by RSA 126-AA:3, the fund covers the cost of medical services and cost-effective related services. As provided in the statute, no state general funds can be used to fund the non-federal share of the program.

House Bill 4 of the 2019 Regular Legislative Session changed the funding of the non-federal share to include profits from the Liquor Commission through the Alcohol, Prevention & Treatment Fund and limited the NH Health Plan Assessment to no more than the funding needed to cover the Remainder Amount not

to exceed the monies from Insurance Premium Tax Revenue and Alcohol, Prevention & Treatment Fund, as well as Other Funds Returnable.

House Bill 4 of the 2019 Regular Legislative Session also amended RSA 126-AA:3 VI to read:

The Commissioner, in accordance with the most current available information, shall be responsible for determining, quarterly commencing no later than December 31, 2018, whether there is sufficient funding in the fund to cover projected program costs for the non-federal share for the next 6-month period. If at any time the Commissioner determines that a projected shortfall exists, then the sum necessary to cover such shortfall shall be transferred to the fund from the Liquor Commission Fund established in RSA 176:16.

Statutory Calculation of the GAHCP Finances

	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026
Cost of Coverage for the Program	$540,381,295	$556,650,586	$581,767,612	$475,468,833	$613,854,198	$748,863,608
Administrative Costs	$1,417,237	$1,546,454	$1,501,831	$2,681,274	$3,018,012	$3,047,186
Total Program Costs	$541,798,532	$558,197,039	$583,269,443	$478,150,107	$616,872,210	$751,910,794
Less:						
Federal Reimbursement: Program & Admin	$487,219,024	$502,010,942	$523,572,072	$427,447,013	$542,663,946	$663,014,150
Actual/Est. Insurance Premium Tax Revenue	$8,603,891	$10,206,253	$11,252,390	$10,348,377	$10,518,324	$11,300,224
Alcohol Abuse, Prevention & Treatment Fund	$10,024,300	$10,328,200	$11,540,250	$11,794,136	$12,242,313	$12,609,582
Total Reimbursement & Tax Contributions	$505,847,215	$522,545,395	$546,364,712	$449,589,526	$565,424,583	$686,923,956
Remainder Amount	$35,951,317	$35,651,644	$36,904,731	$28,560,581	$51,447,627	$64,986,839
	$8,499,999	$8,736,916	$7,238,647	$0	$0	$0

The higher costs in SFY 2025 and SFY 2026 compared to SFY 2023 and SFY 2024 are primarily related to program payment and rate acuity changes to the Granite advantage enrolment population. In June of 2025 there was an agreement reached between the Department and the hospitals to transition away from Disproportionate Share Hospital (DSH) payments to a Directed Payment methodology. The increase in the directed payment approach allowed the Division of Medicaid Services to focus resources on Medicaid reimbursement to providers.

Costs associated with the federal share are drawn and reimbursed by CMS immediately after the payment is made by the State. The 26% increase in SFY 2025 costs compared to SFY 2024 is the result of the provider rate increases approved as part of HB2 2023. The rate increases included $33M attributable to the GAHCP population; the first full 12-month period of that expense occurred in SFY 2025. SFY 2026 was the first year the increased Directed Payment pool for larger in-state general acute care hospitals was included in the Managed Care Organization (MCO) capitation rates as a payment methodology. SB 249 of 2025 reduced the amount of Disproportionate Share Hospital (DSH) funding to in-state general acute care hospitals and increased the amount of funding related to the in-state general acute care hospital Directed Payment pool.

The composite rate for all individuals, under the current contract procurement, by the Medicaid Care Management Program for SFY 2026 excluding Directed payments for Amendment #4 was $620.44 compared to SFY 2025 Amendment #2 was $612.97, compared to the prior procurement SFY 2024 Amendment #11 was $519.81 and SFY 2023 Amendment #9 composite rate of $476.60. In addition, the provisions in the Managed Care Contract to protect against overfunding the Managed Care Organizations which is addressed in a Risk Settlement mechanism. The non-federal funds returned to the Granite Advantage Health Care Program Trust fund totaled $941,110 in SFY2021, $3,855,211 in SFY 2022,

$2,971,616 in SFY 2023, $1,187,783 in SFY 2024. There was a reconciliation of the MCO 2.0 contracting period (SFY 2020 through SFY 2024) and there was not a refund of non-federal dollars related to the overall contracting period in SFY 2025 or SFY 2026.

Respectfully Submitted,

For:

Lori A. Weaver
Commissioner